REVEL EXECUTIVE BRIEF

2020 Medicare Star Ratings Release and Trend Report

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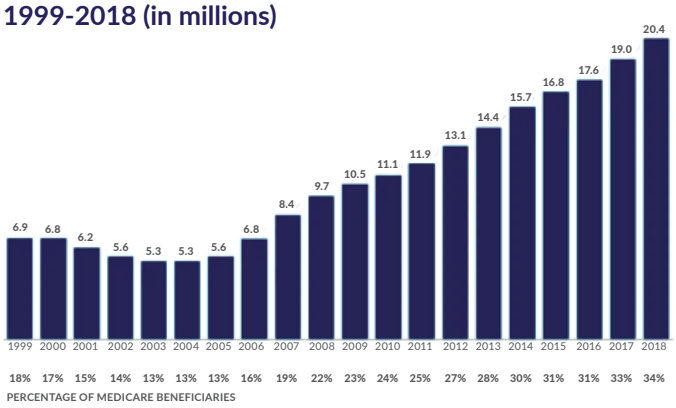
Background

The Medicare Advantage ("MA") Star Ratings program dates back to 2009 (affecting 2010 plan years), back before the quality bonus program existed with 22 of the measures being consistently used throughout the years. The rating's genesis was from the desire to inform beneficiaries about MA plan quality, but subsequently also used as the basis for calculating health plan bonus payments. The Affordable Care Act authorized bonus payments to plans with 4 (out of 5) Stars or more as a way to incent plans to improve quality.[1] These bonus payments can be used to (1) reduce the member premium, or (2) provide supplemental or enhanced benefits. Plans are leveraging these dollars to create a more attractive set of benefits and increase membership.

Exhibit 1: Total Medicare Advantage Enrollment, 1999-2018 (in millions)

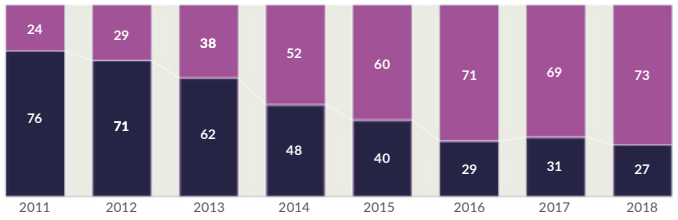


NOTE: Includes cost plans as well as Medicare Advantage plans. About 61 million people enrolled in Medicare in 2018. SOURCE: Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2018, and MPR, 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is April.

Plan Improvement Trend

The Stars program has had a validated impact on plan performance and member health. Twenty million Medicare beneficiaries (34%) are enrolled in an MA plans, compared to 2012 where penetration was 27% (13 million enrollees)(Exhibit 1).[2] As shown in Exhibit 2, the percentage of MA-PD members in plans with 4 or more Stars has risen from 24% to 73%.[3] These enrollees are receiving the extra benefits associated with quality bonuses (e.g., reduced premiums, additional vision or dental coverage, and other additional benefits).[4]

Exhibit 2: Percentage of MA-PD Plan Enrollees by Star Ratings



MA-PD, Medicare Advantage prescription drug.
SOURCE: CMS Star Ratings fact sheet (2013-18)

A recent study reviewed performance data for 16 clinical quality measures and 6 patient experience measures for 9.9 million beneficiaries living in California, New York, and Florida. MA outperformed FFS on all 16 clinical quality measures and MA enrollees reported better experiences overall.[5]

Another recent study by Avalere Health found that MA patients with chronic conditions had 23% fewer inpatient stays and 33% fewer emergency room visits compared to FFS Medicare.[6] Medicare Advantage outperformed FFS Medicare on several quality measures, including a nearly 29% lower rate of all potentially avoidable hospitalizations (17% versus 24% in FFS Medicare), 41% fewer avoidable acute hospitalizations, 18% fewer avoidable chronic hospitalizations, and higher rates of preventive screenings/tests, including LDL testing (5% more) and breast cancer screenings (13% more).[7] While some of this may be due to the fact that the ACA eliminated cost-sharing for preventive screenings, much of it is due to the MA plans investing in additional services and programs to manage beneficiaries in unique ways. Medicare Advantage provides more preventive services and utilizes interventions designed to better manage chronic conditions, which may avert preventable complications and result in lower overall costs.

Impact

Plan consolidation has been a driver of improved star ratings. When a poor performing plan is acquired by a higher rated one, the poorer performing plan assumes the higher plan's Star Rating. As a result, in the past few years, Star Ratings have been a factor in the increasing rate of plan consolidation: 724 plans changed contracts between 2015 and 2018, compared with 361 between 2011 and 2014.[8] In 2017, approximately 1.3 million additional enrollees were in plans receiving a bonus because their plans moved from a non-bonus contract to a bonus-eligible contract.[9] As referenced above, largely due to plan consolidation, two-thirds of enrollees are in a four or higher Star plan.[10] The improved Star Ratings continue a cyclical process of enabling additional benefits and premium reductions.

In addition, high plan satisfaction continues the trend in members moving from FFS to MA plans. In the 2019 CAHPS survey results, MA continued to outperform FFS across all domains.[11] Offering a better member experience, more expansive and diverse benefits, and a more consumer-centric approach fosters a halo effect and is high accretive to consumer satisfaction.

Direct and indirect consumer satisfaction accounts, in some manner, for 40% of Star Ratings. Plans with higher Stars sustain high growth since these plans can offer better enhanced benefits, which contributes to satisfaction, better health, and high member retention and acquisition.

Criticism

While the Stars program has produced many benefits, there is concern that since Stars are assigned at the MA contract level, and these contracts can cover noncontiguous geographic areas, Stars aren't an accurate measurement of quality for comparing different plans in the same location. Additionally, and as described above, the market is experiencing hyper consolidation so when a higher performing plan acquires a lower performing one, the lower performing takes on the more favorable higher rating. While this boosts lower performing plan Star Ratings, it can misrepresent the level of performance and hide areas of concern.

Further, the tournament model approach (instead of absolute targets), where plans are scored relative to their peers/ranked on a curve, creates tremendous difficultly for MA plans to know the targets in advance and to plan accordingly.

2020 Technical Notes

On September 9th, 2019 CMS released the Draft Medicare 2020 Part C and D Star Ratings Technical Notes. Annually, this, and the actual Medicare Advantage Plan Star Ratings, are long-awaited government publications that set forth CMS's quality strategy for the program cycle, changes in reimbursement methodology, and lists the methods by which plans qualify for reimbursement modifications. This provides insight into historical achievement of certain standards as well as the government's priorities. Depending on the health plan's ratings, this also can reestablish priorities, areas of focus, and financial projections.

Changes

The following is a summary of the Star areas impacted by the technical notes:

Changes to Existing Ratings	
C30 Health Plan Quality Improvement	Adds C21 (Statin Therapy for Patients with Cardiovascular Disease) to the measure
D06 Drug Plan Quality Improvement	Adds D14 (Statin Use in Persons with Diabetes)
D10, D11, D12 Medication Adherence of Diabetes Medication, Hypertension, and Cholesterol	Excludes beneficiaries electing to receive hospice care at the time in the measurement period per PQA measure specifications
D12 Medication Adherence for Cholesterol	Excludes beneficiaries with ESRD per PQA measure specifications
D13 MTM Program Completion Rate for CMR	Per the PQA measure specifications, included beneficiaries who were enrolled in the contract's MTM program for less than 60 days at any time in the measurement year in the denominator and numerator if they received CMR during this timeframe. Beneficiaries who were enrolled in the contract's MTM program for less than 60 days at any time
New Star Ratings	
	None
Moved to Display Page	
Controlling Blood Pressure	Moved for the 2020 and 2021 Rating years since NCQA is making changes to the measure specifications
Retired	
Adult BMI Assessment and Part D Appeals Measure	Beginning in the 2022 Star Ratings

Largest Changes

Reward Factor

CMS applies a reward factor for plans that demonstrate consistently high performance across a number of measures. The range of factors applied for high performance is 0.1 to 0.4 Stars. This adjustment can have a meaningful impact on the final MA Star Rating. In many scenarios it can increase a plan's performance from 3.5 to 4 Stars – a critical bonus payment threshold that creates a substantial competitive advantage.

In 2018, the 65th threshold for the reward factor was 3.70. In 2019, the 65th threshold for the reward factor threshold is 3.86. The .16 minimum threshold increase is a large change and has impacted plans in several ways:

- Plans that were at 3.70 or above in 2018 now require an approximate 10 Star improvement in 2019 to fall within the minimum range for the reward factor.

- This change signals that many plans improved their ratings from 2018 to 2019 which is positive for beneficiary choice and cost.
- The threshold should contain the same percent of plans as last year; to be in the top 45% of all plans in 2019 the threshold increase from 3.70 to 3.86 signifies this top percentage of plans increased their Star Ratings.
- Conversely, those plans who qualified for the threshold last year may no longer benefit and could see a decrease in Star Ratings.
- Those plans that improve their contracts can offer additional supplemental benefits and a greater divide exists between high and low performing plans.

The following demonstrates an example of this change:

2019 Performance Summary Thresholds

STATINS	IMPROVEMENT	PERCENTILE	PART C RATING	PART D RATING (MA-PD)	PART D RATING (PDP)	OVERALL RATING
With	With	65th	3.635514	3.923077	3.636364	3.710345
With	Without	65th	3.670103	3.866667	3.511111	3.703125
Without	With	65th	3.639175	3.960000	3.698113	3.711111
Without	Without	65th	3.678161	3.906977	3.488372	3.720930

2019

STATINS	OVERALL RATING
With	3.71
With	3.70
Without	3.71
Without	3.72

2020 Performance Summary Thresholds

STATINS GONE	IMPROVEMENT	PERCENTILE	PART C RATING	PART D RATING (MA-PD)	PART D RATING (PDP)	OVERALL RATING
	Without	65th	3.831325	4.095238	3.844444	3.874016
	With	65th	3.806452	4.072727	3.886364	3.859155

2020

STATINS	OVERALL RATING
Without	3.87
With	3.86[12]

Cut Point Changes

For Part C, the measures that increased in difficulty are Care for Older Adults Medication Review (C09), and Medication Reconciliation Post-Discharge (CC19). Those that became easier most frequently are Rheumatoid Arthritis Management (C16) and Osteoporosis Management for Women Who Had a Fracture (C12).

For Part D, the measures increasing in difficulty include Appeals Auto-Forward (D02) and Appeals Upheld (D03). Those becoming easier are Call Center – Foreign Language Interpreter and TTY Availability (D01) and MTM Program Completion Rate for CMR (D13).

Part C Largest Changes

2 STAR

MEASURE	INCREASE/DECREASE DIFFICULTY
Care for Older Adults Medication Review	↑
Care for Older Adults Functional Status	↑
Medication Reconciliation Post-discharge	↑
Rheumatoid Arthritis Management	↓

3 STAR

MEASURE	INCREASE/DECREASE DIFFICULTY
Care for Older Adults Medication Review	↑
Care for Older Adults Pain Assessment	↑
Medication Reconciliation Post-discharge	↑

4 STAR

MEASURE	INCREASE/DECREASE DIFFICULTY
Care for Older Adults Functional Status	↑
Osteoporosis Management in Women Who Had a Fracture	↓
Diabetes Care - Blood Sugar Controlled	↓

Part D Largest Changes

2 STAR

MEASURE	INCREASE/DECREASE DIFFICULTY
Call Center - Foreign Language Interpreter and TTY Availability (PDP)	↑
Call Center - Foreign Language Interpreter and TTY Availability (MAPD)	↓
Appeals Auto-Forward (PDP, MAPD)	↑
Appeals Upheld (PDP, MAPD)	↑
Members Choosing to Leave Plan	↓

3 STAR

MEASURE	INCREASE/DECREASE DIFFICULTY
Call Center - Foreign Language Interpreter and TTY Availability (MAPD)	↓
Appeals Auto-Forward (PDP, MAPD)	↑
Appeals Upheld (PDP, MAPD)	↑
MTM Program Completion Rate for CMR (PDP)	↓

4 STAR

MEASURE	INCREASE/DECREASE DIFFICULTY
Call Center - Foreign Language Interpreter and TTY Availability (MAPD)	↓
Appeals Auto-Forward (MAPD)	↑
MTM Program Completion Rate for CMR (PDP and MAPD)	↓

Part C Largest Changes

5 STAR

MEASURE	INCREASE/DECREASE DIFFICULTY
Monitoring Physical Activity	↓
Osteoporosis Management in Women Who Had a Fracture	↓
Rheumatoid Arthritis Management	↓
Medication Reconciliation Post-discharge	↑

Part D Largest Changes

5 STAR

MEASURE	INCREASE/DECREASE DIFFICULTY
Call Center - Foreign Language Interpreter and TTY Availability (MAPD)	↓
Appeals Auto-Forward (MAPD)	↑
MTM Program Completion Rate for CMR (PDP and MAPD)	↓

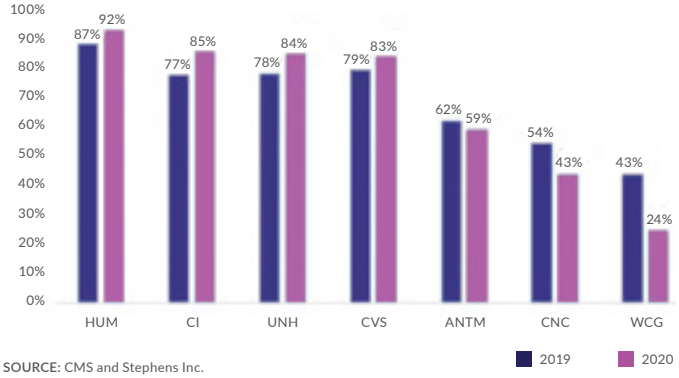
New 2020 Stars

On average and since 2017, Star Ratings and the number of 4 and 5 Star MA plans have increased. In 2020, there were 4.99% 5 Star MA plans compared to 3.72% in 2019, and 29.43% 4 Star MA plans compared to 25% in 2019. Further, the number of 3 and 2.5 Star plans decreased from 2019 to 2020.

Part D high performing plan performance has varied more with the number of 5 Star plans decreasing in 2020 to 3.70% compared to 7.69% in 2019. The number of 4 Star Part D plans has remained relatively stable, the percent of 3.5 Star plans increased by 10% and 3 Star plans decreased by 5%. However, 2.5 Star Part D plans increased from 3.85% to 5.56%.

As it relates to members, 81% of enrollees are in contracts with 4 or more Stars (in 2019 there were 69%). Exhibit 3 shows that WellCare Health Plans and Centene Star Ratings came in lower overall, while United Healthcare, Cigna, and Humana Stars went up.

Exhibit 3: MA Membership Mix in 4+ Star Plans, by MCO, 2019 vs. 2020



SOURCE: CMS and Stephens Inc.

In addition, fifteen Plans went from 3.5 to 3 Star, and 21 moved from 4 Star to 3.5 or below. The impact of losing Star Ratings is large and demonstrated through the following example:

> **Plan A is a 500K member plan, with a bid of $796 and benchmark of $805. The following is the difference in impact per month between a 3.5 and 4 star plan.**

STARS	PLAN 3.5	PLAN 4.0
Plan Bid	$796	$796
Quality Bonus Payment	0%	5%
MA Benchmark	$805	$845
Savings	$9	$49
Rebate Percentage	65%	65%
MA Rebate	6	32
Monthly Rebate	$2,925,000	$16,006,250
Marginal Impact Per Month		$13,081,250

The chart represents a 29% reduction in rebates that can be distributed, with no additional cost to the member, through new supplemental programs and services not otherwise covered and/or reduced premiums. Articulated in more concrete terms, the difference between a 3.5 and 4 Star plan is $13M per month or $156M annually in risk.

In addition, a sensitivity analysis in Table 4 demonstrates the impact to the rebate when there is either an increase or decrease in Star Ratings. The highest marginal impact comes between 3.5 and 4.0 Stars demonstrating the criticality in maintaining 4 Star status.

PER MEMBER PER MONTH BENEFIT CHANGE		2020 STAR RANK			
		4.5	4.0	3.5	3.0
2019 STAR RANK	4.5	$0	-$7	-$33	-$48
	4.0	$7	$0	-$26	-$41
	3.5	$33	$26	$0	-$15
	3.0	$48	$41	$15	$0

Plan year 2020 is the first year the industry is experiencing the expansive supplemental benefits offered by plans. Many of these benefits are targeting specific Star Ratings for improvement. For example, we know that for C18 – Reducing the Risk of Falling – the average Star Rating went down from 3 to 2 Stars. As a result, the industry will likely see plans start to invest more heavily in items that help improve this area such as: shower and home guardrails, technology that senses falls, and home providers that can assist with daily activities to prevent additional falls or accidents. Some plans are investing in building homes or apartments for seniors at particular risk, and others creating dietary food packages that target improving individual conditions, such as diabetes. With transportation continuing to be a core barrier for seniors, most plans are investing in better transportation programs and leveraging technology, such as Lyft or Uber, to make seeing a doctor an easier and barrierless process.

Investments in 2020 and beyond will continue to support the benefits that help improve MA members conditions and create a better competitive benefit design. In addition, these benefits don't simply target the condition but also address the circumstances that exacerbate conditions – social determinants of health. For example, transportation assistance may not only be used to go to the doctor but could also be to the grocery store or gym since helping an individual with these can improve health. As a result, the industry will continue to see highly rated plans creatively deploying new resources to help attract and retain membership. Consequently, Stars will continue to be one of the paramount areas of focus.

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[1] 124 STAT. 1040 PUBLIC LAW 111–152—MAR. 30, 2010
[2] Jacobson, G., Freed, M., Neuman, T., A Dozen Facts About Medicare Advantage in 2019 (June 6, 2019); Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2018, and MPR, 1999-2007.
[3] Jamieson, D., Machado-Pereira, M., Carlton, S., Repasky, C., McKinsey & Company, Assessing the Medicare Star Ratings, July 2018.
[4] Id.
[5] Timblie, J., Bogart, A., Damberg, C., Elliot, M., et al., Medicare Advantage and Fee-for-Service Performance on Clinical Quality and Patient Experience Measures: Comparisons from Three Large States (December 2017).
[6] Medicare Advantage Achieves Cost-Effective Care and Better Outcomes for Beneficiaries with Chronic Conditions Relative to Fee-for-Service Medicare (July 2018).
[7] Medicare Advantage and Fee-for-Service Performance on Clinical Quality and Patient Experience Measures: Comparisons from Three Large States, Avalere Health (July 2018).
[8] McKinsey, supra 3
[9] Id.
[10] Jacobson, G., Freed, M., Damico, A., Neuman, T., Kaiser Family Foundation, A Dozen Facts About Medicare Advantage in 2019, June 6, 2019.
[11] State and National Benchmarks for MA & PDP CAHPS Survey, 2019, Centers for Medicare and Medicaid Services 2018.
[12] Compare Medicare 2020 Part C & D Star Ratings Technical Notes, to Medicare 2019 Part C & D Technical notes, see p. 14 in 2019 Technical Notes, and p 13 in 2020 Technical Notes.