Issue Brief

Quality Ratings of Medicare Advantage Plans

Key Changes in the Health Reform Law and 2010 Enrollment Data

September 2010

Quality Ratings of Medicare Advantage Plans: Key Changes in the Health Reform Law and 2010 Enrollment Data

Prepared by Gretchen Jacobson, Anthony Damico, Tricia Neuman, and Jennifer Huang

Beginning in 2012, Medicare Advantage plans with the highest quality ratings will be rewarded with quality-based payments. Over the past several years, the Centers for Medicare and Medicaid Services (CMS) has collected information about the quality and performance of Medicare Advantage plans, and used this information to create a system for rating the relative quality of the Medicare Advantage plans. Ratings are posted on the Medicare.gov website to provide beneficiaries with additional information about the various Medicare Advantage plans offered in their area. CMS rates plans on a scale of 1 to 5 stars, with 5 stars representing the highest quality. The summary score provides an overall measure of a plan's quality, based on indicators related to quality of care, access to care, responsiveness, beneficiary satisfaction, and customer service.

This issue brief describes how quality ratings for Medicare Advantage plans are currently calculated. It explains key changes in the 2010 health reform law that will result in new bonus payments to plans that receive high quality ratings. The brief also analyzes data posted by CMS to examine the extent to which beneficiaries are enrolled in the highest rated plans, and builds on our previous work that found higher quality ratings among certain types of plans (primarily HMOs), not-for-profit plans, and plans with more years of experience.[1] This analysis does not attempt to assess the validity of the quality ratings; like the previous analysis, it examines the data posted by CMS to consider the implications for consumers and policymakers.

How Quality Ratings for Medicare Advantage Plans are Currently Calculated

In 2010, the 5-star quality scores for Medicare Advantage plans are based on standard performance measures that are derived from four sources: (1) the Healthcare Effectiveness Data and Information Set (HEDIS®), (2) the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), (3) the Health Outcomes Survey (HOS), and (4) CMS administrative data; the latter data includes information about member satisfaction and disenrollment, as well as plans' appeals processes, audit results, and customer service. CMS groups the individual quality measures into five domains: (1) staying healthy: screenings, tests, and vaccines; (2) managing chronic conditions; (3) ratings of health plan responsiveness and care; (4) health plan member complaints, appeals, and choosing to leave the health plan; and (5) customer service.

CMS assigns quality ratings at the contract level, rather than for each individual plan. This means that every Medicare Advantage plan covered under the same contract receives the same quality rating (and most contracts cover multiple plans). Each contract is assigned a number of stars for each of the individual quality measures, based on its performance relative to all others. The stars for the individual measures are then averaged to obtain an overall summary score for the contract. The individual quality measures are adjusted for patient characteristics, when possible. The CAHPS® responses, for example, are generally adjusted for age, education, mental and physical health status, eligibility for Medicaid, eligibility for Medicare Part D low-income subsidies, state of residence, and whether the survey was completed by the enrollee or a proxy. The composite score also takes into account whether contracts have demonstrated both high and stable quality ratings across all measures, relative to other contracts.

Contracts may improve their quality rating from one year to the next, but it is not possible for all contracts to significantly improve their quality rating in the same year because performance measures are scored on a relative scale (or "curve") for each measure.

Health Reform Law Establishes Quality-Based Payments for Plans in 2012

The health reform law of 2010, known as the Affordable Care Act of 2010, requires CMS to use a star rating system to reward highly-rated plans with higher payments, beginning in 2012.[2] Highly-rated plans will receive bonus payments that are based on the contract's benchmarks (i.e., the maximum amount Medicare will pay a plan in a specific county or region). In 2012, quality-based payments will be based on the quality ratings for the 2011 plan year, which will be posted by CMS in October of 2010.

- **Bonus payments for plans with 4 or more quality stars.** Plans that receive 4 or more stars will receive bonuses of 1.5 percent in 2012, 3.0 percent in 2013, and 5.0 percent in 2014 and later years; highly-rated plans in certain counties will receive double bonuses.[3]
- **Larger rebates for highly-rated plans that submit bids below the benchmark.** Plans receiving 4.5 or 5 stars that submit bids below the county or regional benchmark will be permitted to retain 70 percent of the difference between the benchmark and the plan bid (i.e., the "rebate").
  - Plans receiving 3.5 or 4 stars will retain 65 percent of the difference, and plans receiving less than 3.5 stars will retain only 50 percent of the difference.
  - Previously, all plans retained 75 percent of the difference between the plan bid and the benchmark; these changes will be phased-in between 2012 and 2014.
- **Bonuses and rebates for small or low enrollment plans.** In 2012, all small or low-enrollment plans will receive quality bonuses, and rebates of 70 percent of the difference between the bid and the benchmark; the Secretary of Health and Human Services is required to establish a method for computing quality ratings for small plans for 2013 and subsequent years.
- **Bonuses and rebates for new plans.** All new plans will receive quality bonuses (1.5 percent in 2012, 2.5 percent in 2013, and 3.5 percent in 2014) and rebates of 65 percent of the difference between the bid and benchmark in 2012 and subsequent years. New plans are defined as those offered by organizations that did not have a Medicare Advantage contract in the previous three years.

The agency also plans to update the current methodology for calculating the quality ratings for the 2011 plan year in September 2010. For example, CMS has discussed changing the scoring of individual quality measures by setting targets for measures so that all contracts with scores above the target will receive 4 stars for that measure.[4] CMS has also stated that, since plans have no opportunity to change their ratings for 2012, and little opportunity to change their ratings for 2013, the agency may modify and upwardly adjust the quality rating summary scores for the purpose of making bonus payments in 2012 and 2013 to allow plans some time to transition; specifically, all plans that receive a quality rating of 4 stars would receive a bonus payment, but some plans that receive 3.5 stars may also receive bonuses. CMS will also give insurers the opportunity to preview and appeal the data used to support the plan ratings in September 2010, although they will not be allowed to appeal quality measures derived from HEDIS®, CAHPS®, or HOS data, nor the methodology for determining the quality bonus payments.[5]

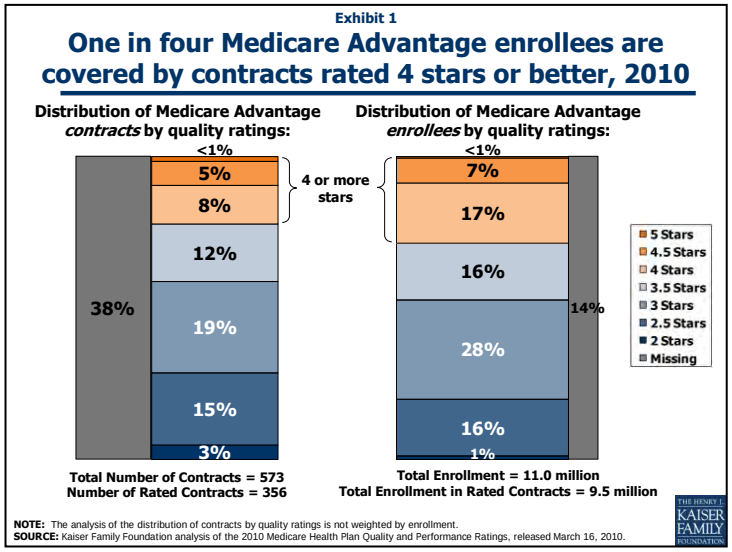
Also, beginning with the 2011 plan year, CMS will add a warning symbol next to all plans on Medicare.gov that receive less than 3 stars for three or more consecutive years.[6]

Enrollment in Medicare Advantage Plans in 2010 by Quality Ratings

The following analysis uses data published by CMS to examine the extent to which Medicare beneficiaries are enrolling in plans with high quality ratings. The analysis excludes Medicare Advantage plans that limit enrollment to certain types of Medicare beneficiaries, such as employer-direct contracts, Health Care Prepayment Plans (HCPPs), demonstrations, Program of All Inclusive Care for the Elderly (PACE) plans, and Religious Fraternal Benefit (RFB) plans. All reported differences are significant at the 95 percent confidence level.

Most Medicare Advantage Enrollees Are in Plans with Fewer than 4 Quality Stars.

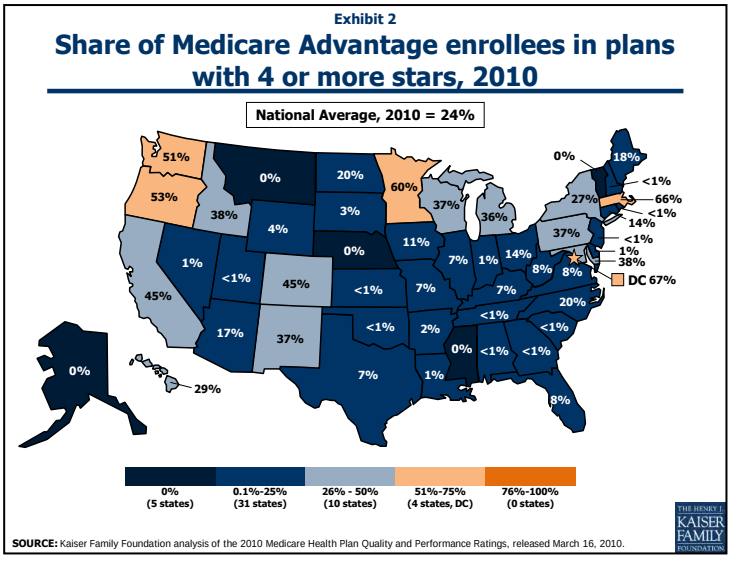
- Nearly one-quarter (24 percent) of all Medicare Advantage enrollees, including enrollees in unrated contracts, are covered under a contract receiving 4 or more stars --- the minimum quality rating needed to receive plan bonus payments beginning in 2012. However, the majority of Medicare Advantage enrollees are not currently enrolled in a highly-rated plan; nearly half (46 percent of all enrollees) are in a plan with 3 or fewer quality stars, and 17 percent are in contracts with fewer than 3 stars. **(Exhibit 1)**



- Medicare Advantage contracts received 3.32 stars in 2010, on average, weighted by 2010 enrollment. This average is similar to the average reported in December 2009 (3.27 stars), which was weighted by 2009 enrollment.
- Almost two-thirds (62 percent) of Medicare Advantage contracts for plans in 2010 received quality ratings; these contracts cover 86 percent of all beneficiaries in Medicare Advantage plans in 2010.
  - Conversely, 38 percent of contracts, accounting for 14 percent of all Medicare Advantage enrollees, did not receive quality ratings.

Enrollment in Plans with High Quality Ratings Varies Across and Within States.

- The share of Medicare Advantage enrollees in plans with 4 or more stars varies across states, ranging from 67 percent of all Medicare Advantage enrollees in DC to zero percent in five states (AK, MS, MT, NE, and VT). **(Exhibit 2)**
  - In 29 states, less than 10 percent of Medicare Advantage enrollees are in contracts with 4 or more stars, and in three of these states (NV, DE, and FL) more than 80 percent of Medicare beneficiaries have access to a highly-rated plan.
  - The share of Medicare Advantage enrollees in Medicare Advantage plans with 4 or more stars also varies across counties. **(Appendix Table A1)** In some counties, such as Hennepin, Minnesota (which includes Minneapolis) or Middlesex, Massachusetts (which includes Cambridge), more than two-thirds of Medicare Advantage enrollees are in a plan with 4 or more stars. Conversely, in other counties, such as Clark County, Nevada (which includes Las Vegas) and Cook County, Illinois (which includes Chicago), less than 1 percent of all enrollees are in contracts with 4 or more quality stars.

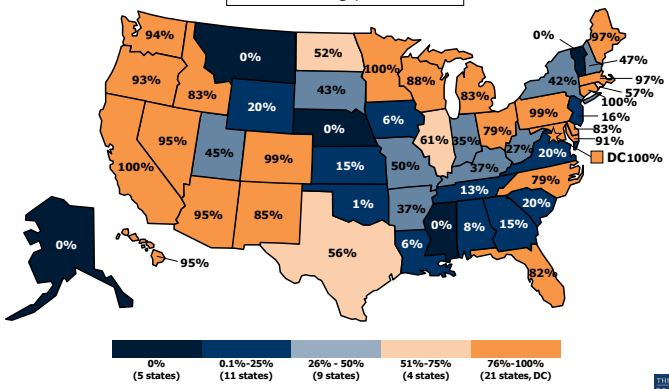


Access to Medicare Advantage Plans with High Ratings Also Varies by State and County.

- More than one-third of beneficiaries (37 percent) do not have access to a Medicare Advantage plan that received 4 or more stars; access to highly-rated plans varies greatly across states and counties. **(Exhibit 3; Exhibit A2** for counties with highly-rated plans**)**
  - The vast majority of beneficiaries living in the Western part of the country could enroll in a plan that received 4 or more stars. Similarly, with the exception of beneficiaries in Indiana, the majority of beneficiaries living in the Midwest could enroll in a highly-rated plan.
  - In 19 states and DC, more than 80 percent of beneficiaries could enroll in a plan receiving 4 or more stars; however, in nine states, less than 10 percent of beneficiaries could enroll in a plan receiving 4 or more stars, including 5 states (AK, MT, NE, MS, and VT) in which no beneficiaries would have this option.

Exhibit 3

Share of Medicare beneficiaries with access to a plan with 4 or more stars, 2010



SOURCE: Kaiser Family Foundation analysis of the 2010 Medicare Health Plan Quality and Performance Ratings, released March 16, 2010.

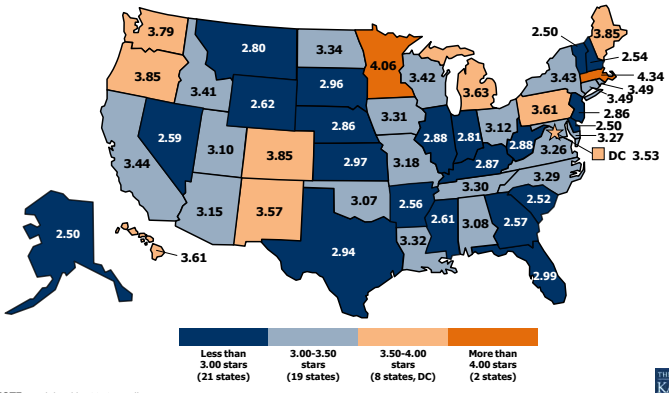
- In 24 percent of counties, every plan offered in the county received fewer than 3 stars, although, even all together, these counties account for just 2 percent of all Medicare Advantage enrollees and 8 percent of all Medicare beneficiaries. In these counties, every Medicare Advantage plan offered to enrollees will be posted on Medicare.gov with a warning flag, if the plan ratings remain below 3 stars for three consecutive years.

Average Quality Ratings for Medicare Advantage Plans Vary by State and County.

- Average quality ratings for Medicare Advantage contracts, weighted by 2010 enrollment, vary across states and within counties. **(Exhibit 4; Exhibit A3** for county differences**)**
  - In 27 states and DC, the average quality rating for Medicare Advantage contracts is between 3 and 4 stars.
  - In two states (MA and MN), the average quality rating for Medicare Advantage contracts is 4 or more stars, and the highest average quality rating is in Massachusetts.
  - The average quality ratings for Medicare Advantage contracts are lowest (2.50 stars) in Alaska, Delaware, and Vermont.

Exhibit 4

Average quality rating of Medicare Advantage contracts, by state, 2010



NOTE: Weighted by 2010 enrollment.
SOURCE: Kaiser Family Foundation analysis of the 2010 Medicare Health Plan Quality and Performance Ratings, released March 16, 2010.

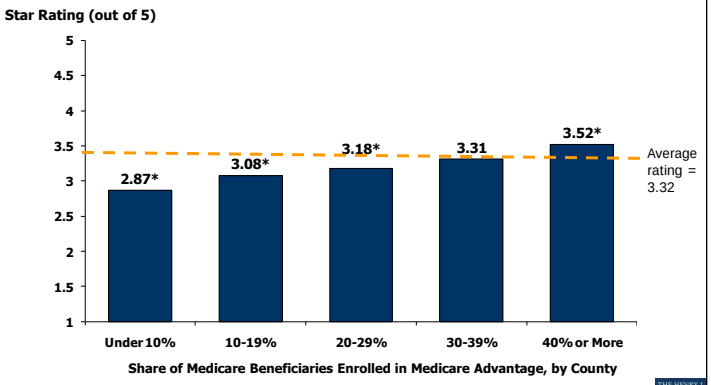
- In 24 percent of counties, the average quality rating for Medicare Advantage plans is less than or equal to 2.50 stars, and in 59 percent of counties, the average quality rating is less than 3.00 stars.

Quality Ratings are Higher in Counties with High Medicare Advantage Penetration.

- Average quality ratings are higher in counties with a large share of Medicare beneficiaries enrolled in Medicare Advantage plans, rather than Medicare fee-for-service. **(Exhibit 5)**
  - In counties with more than 40 percent of Medicare beneficiaries enrolled in Medicare Advantage plans, the average quality rating for contracts is 3.52.
  - In comparison, in counties with less than 10 percent of Medicare beneficiaries enrolled in Medicare Advantage plans, the average quality rating for contracts is 2.87.
  - Differences in average quality ratings based on Medicare Advantage enrollment penetration across counties remain statistically significant even after controlling for the type of plan, the tax status of the plan, and the year the plan's contract began --- plan features that previous work found to be significantly associated with quality ratings.[7]

Exhibit 5

Contracts covering counties with a greater share of Medicare beneficiaries enrolled in Medicare Advantage have higher average quality ratings, 2010



NOTE: Asterisks (*) denote differences that are significantly different from the mean at the p<0.05 level. Differences remain statistically significant after controlling for plan type, tax status of the plan, and year the plan's contract began.
SOURCE: Kaiser Family Foundation analysis of the 2010 Medicare Health Plan Quality and Performance Ratings, released March 16, 2010.

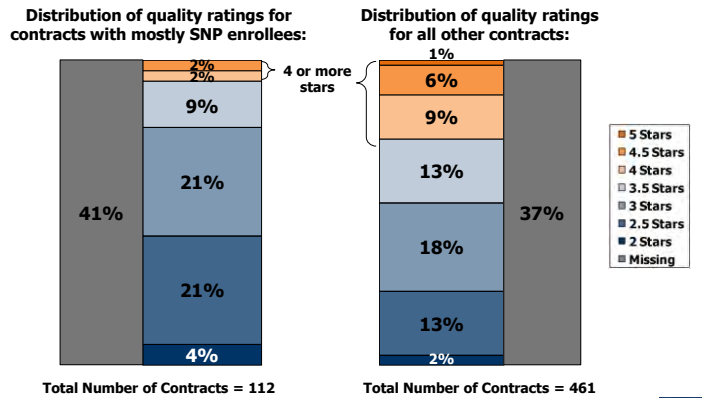
Quality Ratings for Special Needs Plans are Difficult to Discern.

There has been some interest in the quality of care provided by Special Needs Plans (SNPs), which are specialized plans that serve the most vulnerable Medicare beneficiaries, including beneficiaries who are dually eligible for Medicare and Medicaid, live in a long-term care facility, or have certain chronic conditions. There is very little information available on how well these specialized plans are serving the needs of vulnerable beneficiaries, and quality ratings for SNPs may, in theory, shed some light on this question. However, quality ratings for SNPs are not easy to analyze because SNPs and non-SNPs are often included in the same contract. More than 5.2 million Medicare beneficiaries in 2010 are enrolled in Medicare Advantage plans that include a SNP under the same contract, but only 1.3 million beneficiaries are enrolled in SNPs in 2010, leaving 3.9 million beneficiaries enrolled in plans that are not SNPs but are included with SNPs under the same contract.

To begin to look at the quality ratings of SNPs, we examined the quality ratings for the contracts with the majority of enrollees (more than 50 percent) in SNPs. For these contracts, we find consistently lower quality ratings (average of 2.92 stars) than all other contracts (average of 3.34 stars). **(Exhibit 6)**

Exhibit 6

Contracts with a majority of enrollees in SNPs have lower average quality ratings than other contracts



NOTE: SNPs are Special Needs Plans. Contracts with mostly SNP enrollees are those with at least 50% of the contracts' enrollees in SNPs. The distribution of quality ratings is not weighted by enrollment.
SOURCE: Kaiser Family Foundation analysis of the 2010 Medicare Health Plan Quality and Performance Ratings, released March 16, 2010.

The groups are not directly comparable, though, because in more than half (55 percent) of the contracts that include SNPs, the majority of enrollees are not in the SNPs. That is, contracts with the majority of enrollees in SNPs comprise only 45 percent of all contracts that include SNPs. Similarly, contracts with only SNP enrollees could not be analyzed because those contracts only comprise 29 percent of all contracts that include SNPs. Also, contracts with the majority of enrollees in SNPs are slightly more likely than all other contracts to be missing quality ratings (41 percent compared to 37 percent).

At this time, it is difficult to draw conclusions from the current quality ratings regarding differences between SNPs and non-SNPs. Beginning with plan year 2011, CAHPS® and HOS will oversample SNPs within each eligible contract "to allow for a more focused analysis of SNP results."[8] CMS is currently analyzing aggregate SNP data and has stated that the findings will be publicly shared in a report to be released in late 2010.

Implications

In a previous analysis, we found quality ratings tend to be higher among HMOs, more experienced plans, and not-for-profit plans. In this analysis, updated for 2010 enrollment, we find one-quarter of Medicare Advantage enrollees nationwide covered by contracts receiving 4 or more stars --- the minimum quality rating needed to receive bonus payments beginning in 2012. At the other end of the spectrum, most enrollees are in plans with less than 4 quality stars, and 17 percent of enrollees are in contracts with fewer than 3 quality stars.

Enrollment in and availability of highly-rated contracts varies greatly by state and county. In 32 states, less than 20 percent of Medicare Advantage enrollees are covered by contracts that received 4 or more stars. Some beneficiaries are not enrolled in plans with high quality ratings because they select their plan based on factors unrelated to the plan rating, such as the plan's premium, the additional benefits offered by the plan, and whether their physician is included in the plan's network. Also, it is not clear how many beneficiaries use Medicare.gov to select their Medicare Advantage plan, and thus many may not know how their plan rated relative to others in the area. Other beneficiaries live in areas in which all plans received either average or low quality ratings. In five states, every contract received fewer than 4 stars, and in 24 percent of counties (with 2 percent of all Medicare Advantage enrollees), every contract received fewer than 3 stars.

Beginning in 2012, Medicare will begin to use the quality rating system to provide bonuses to Medicare Advantage plans. Policy researchers have discussed doing this for many years as a way to improve the quality of care provided to all Medicare beneficiaries.[9] Still, this represents the first time Medicare Advantage plans will be rewarded for quality. A careful review of the current rating system is warranted to be sure that the ratings are a valid and meaningful measure of a plan's quality, particularly now that the quality ratings will be used for payment purposes. CMS is currently reviewing the quality ratings, which may affect the future distribution of quality-based payments. More information is also needed about the quality of SNPs, given that SNPs serve a particularly disadvantaged population and enrollment in the specialized plans continues to increase. Such information about SNP quality and SNP-specific quality ratings would help beneficiaries eligible for SNPs to decide whether to enroll in a SNP, and to distinguish between highly-rated and poorly-rated plans. The new quality-based payments will shine a brighter light on the Medicare Advantage plan quality ratings, particularly with respect to how they are applied, and their implications for plans and beneficiaries.

---

[1] See Jacobson G, Damico A, Neuman T, and Huang J. "What's in the Stars? Quality Ratings of Medicare Advantage Plans, 2010," December 2009.
[2] All Medicare Advantage plans, except PACE plans, are eligible for bonus payments. Plans that do not report the data necessary to compute quality ratings will be given a rating of less than 3.5 stars.
[3] Qualifying counties are defined as those with 1) the Medicare Advantage benchmark equal to the urban floor in 2004; 2) at least a 25 percent penetration rate for Medicare Advantage as of December 2009; and 3) per capita fee-for-service spending lower than the national average expenditures for Medicare fee-for-service beneficiaries.
[4] See Centers for Medicare and Medicaid Services, "Part C and D User Call," June 16, 2010.
[5] HEDIS data is required to be formally approved by auditors before health plans submit the data to CMS. Plans cannot appeal the validity of the data from CAHPS and HOS because the information comes directly from enrollees.
[6] See Centers for Medicare and Medicaid Services, "Update on the Plan Rating System and Plan Finder Tool," August 16, 2010.
[7] Conclusion based on a linear regression of the effect of Medicare Advantage penetration, the type of plan, the plan tax status, the year the plan's contract began (prior to 2005 or later) on a plan's quality rating.
[8] See Centers for Medicare and Medicaid Services, "2011 Call Letter for Medicare Advantage and Medicare Prescription Drug Plans," April 5, 2010.
[9] For example, see Etheredge L, Berenson R, and Ebeler J. "Quality Incentives for Medicare+Choice Plans," Health Insurance Reform Project; no. 11, August 2002.

Appendix

Unrated Plans. CMS does not publish quality ratings for a plan if it is missing too much data to calculate a score for a given component of the summary score. Relatively newer plans are less likely than older plans to have ratings because of missing data. All plans offered for the first time in 2009 or 2010 do not have quality ratings for the 2010 plan year, because the plans would be missing data from both HEDIS® and HOS which collected information in 2008. Data was collected for HEDIS®, CAHPS®, and HOS between January and December 2008, February and June 2009, and April and August 2008, respectively. Very few plans offered for the first time in 2008 were rated for 2010. Plans with relatively low enrollment are also more likely to be missing data because contracts with less than 500 enrollees are not required to report HEDIS® data to CMS. PFFS plans are more likely than other plan types to be missing data and therefore not have quality ratings because many PFFS plans are relatively new and were not required to report HEDIS® measures until calendar year 2010.

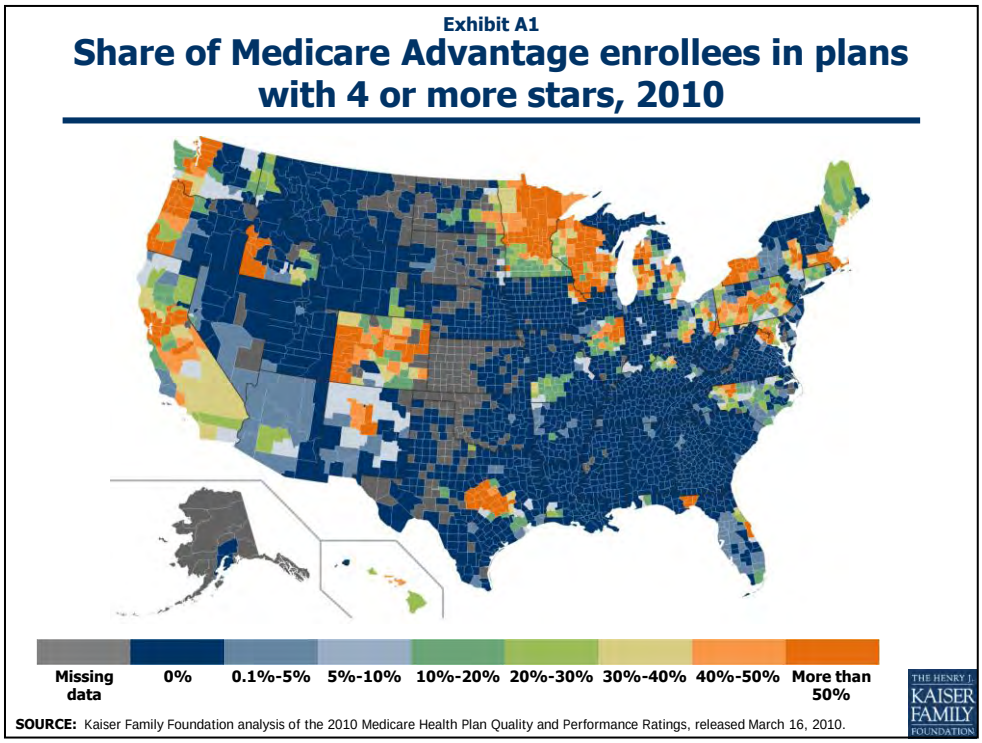
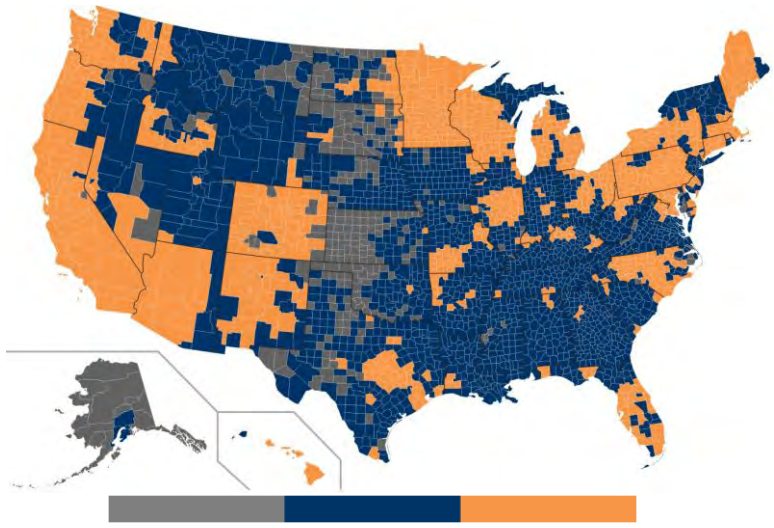


Exhibit A2

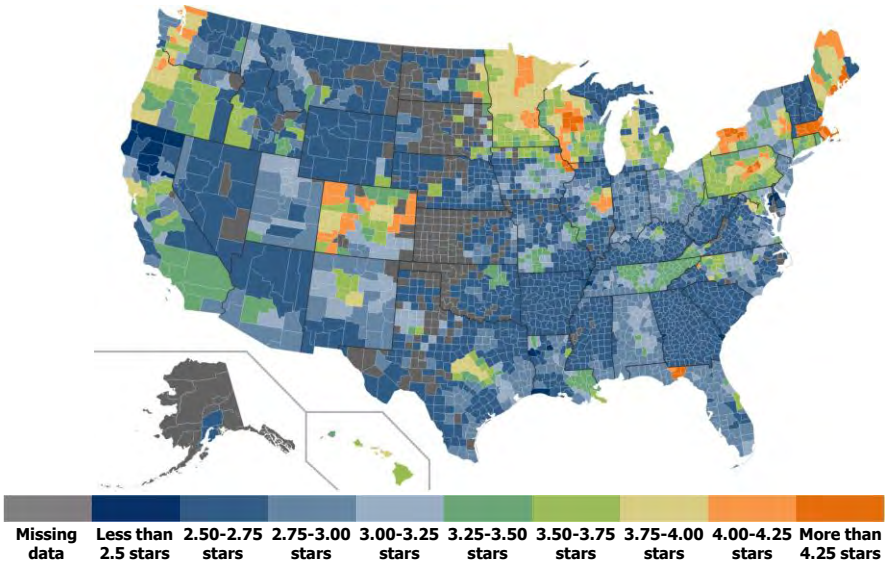
Location of Medicare Advantage plans with 4 or more stars, 2010



SOURCE: Kaiser Family Foundation analysis of the 2010 Medicare Health Plan Quality and Performance Ratings, released March 16, 2010.

Exhibit A3

Average quality rating of Medicare Advantage contracts, by county, 2010



NOTE: Weighted by 2010 enrollment.
SOURCE: Kaiser Family Foundation analysis of the 2010 Medicare Health Plan Quality and Performance Ratings, released March 16, 2010.

Table A1. Share of Medicare Advantage enrollees in plans with 4 or more stars among counties with the largest number of Medicare beneficiaries in the state, 2010.

State	County in each state with the largest number of Medicare beneficiaries	Number of available plans with 4+ stars	Number of Medicare beneficiaries in the county	Number enrolled in Medicare Advantage plans	Number of Medicare Advantage enrollees in plans with 4+ stars	Share of Medicare Advantage enrollees in plans with 4+ stars
AL	Jefferson	0	110,533	44,058	-----	-----
AK	Anchorage	0	25,564	74	-----	-----
AZ	Maricopa	9	473,101	204,135	54,571	27%
AR	Pulaski	1	59,569	7,258	48	1%
CA	Los Angeles	4	1,147,209	431,843	169,512	39%
CO	Jefferson	3	73,401	37,784	17,653	47%
CT	Hartford	2	147,330	28,442	5,226	18%
DC	Washington	1	77,413	7,476	4,983	67%
DE	New Castle	2	76,942	3,494	35	1%
FL	Miami-Dade	2	363,499	183,485	34,394	19%
GA	Fulton	2	94,771	22,632	53	<1%
HI	Honolulu	2	145,061	61,493	17,283	28%
ID	Ada	2	47,161	18,712	10,558	56%
IL	Cook	3	694,447	65,313	141	<1%
IN	Marion	1	118,224	20,449	35	<1%
IA	Polk	0	54,502	8,509	-----	-----
KS	Sedgwick	0	67,418	9,010	-----	-----
KY	Jefferson	2	120,269	27,608	3,893	14%
LA	Jefferson	0	69,512	34,958	-----	-----
ME	Cumberland	1	47,939	7,271	1,233	17%
MD	Baltimore	1	128,891	12,012	3,300	27%
MA	Middlesex	4	219,027	50,285	34,403	68%
MI	Wayne	3	287,722	47,621	22,146	47%
MN	Hennepin	5	148,343	68,606	51,044	74%
MS	Hinds	0	34,843	6,668	-----	-----
MO	St. Louis	1	165,751	46,588	3,252	7%
MT	Yellowstone	0	23,379	5,027	-----	-----
NE	Douglas	0	65,132	12,742	-----	-----
NV	Clark	4	230,158	82,656	482	1%
NH	Hillsborough	1	57,195	5,523	19	<1%
NJ	Bergen	0	144,352	14,947	-----	-----
NM	Bernalillo	2	92,283	39,205	18,443	47%
NY	Kings	0	304,690	102,650	-----	-----
NC	Mecklenburg	3	93,872	15,204	3,553	23%
ND	Cass	1	16,685	1,753	716	41%
OH	Cuyahoga	2	224,500	77,248	1,192	2%
OK	Oklahoma	0	102,166	20,503	-----	-----
OR	Multnomah	5	91,183	48,790	29,339	60%
PA	Allegheny	3	233,071	140,081	57,725	41%
RI	Providence	1	102,723	37,573	65	<1%
SC	Greenville	1	69,944	15,274	27	<1%
SD	Minnehaha	3	24,660	2,452	175	7%
TN	Shelby	1	115,566	20,131	23	<1%
TX	Harris	3	371,860	105,520	11,465	11%
UT	Salt Lake	1	100,984	38,221	15	<1%
VT	Chittenden	0	21,769	833	-----	-----
VA	Fairfax	2	106,554	10,368	7,076	68%
WA	King	7	233,436	60,981	36,523	60%
WV	Kanawha	0	41,128	10,826	-----	-----
WI	Milwaukee	1	132,566	35,768	106	<1%
WY	Laramie	1	13,729	1,015	130	13%

SOURCE: Kaiser Family Foundation analysis of the 2010 Medicare Health Plan Quality and Performance Ratings, released March 16, 2010.
NOTE: The denominator of the share of enrollees in plans with 4 or more stars includes enrollees in unrated contracts.

The Henry J. Kaiser Family Foundation

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
(650) 854-9400 Fax: (650) 854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
(202) 347-5270 Fax: (202) 347-5274

www.kff.org

This publication (#8097) is available on the Kaiser Family Foundation's website at www.kff.org.