NEW PERSPECTIVES IN VALUE-BASED CARE:

Meeting Quality Measures to Improve Star Rating

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ABSTRACT

This paper will provide an overview of the Medicare Advantage (MA) Plan Star Rating system administered by the Centers for Medicare and Medicaid Services (CMS). The authors also consider the details of the recent fall in overall ratings for MA plans in 2023, highlighting changes in measures and what this means for providers, payers and beneficiaries. Finally, we consider ways by which plan providers and payers can improve their Star Ratings, including opportunities to utilize DataLink's product and service offerings to boost financial and operational performance.

The Relevance of MA Plan Star Ratings

In 2022, Medicare Advantage (MA) plans have enrolled over 28 million people which is nearly half of the eligible population (48%).[1] These alternatives to traditional Medicare plans have doubled their share of eligible Medicare beneficiaries since 2007 (19%) and are expected to record a significant rise by 2030.[2] Such immense potential for growth makes it imperative that the quality of the plans provided live up to the highest standards for efficiency.

The MA Star Rating is a tool developed in 2007 by CMS for providing data to help beneficiaries in choosing healthcare plans. The yearly ratings are released before the enrollment period (October 15 to December 7) for the following year, hence the ratings released in one year are labeled for the following year. The enrollment period allows beneficiaries to switch between traditional Medicare plans to an MA plan, change from one MA plan to another MA plan or change their Part D coverage.

The Star Rating system uses a 1-5-star system to score plans based on several data-based measures - 1 being assigned for the lowest performance and 5 for the highest. The quality and performance data used in the scoring system documents each plan's performance over 18 months. MA contracts with prescription drug (Part D) coverage (MA-PD) are evaluated on about 38 measures, MA-only contracts are evaluated on about 28 measures, while solely Part D contracts are evaluated on up to 12 measures. All of these measures apply to five major categories including outcomes, intermediate outcomes, patient experience, access and process. Each of these measure categories has a designated weight.

The evaluation system builds on the framework of CMS's Quality Strategy for improving quality, transforming the healthcare system and optimizing health outcomes. The numeric scores and star values for each measure are grouped appropriately to determine the overall rating of the plans. The data used in Star Ratings are obtained from four major sources which are CMS administrative data, health and drug plans, data obtained by CMS contractors and a survey of enrollees. Contracts are required to comply with the Health Effectiveness Data and Information Set (HEDIS®), Health Outcomes Survey (HOS) or Consumer Assessment of Healthcare Providers and Systems (CAHPS) reporting requirements to eliminate data biases and inaccuracies.

There is limited research to establish the impact of Star Ratings on patient outcomes in each plan. It is generally expected that plans with higher Star Ratings produce better outcomes and might have greater appeal to enrollees. While the Star Ratings serve as a guide for plan selection for beneficiaries, they should also serve as a pointer to aspects of the plan that need to be revised, for providers and payers. These ratings are not fully descriptive of health outcomes because measures detailing these outcomes, despite weighing highly, are outnumbered by others, such as administrative measures. Therefore, plan providers might be able to improve Star Ratings by paying more attention to these measures. Plans that can maintain a Star Rating of four and above are positioned more advantageously to attract and serve members appropriately as they remain financially stable.

Recent Fall in Star Ratings 2022–2023

The enrollment-weighted average Star Rating for MA plans was 4.37 stars in 2022. This was an all-time high in the 12 years that the rating program had been running. Consequently, this has been attributed to favorable changes in the evaluation of measures due to the COVID-19 public health emergency (PHE) and investments in improvement initiatives by plans. This unprecedented rise was an upturn from the 2021 average overall rating of 4.06 stars recording the largest increase ever recorded.[3] Similarly, the 2023 drop to 4.15 stars dethroned that of 2020 to 2021 (0.1 star) as the largest ever at 0.22 stars.[4]

Analysts predict that such changes in ratings could result in up to $800 million in revenue impacts by 2024.[5] Payers are rightly concerned about how the volatility in ratings will influence their earnings per share as this will influence what percentage of Medicare bonuses accrue based on Star Ratings in said year. MA Star Ratings determine whether a plan gets a bonus and the size of that bonus. Since it is also a measure of quality, it affects the plan's ability to challenge the benchmark rate in bidding. With higher rebate percentages, plans can enlarge their benefit offerings and provide more value to enrollees.

Only 57 MA contracts fell in the five-star category compared to 74 in 2022 and only 67 fell within the 4.5-Star Rating compared to 96 in 2022. At this rate, only about 72 percent of enrollees will get contracts that fall in the four or more stars category in 2023.[6] Enrollees will compare plan Star Ratings to decide which works for them, and we can expect that they will be looking out for specific measures that satisfy their needs in addition to considering the average Star Ratings for each plan.

Following the news about the decrease in Star Ratings from 2022 to 2023, plan providers and partners are looking for ways to increase Star Ratings to compete more favorably for enrollees. Understanding why the biggest rating drop was recorded between both years is fundamental for crafting a foolproof quality improvement plan for contracts. This is even more important if plans are to avoid the low-performing icon on the Medicare Plan Finder. Although no plans fell into this category in the 2022 ratings, one contract did fall in the 2023 ratings.

Since the 2022 Star Ratings were based on data from 2020, the boost in the rating has been attributed majorly to adjustments for extreme and uncontrollable circumstances enforced by CMS in response to the COVID-19 PHE. CMS reviews its methodology and measures from year to year, raising expectations for these kinds of changes. However, a major difference in the 2022 data was that rather than these adjustments being applied to a few measures in certain locations affected by disasters, it was applied to about 28 measures. Therefore, plans were allowed to use the better of approach to sorting current or historical data, retaining data in measures where there was a decline and recording only improvements. In the 2023 ratings, only three HEDIS® measures that were obtained from the 2021 Health Outcomes Survey (HOS) received COVID-19-related PHE adjustments.

In the October 6th report by CMS, the comparison of the 2022 and 2023 Part C and D Measure Star Ratings show minimal changes in either direction, across the board. This is important because these are the performance ratings for measures before the adjustments for extreme and uncontrollable circumstances are applied. Measures like complaints about a plan and members choosing to leave a plan, gives a picture of patient satisfaction and documents a decrease in scores. A correlation was also established between the Star Ratings and the length of time that Medical Advantage Prescription Drug (MA-PD) and Prescription Drug Plans (PDPs) have been running. Those that have been on for over 10 years are more likely to fall in the 4 or more stars category.

Part C and Part D improvement measures, including those for drug plan and health plan quality, also experienced a decline from 2022 to the 2023 Star Ratings. This comes after the increase recorded between 2021 and 2022 which could be attributed to increased investments and the availability of resources for plans and providers. The drop in the 2023 rating could be taken to reflect a lack of sufficient resources for the provider.

Certain changes to the rating system such as the removal of the Part C measure, Rheumatoid Arthritis Management are also documented; the drop in the weight of the Part D measure, Statin Use in Persons with Diabetes from 3 to 1 is also a notable change. The weight change is due to the change in measure class from an outcome measure to a process measure. Access measures and patient complaints/experience measures were raised in weight from 2 to 4. Finally, the Controlling Blood Pressure measure was moved from the display page into the rating system for 2023 and it weights one for the said year and three for years thereafter.

The introduction of guardrails from the 2023 rating year for non-CAHPS Part C and Part D measures that have been included in the rating program for over three years is a new adjustment that will surely affect how plans fare in future ratings. These guardrails are bi-directional caps (limits) on the movement of a measure cut points from the previous year's ratings. They will also not be applied to Part C and Part D improvement measures.

How Plans Can Improve Star Ratings

About 56% of eligible enrollees have Star Ratings as a top consideration when shopping for MA contracts.[7] As a result, only plan providers and payers that pay attention to improving their performance every year can compete favorably. A thorough performance analysis is necessary for all plans at the measure level if they are going to keep up with the changing CMS evaluation methodology and enjoy financial stability and other supplemental benefits. Such analysis will expose measures that were covered by the COVID-19 PHE provision and are more likely to record poor performances. The Star Rating system will continue to push the limits of quality requiring plans to outperform their last performance to maintain current ratings and stay profitable.

The Transition of Care (TRC) measure is essentially a process measure aimed at reducing readmission rates, improving patient experience, and reducing costs which are beneficial outcome for plans. The measure is single-weighted but is surely on its way to being triple-weighted.[1,7] Therefore, health plans must pay attention to facilitating successful transitions. Transitions of care are critical periods in a patient's care trajectory which relies heavily on the coherence of data. Therefore, plans can take advantage of this metric to improve the patient experience by ensuring seamless data collection, analysis and retrieval using continuity of care documents (CCDs) in an efficient EHR system. These documents can reduce the need to obtain patient data on a per-patient request basis by providing more than just diagnostic and procedure codes.

Plans that commit immense time and resources towards improving data interoperability and medication reconciliation will record improved patient experiences and might be better positioned to achieve higher ranking. CCDs can be used to collect SNOMED-CT and LOINC codes (international standards for identifying health measurements, observations and documents) in addition to CPT and ICD-10 codes to provide more robust documentation. These codes are used to document structured data elements that may not reflect on claims. Using LOINC codes, for example, to document data like Care for Older Adults (COA) and Blood Pressure (BP) measures compliments the need for CPT II codes. However, in our experience most smaller provider offices do not code CPT II for these measures as they are not billable codes. This emphasizes the dependence of the information format on the physician's style of documentation. Plans will benefit from this by avoiding the losses that result from miscommunication and misinterpretation-related medical errors.

Improvement measures hold the highest weight at five points per measure, making it wise to pay more attention to these in boosting plan performance and Star Ratings. Since they are fewer, however, measure groups like administrative and process measures which account for the majority could be the better way to go. Focusing on the measures that ultimately improve patient experience and by extension, health outcomes will help plans rank well and compete favorably. For example, blood pressure (BP) is captured at every visit and can provide data that shows how process and administrative adjustments are helping more patients maintain a healthy range. Glycated hemoglobin (HBA1C)

is another lab information that can be easily collected. Colorectal Cancer Screening (COL) and Breast Cancer Screening (BCS) are some of those that may not be captured by other methods of submission for HEDIS®, but these are also measures that merit increased focus to improve Star Ratings.

The CMS suggests that HEDIS® performance data provides pointers for risk adjustment and service quality optimization. The newest additions to HEDIS® address pediatric dental care, safety and appropriateness, diabetic care and social needs screenings and interventions. The Social Need Screening and Intervention (SNS-E) documents efforts by plans to improve social determinants of health (SDoH). The National Committee for Quality Assurance (NCQA) annually updates and releases measures in the Healthcare Effectiveness Data and Information Set (HEDIS®), providing new guidance to the healthcare industry.

DataLink Empowers Plans, At-Risk Provider Organizations to Boost Star Ratings

Led by professionals with decades of experience, DataLink has bench strength and unmatched capabilities to support organization goals in meeting NCQA HEDIS® measures that lead to exemplary CMS annual Star Ratings and optimal reimbursement.

Our solution, which has earned HITRUST and SOC2 certifications and uses FHIR®, HL7 and secure retrieval and data encryption, is designed for interoperability and access to data from all major Electronic Health Records that are meaningful use certified. Access to data from disparate sources optimizes quality, reduces administrative burdens, enables value-based care and enhances financial performance. These capabilities support communication with and visibility into all health plan operations in one point-of-care solution. Health plans and providers can count on DataLink's commitment to accurate data that enables them to create a data file to assist in closing care gaps, improve quality measures for preventive care and screenings and comply with treatment recommendations.

DataLink's Evoke360 platform is NCQA-certified for HEDIS® Health Plan and Allowable Adjustment Measures. Meeting highly demanding requirements across the board, this major accomplishment further validates our adherence to the highest quality standards and is empowering stakeholders to earn the Star Ratings they deserve. Evoke360's ability to help organizations improve quality scores and simplify healthcare navigation contributes to better outcomes.

DataLink is a year-round partner in organizational efforts to drive better member experiences, higher engagement in preventive care and chronic condition management – the elements needed to achieve improved Star Ratings on an annual basis.

CONCLUSION

The recent news of the drop in Star Ratings from the 2022 to 2023 rating report has raised questions about how plans will keep up with the CMS ratings which have recorded some methodological changes over the years. MA Star Ratings give an overview of a plan's performance which can be compared to other plans by patients shopping and selecting a plan during the enrollment period. The ratings also provide a challenge for plan providers and payers to identify loopholes in service quality and patient experience that merit additional work. This is essential because patients pay a lot of attention to the quality of the service they will be receiving vs. the outcomes recorded.

Recent changes in the CMS ratings, like in the inclusion of the BP control measure, SDoH, activities and weight changes for measures associated with access and patient experience from 2 to 4, reveal that the CMS wants plans to be more invested in improving the overall quality of their services. Only plans that can maintain a Star Rating of 4 stars and above consistently will maintain a competitive advantage that allows them to increase their enrollees. To avoid headwinds to growth in earnings per share, plans must conduct thorough analyses into their process and key measures that contribute to overall Star Ratings. This will provide a foundation for crafting a strategy for a smooth-running system and an improved patient experience.

Plans will benefit immensely from improved data acquisition, storage and access processes. This reduces the rate of errors from miscommunication and ensures that all the progress that payers are making in improving provider efficiency is duly reflected in processes and patient outcomes. Actionable data and seamless data flow are key elements for achieving successful transitions of care and improvement in other measures toward the plan performance and overall Star Rating.

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7. Ibid.