Plan Management Navigator
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The Cost of Medicare Star Ratings

Medicare star ratings are intended to help seniors "consider the plan's quality in addition to looking at the plan's costs and coverage." But achieving high ratings may entail significant investment by the health plan. This article attempts to measure the magnitude of the investment relative to the star ratings.

Background

Medicare Advantage plans are rated based on their performance in five categories.

- Staying healthy: screenings, tests, and vaccines
- Managing chronic (long -term) conditions
- Member experience with the health plan
- Member complaints, problems getting services, and improvement in the health plan's performance
- Health plan customer service

According to CMS, a plan can get ratings between 1 and 5 stars. (Some plans may be too new or not have enough data to be rated.) The stars correspond with descriptions so that 5 stars indicates "Excellent", 4 indicates "Above average", 3 is "Average", 2 means "Below average" and 1 indicates "Poor" performance.

In addition to the marketing advantages of the appeal of high ratings to plans' prospective customers, the Centers for Medicare and Medicaid Services provides bonus payments for superior performance. The methodology is complex because it is based on county by county payments which depend on traditional Medicare. According to a Booz & Company analysis, "plans can potentially receive 5 percent in additional reimbursements if they improve from 3 to 4 stars." Since profit margins were approximately 4% among Medicare plans participating in Sherlock Company's 2012 benchmarks, such a bonus would have a powerful effect on health plan earnings. Put a different way, with a median monthly revenue yield of $916 PMPM for 2013 Independent/Provider-Sponsored plan Medicare Advantage products, that would amount to $46 PMPM.

Last fall, one of our health plan participants asked us to model the relationship between Medical Management costs and star ratings. This analysis builds on our participant's suggestion.

Sherlock Company is well-positioned to measure this relationship. We gather both costs and ratings from plans participating in the *Sherlock Expense Evaluation Report*. Costs are segmented by product, so we can isolate those costs that are associated with Medicare Advantage, and we can specifically isolate Medical Management expenses associated with this product.

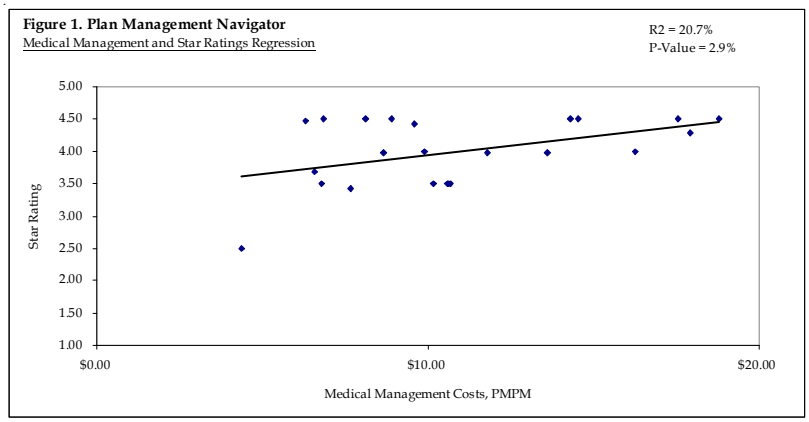
Moreover, we think that that our client's hypothesized link is plausible. Medical Management is reasonably associated with the performance criteria, above, since the function includes Case and Disease Management, Nurse-Based Counseling, Health and Wellness, Quality Components (direct costs of NCQA, HEDIS, reporting for star purposes), Medical Informatics and Other Medical Management. (This latter category is focused on the costs of medical directors and formation of medical policy.) In addition, Medical Management includes Pre-Certification and Utilization Review. Happily, our participants report these subfunction costs as well.

Results

So far, 24 participants in this year's benchmarking studies have reported Medicare Advantage expenses. Collectively, these plans served 1.8 million Medicare Advantage members in 2012. (Our Medicare Advantage universe has not yet reported but we expect it will add 700,000 members to our data set. So, in total, 19% of Medicare Advantage members are served by plans participating in this year's Sherlock benchmarking study.)

Of the 24 plans, we rejected one as an outlier. The omitted plan had a low rating and, in response to this, increased its PMPM expenses in 2012 by 70%.

The analysis of the relationship between Medicare Advantage Medical Management costs and star ratings is shown in Figure 1. The regression line explains 20.7% (R^2) of the relationship between costs and star ratings, but the chance that there is no relationship is 2.9% (p-value).



We performed the same analysis once again for just the Blue Cross Blue Shield plans, the R^2 climbed to 44.3%, and the p-value declined to 1.3%. While this reduces the sample to only 13 organizations, the consistency of the business model between the organizations may have been enhanced.

We then measured the relationship between sub-functions and star ratings. Of the various sub-functions listed earlier only Disease Management and Other Medical Management costs indicated a relationship with star ratings.

In the case of Disease management, the R^2 was 19.9% and the p-value was 3.8%. Considering that "Managing chronic (long -term) conditions" is one of the criteria for the star ratings, and disease management, according to the Disease Management Association of America entails the "management of chronic disease specific and co-morbid conditions for eligible members, across the continuum of care," this makes sense.

The relationship between Other Medical Management and star ratings is an R^2 of 27% with a p-value of 0.9%. Other Medical Management includes peer review, assuring proper process flows, some physician education activities, communication with case managers, field audits and associated medical directors.

Finally, we looked at the relationship between Medical Management costs, but excluding those activities that might have only a loose relationship with achieving star ratings. Excluded functions were Precertification, Utilization review, Health and Wellness and Medical Informatics. The R^2 was 31.9% and the p-value was 0.5%.

Conclusion and Discussion

There appears to be a relationship between the costs of Medical Management and the Medicare star ratings, though other factors are apparently important as well. Plans spending more for Medical Management tended to have higher Medicare star ratings. Moreover, there appears to be a minimum level of Medical Management expenses consistent with acceptable performance: the lowest Medical Management cost value for any plan with a 3.0 star ("average") rating exceeded $6.00 PMPM.

It is possible that this analysis understates the relationship between Medical Management costs and star ratings. First, our sample is comprised of organizations that tend to score higher than average. The average rating of the 576 organizations contracting with CMS to provide Medicare Advantage was 3.4. But only two of our benchmark participating plans were below average. The average star rating for all of our participants was 4.0: 4.3 for IPS plans and 3.8 for Blue plans.

Moreover the star ratings are highly segmented, like pass-fail grades: they range from 1-5 in 0.5 increments. Accordingly, the enterprise star ratings, which we calculated by weighting the membership, was a multiple of 0.5 in fifteen cases. The 24 plans had only 13 different values. This has the effect of muting any link between effort and outcome.

Finally, the Medical Management areas of health plans that participate in the Sherlock benchmarking study do other things other than those the affect quality ratings. (Note that quality ratings are not necessarily the same as quality.) For instance effective Medical Management may keep people out of hospitals and reduce costs while enhancing quality. In fact, approximately one-half of health plan medical management costs are classified as medical expenses for MLR ratio reporting purposes.