

# Medicare Advantage star ratings: COVID–19 impacts on 2021 and 2022 star rating calculations

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The healthcare industry relies heavily on historical claims data to assess performance of providers and health plans, including Medicare Advantage (MA) star ratings.

A star rating is closely tied to the revenue of Medicare Advantage organizations (MAOs) in two ways:

1. It impacts the revenue each MAO will receive from the federal government.
2. It also impacts members' enrollment decisions because each plan's star rating is displayed in Medicare Plan Finder.

Every month that passes with the COVID-19 pandemic significantly impacting our lives is another month of data that may be unreliable in making these assessments. The Centers for Medicare and Medicaid Services (CMS) has reacted rapidly to this issue.

This paper describes the changes outlined in the interim final rules (IFRs) published by CMS on March 31, 2020,<sup>1</sup> and August 25, 2020,<sup>2</sup> as they relate to the star rating program, and what they may mean to the MAOs expected to be most impacted.

## Star rating calculation basics

Every year, CMS calculates and publishes Part C and D star ratings indicating the performance of each Medicare Advantage contract. These ratings range from 1.0 to 5.0 stars. The full detail of the calculation methodology is beyond the focus of our paper. However, we discuss the basics to lay the groundwork for a discussion of how the final rules may impact plans.

Each year, CMS collects data from the following data sources:<sup>3</sup>

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys
- Health Outcomes Survey (HOS)
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Part C reporting requirements
- Part D reporting requirements
- Other administrative data, e.g., independent review entity (IRE), call center monitoring, prescription drug event (PDE) data, complaints tracking module (CTM), transition monitoring program analysis

For 2021, CMS used the data it collected to develop up to 46 unique quality and performance measures. Each measure is assigned a numeric score, which CMS then converts to a measure-level star rating. The measures are categorized into five weighting categories<sup>4</sup> related to different aspects of health plan services or patient care. The Part C and Part D summary ratings are then calculated by taking a weighted average of the measure stars for Parts C and D, respectively. For MA prescription drug (MA-PD) plans, CMS calculates a composite star rating using the weighted averages of all unique Part C and Part D measure stars. Lastly, CMS calculates the final overall star ratings with improvement measures included. The final overall star rating is determined based on the logic<sup>5</sup> summarized in Figure 1.

**FIGURE 1: OVERALL STAR RATING CALCULATION LOGIC**

INITIAL STAR RATING	FINAL OVERALL STAR RATING
<= 2.0	Same as star rating calculated without improvement measures
2.5 - 3.5	Same as the star rating calculated with improvement measures included
>=4.0	Higher of the star ratings calculated with and without improvement measures

<sup>1</sup> Full text available at <https://www.cms.gov/files/document/covid-final-ifc.pdf>. Retrieved February 11, 2021.

<sup>2</sup> Full text available at <https://www.cms.gov/files/document/covid-ifc-3-8-25-20.pdf>. Retrieved February 11, 2021.

<sup>3</sup> CMS (October 1, 2020). Medicare 2021 Part C & D Star Ratings Technical Notes. Retrieved February 11, 2021, from <https://www.cms.gov/files/document/2021technotes20201001.pdf-0>.

<sup>4</sup> The five weighting categories for 2021 star ratings are: outcomes, intermediate outcomes, patient experience/complaints, access, and process.

<sup>5</sup> CMS, Technical Notes, op cit.

Unlike the other measures, which are developed using the data collected from the sources listed above, improvement measures are calculated by comparing a contract's current and prior year measure scores for select measures, such as measure C01 (breast cancer screening), measure C02 (colorectal cancer screening), and measure C03 (annual flu vaccine).<sup>6</sup> Because contracts with high star ratings would have less room for improvement, CMS applies the hold harmless provision for contracts with a 4.0 or higher star rating. CMS assigns the highest weight (5.0) to the improvement measures, therefore any changes to measures that fall into the improvement category could potentially have significant impacts on star ratings.

It is also worth noting that star ratings are generally based on plan performance during a period before the year for which the ratings impact revenue. For example, 2021 HEDIS benchmarks are set using 2020 star rating data, which is collected in 2019 and reflects 2018 performance. It is important to recognize this long timeline as we consider how current and future star rating calculations will be impacted by the pandemic.

## Changes published in CMS IFRs

To address the challenges caused by COVID-19, CMS has published two IFRs since the beginning of the pandemic, one in March 2020 followed by the second in August 2020. Both IFRs outlined changes to the star rating program as a result of changing claims patterns and service disruptions due to COVID-19. These changes will impact ratings for the 2021 and 2022 calendar years (which affect MAO revenue in plan years 2022 and 2023, respectively).

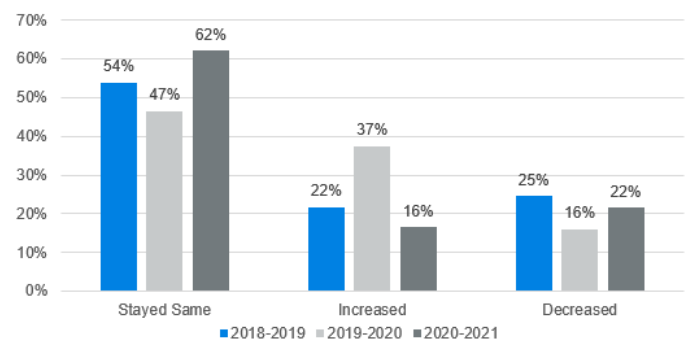
### IMPACT TO 2021 STAR RATINGS

For the 2021 star rating calculation, CMS eliminated 2020 HEDIS and Medicare CAHPS data collection in order to lessen the administrative burden on health plans during the pandemic. As a direct result, the 2021 star ratings were calculated based on the same HEDIS and Medicare CAHPS data used for calendar year (CY) 2020 ratings, which for HEDIS is based on the CY 2018 performance year, 2019 measurement year, and CAHPS survey data collected in 2019. The HEDIS/HOS measures (Monitoring Physical Activity, Reducing the Risk of Falling, and Improving Bladder Control) were not included in the set of measures, with

values being carried forward from the 2020 ratings.<sup>7</sup> For improvement measures that are based on HEDIS and CAHPS, CMS used earlier values from 2020 and 2019 ratings. For non-HEDIS-based and non-CAHPS-based measures, the data and calculation methods were unchanged from what was published in the April 2018 final rule.<sup>8</sup>

Based on our analysis of CMS's historical data for 2018 to 2021 star ratings from Part C and D performance data, the final overall impact of these changes is a higher number of contracts being assigned the same rating in 2021 as they had been in 2020, as seen in Figure 2.

FIGURE 2: CHANGES IN STAR RATING, 2018-2021



- About 62% of 2021 contracts received the same ratings as in 2020, which is about 10% to 15% higher than the proportion from 2018 and 2019. This is likely to be a result of using the same underlying HEDIS and CAHPS data for 2020 and 2021 star rating calculations because they account for more than 45% of the metrics.
- Only 16% of contracts have increased ratings from 2020 to 2021. This is a significant decrease compared to the 37% difference between the 2019 and 2020 ratings.
- 22% of contracts have decreased ratings from 2020, which is a larger percentage than the 2019 to 2020 rating comparison (16%).

<sup>6</sup> CMS, Technical Notes, op cit.

<sup>7</sup> CMS, Technical Notes, op cit.

<sup>8</sup> See full text at <https://www.cms.gov/files/document/covid-final-ifc.pdf>.

Because star ratings determine the rebate and quality bonus payment amounts received as revenue, the changes in rating methodology can impact plans differently. Plans that do not have strong star rating improvement programs and may have been expecting a reduction in their ratings may benefit by locking in their 2020 ratings for another year. In contrast, for plans that have been making strides toward increasing their star ratings, the decision to use the same HEDIS and Medicare CAHPS data as CY 2020 ratings may delay the return on their investments for at least another year.

For plans that may or may not have strong star rating improvement programs, the new policy could have a major financial impact. For example, on average, a plan that would have fallen from a 4.0 to a 3.5 star rating in 2021 will avoid a 3.3% reduction in revenue due to rebate and the quality bonus payment (QBP), while a plan that would have risen from a 3.5 to a 4.0 star rating in 2021 will miss an increase in revenue of around 3.4%.<sup>9</sup>

### IMPACT TO 2022 STAR RATINGS

The IFRs included several changes for 2022 star rating calculations. CMS will:

1. Replace measures calculated based on HOS data with earlier values that are not affected by COVID-19.
2. Expand the existing hold harmless provision for improvement measures to include all contracts.
3. Revise the definition of “new MA plan” to an MA contract offered by a parent organization that has not had another MA contract in the previous four years, so contracts started in 2019 will still be considered as new for 2022 star rating calculations.
4. Apply the Extreme and Uncontrollable Circumstances (EUC) policy to all contracts.

For 2022, star ratings for all contracts will receive the better of the ratings calculated with and without the improvement measures. This mostly affects existing contracts with ratings between 2.5 and 3.5, which otherwise could have received adverse adjustments from improvement measures.

Under normal circumstances, plans that entered the market in 2019 would have received a contract-level rating in CY 2022. However, due to the new IFR changes, their new contract status will still be in force in 2022, which means they will receive a 3.5% quality bonus payment (QBP). Based on previous Milliman research, “the average 2011 to 2018 star ratings for contracts coming off new contract star rating is 3.48,”<sup>10</sup> which would correspond to a 0% QBP. Thus, the IFR changes will be favorable for many of the plans that entered the market in 2019.

The EUC policy was developed to address the impacts on well-defined geographic areas due to natural disaster and not the nationwide impacts as a result of the COVID-19 pandemic.<sup>11</sup> The EUC policy states that if 60% or more of a contract’s enrollees are living in a Federal Emergency Management Association (FEMA)-designated Individual Assistance Area during an “emergency period,” then the contract is excluded from the measure-level cut point calculation for non-CAHPS measures and from the performance summary and variance thresholds for the Reward Factor.<sup>12</sup> If contracts have 25% or more of their enrollees living in FEMA-designated Individual Assistance Areas, then CMS considers those contracts as “affected contracts,” and the regulation allows those contracts to use the previous year’s measure-level rating and corresponding measure score if they are higher on most star rating measures.<sup>13</sup>

The IFR removes the 60% rule from the EUC policy, so the calculations for non-CAHPS measures and the determination of performance summary and variance thresholds for the Reward Factors are still relevant. By keeping the 25% rule nearly all contracts will be counted as “affected contracts,” and they will receive the higher of their measure-level ratings from 2021 or 2022 for the purposes of calculating 2022 star ratings. Thus, contracts that entered the market prior to 2020 will be able to take advantage of this new change.

<sup>9</sup> Calculated using \$700 bid amount and \$800 benchmark amount as proxy. Note that actual revenue shifts will vary based on a plan’s quartile and other factors.

<sup>10</sup> Backes, K.S., Friedman, J.M., Grzeskowiak, D.J. et al. (February 2018). Medicare Advantage Star Ratings: Expectations for New Organizations. Milliman Research Report. Retrieved February 11, 2021, from [http://assets.milliman.com/ektron/MedicareRR\\_20180222\\_appended2019.pdf](http://assets.milliman.com/ektron/MedicareRR_20180222_appended2019.pdf).

<sup>11</sup> Full text available at <https://www.cms.gov/files/document/covid-ifc-3-8-25-20.pdf>. Retrieved February 11, 2021.

<sup>12</sup> See full text at <https://www.cms.gov/files/document/covid-ifc-3-8-25-20.pdf>.

<sup>13</sup> Ibid.

## Conclusion

Star ratings are paramount to the success of Medicare Advantage contracts because of their impact to enrollment and financials. The financial incentives tied to higher ratings contribute to plan sustainability through increased revenue and potentially higher membership, while the operational requirements to attain higher ratings can result in greater member satisfaction and better health.

CMS is regularly making updates to the star rating program that are intended to improve equity of plan stratification across the star spectrum. However, the COVID-19 pandemic has forced some temporary changes that will delay recognition of increased ratings for some plans and reductions for others, while not significantly penalizing any plans for their pre-pandemic levels.

Even with these delays the overall incentive remains to always be working toward higher star ratings.



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