TOPIC: STAR RATINGS AND THE QUALITY BONUS PROGRAM

Background

CMS introduced the Medicare Advantage (MA) Star Rating system as a mechanism for providing beneficiaries with information about the clinical quality, administrative capability, and patient experience one could expect as an enrollee in an MA plan.[1] The Star Rating system evaluates plans on a 1 to 5 scale based on quality, member experience, and performance.[2] Star Ratings are available on the medicare.gov Plan Finder website and enable beneficiaries to make comparisons across plans.[3]

Key Points

- High star ratings increase payments to MA plans through increased rebates and benchmark bonuses but are not always associated with better care quality or beneficiary experience.
- Incentives for MA organizations to increase star ratings, coupled with shifting cut points and lack of downside risk and potential to game measures, may produce FWA risks.
- Mitigation strategies include increased and aligned oversight of star rating operations, the application of budget neutrality, changes to the QBP measure set and weights, and quality assessments at the local level.

In 2012, the Patient Protection and Affordable Care Act established the MA Quality Bonus Program (QBP). QBP is based on the five-level Star Ratings system, and increases Medicare payments to MA plans in two distinct ways: rebates and benchmark bonuses. Capitated, per-beneficiary-per-month (PBPM) payments to MA plans are based on a comparison of a plan's estimated cost of providing Medicare-covered services (referred to as a bid) relative to the maximum amount the federal government will pay for an MA enrollee (referred to as a benchmark).[4,5] A benchmark is a percentage of estimated spending in traditional Medicare in the same county, ranging from 95% in high-cost counties to 115% in low-cost counties.[6] If a plan's bid is less than the benchmark, its PBPM payment equals its bid plus a rebate.[7] The rebate amount is directly dependent on plan quality (i.e., the plan's Star Rating) and ranges from 50% to 70% of the difference between the bid and the benchmark.[8] Contracts with 3.0 or fewer stars keep 50% of the difference between their bid and the benchmark as a rebate, contracts with 3.5 or 4.0 stars keep 60%, and contracts with 4.5 or 5.0 stars keep 70%.[9] Medicare retains the residual, or the portion of the difference between bid and benchmark not given to the plans in the form of

rebates.[10] If a plan's bid is more than or equal to the benchmark, Medicare's PBPM payment to the plan will be the benchmark amount and each enrollee will therefore pay an additional premium, equal to the amount by which the bid exceeds the benchmark.[11] Rebates must be spent on supplemental benefits, lower premiums, or reduced cost sharing for enrollees.[12] Consequently, the higher a plan's Star Rating rebate, the more revenue a plan has to increase benefits or reduce cost sharing without charging a supplemental premium to the beneficiary.[13]

In addition, the county benchmark for MA contracts with Star Ratings of 4, 4.5 or 5 is increased by 5% as a quality bonus, allowing these contracts to submit higher bids relative to these higher benchmarks and ultimately increase their rebates.[14] Benchmarks for plans with 4 or more stars operating in bonus counties, defined as urban counties with low traditional Medicare spending and historically high Medicare Advantage enrollment, are increased by 10%.[15] Revenues from higher benchmarks due to Star Rating bonuses do not need to finance extra benefits and can be allocated as profit or administrative expenses.[16] Further, five-star contracts can offer year-round enrollment instead of being limited only to Medicare's annual open enrollment period, removing a barrier to entry for potential members.[17]

To illustrate the impact of Star Ratings on payments to MA plans, consider the following example adapted from Xu et al. Three MA plans are operating in the same county. That county's benchmark is $1,000 per member per month, and each plan submitted an $800 bid. Plan A has a 3-star quality rating, Plan B has a 4-star rating, and Plan C has a 5-star rating. Plan A's quality-adjusted, risk-adjusted benchmark remains $1,000. Because plans rated below 3.5 stars receive 50% of the difference between the adjusted benchmark and the bid as a rebate, Plan A receives a $100 rebate for a total payment of $900. Four-star rated Plan B's quality-adjusted, risk-adjusted benchmark is increased by 5% to $1,050. In addition, Plan B receives 65% of the difference between the adjusted benchmark of $1,050 and the $800 bid, resulting in a $162.50 rebate and a total payment of $962.50. Lastly, Plan C's quality- and risk-adjusted benchmark is also $1,050. However, Plan C receives 70% of the difference between the adjusted benchmark of $1,050 and the $800 bid, resulting in a $175 rebate and a total payment of $975.[18] Further illustrating the financial importance of Star Rating performance, several insurers sued CMS in 2024 seeking corrections to their contracts' Star Ratings. One insurer claimed that having an overall Star Rating of 3.5 instead of 4 on a contract cost them $375 million in bonus payments for 2025.[19]

CMS measures the quality of Medicare health and drugs plans annually through the MA Star Ratings system. The system is intended to incentivize plans to provide high-quality care, as described above, and to help people to compare the available MA plans and make informed enrollment decisions. For 2025, and affecting 2026 MA Quality Bonus Payments, MA contracts that include Part D prescription drug plans (PDPs) were rated on up to 40 quality and

performance measures; MA-only contracts (without PDPs) were rated on up to 30 measures; and PDP-only contracts were rated on up to 12 measures. CMS classifies measures into six categories as follows:[20]

- Outcome measures reflect improvements in a beneficiary's health status.
- Intermediate outcome measures reflect actions to assist in improving a beneficiary's health status, such as the "Diabetes Care – Blood Sugar Controlled" measure.
- Patient experience measures reflect beneficiaries' perspectives of care received, such as getting needed care, access to appointments, and customer service.
- Access measures reflect processes and phenomena that could create barriers to receiving needed care, such as the "Plan Makes Timely Decisions about Appeals" measure.
- Process measures capture health care services provided to beneficiaries to assist in maintaining, monitoring, or improving their health status.
- Improvement measures are derived through comparisons of a contract's current and prior-year measure scores. A contract must meet certain requirements to receive a Star Rating in the improvement measures. For example, a contract must have measure scores for both years in at least half of the required measures used to calculate the Part C improvement or Part D improvement measures.

Each measure receives a numeric score (or an assigned "missing data message") that is converted into a Star Rating. Measure Star Ratings are then combined into three groups (Domain, Summary, and Overall) and each group is assigned 1 to 5 stars.[21] Examples of Part C domains include "Staying Healthy: Screenings, Tests, and Vaccines," "Managing Chronic (Long Term) Conditions," and "Member Experience with Health Plan."[22] A domain rating is the average, unweighted mean of the domain's measure stars.[23] The summary and overall ratings are calculated as weighted averages of the measure stars.[24] For the 2026 Star Ratings, CMS assigns the highest weight to improvement measures, followed by outcome and intermediate outcome measures, then patient experience/complaints and access measures, and finally, the lowest weight is assigned to process measures.[25] New measures included in the Star Ratings are given a weight of 1 for their first year of inclusion; in subsequent years the weight associated with the measure weighting category is used.[26] Notably, CMS can change both the measures included in the Star Ratings system and the weight assigned to measure categories year over year. For example, the weight of the patient experience, complaints, and access measures decreased from 4 to 2 between 2025 and 2026. Further, the Part C Kidney Health Evaluation for Patients with Diabetes measure moved into the 2026 Star Ratings as a new measure with a weight of 1.[27]

Data used to determine Star Ratings come from four source categories: (1) data collected by CMS contractors, (2) CMS administrative data, (3) health and drug plans, and (4) surveys of enrollees.[28] For each measure, CMS establishes thresholds or "cut-points" that are used to determine each contract's performance for that measure, expressed as a 1-, 2-, 3-, 4- or 5-star rating.[29] Numeric measure scores are converted into Star Ratings through a clustering method or, for Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey measures, relative distribution and significance testing. As described by CMS, "The clustering algorithm identifies the 'gaps' among the scores and creates four cut points resulting in the creation of five levels (one for each Star Rating). The scores in the same Star Rating level are as similar as possible; the scores in different Star Rating levels are as different as possible."[30] Cut points separating the five levels may change from year to year, creating shifting performance targets and distributions of scores.[31] Notably, CMS measures Star Ratings at the MA contract level to ensure an adequate sample size and retrospectively determines the cut points used to compare contract performance. MA contracts can cover large multi-state geographic areas.[32]

Potential for FWA

QBP Effectiveness and Resource Allocation

Despite major budget outlays on behalf of the federal government and significant investments by plans, some researchers found that the QBP is not associated with improvements in plan quality.[33] Meyers et al. concluded that "exposure to a higher rated Medicare Advantage contract does not appear to convey any improved enrollee reported outcomes. For both the health status measures and the patient contract experience measures, increased Star Ratings did not consistently lead to any improvements."[34] Similarly, findings suggest that increased bonuses given to MA plans with relatively high-quality performance operating in eligible counties do not improve quality and distort the distribution of Medicare funds.[35,36] Diversion of plan resources toward strategies aimed at boosting Star Ratings without commensurate quality improvement and enhanced beneficiary experience represents a risk of waste. Iterative changes by different administrations have created complexity and inconsistency, resulting in a less coherent, long-term Star Rating strategy that may not effectively support quality programs. This may have led to wasteful spending by plans to frequently change their Star Rating policy implementation approaches.

High Reward Without Downside Risk

The QBP is a reward-only program that does not limit how many plans can be highly rated by enforcing a normal distribution. As such, the program is financed through additional payments, does not impose financial penalties on low-performing contracts, and the amount paid to plans because of Star Rating performance (via increases to county benchmark amounts and rebates) is not constrained.[37,38] The financial and operational benefits of achieving relatively high Star

Ratings for MA insurers are significant. To illustrate, MA insurers received $10 billion in QBP payments in the form of additional allocated funds in 2022, representing a sizable source of revenue.[39] Federal spending on MA bonus payments tied to Star Ratings is consistently increasing. MA QBP payments totaled at least $12.7 billion in 2025, which is similar to 2023 spending, and more than four times higher than spending in 2015. Since 2015, Medicare has spent at least $87 billion on QBP payments.[40] MA organizations may be incentivized, by potential payment increases and lack of downside financial risk, to engage in activities aimed at optimizing Star Ratings, and some of these activities may carry risks of FWA. These risks may be exacerbated by CMS's decision not to implement the Excellent Health Outcomes for All reward for the 2027 Star Ratings and continue the historical reward factor,[41] making it easier for highly rated plans to maintain high ratings.

Shifting Cut Points

As described earlier, QBP performance is determined by comparing contract performance relative to other contracts, instead of comparing performance to predetermined targets.[42] CMS has indicated that this approach incentivizes continuous quality improvement, reduces misclassification of a contract's performance, and also allows cut points to adapt to significant external events that could affect overall plan performance (such as those that occurred during the COVID-19 pandemic).[43] However, MA organizations do not definitively know the definitions of success, in the form of cut points, in advance of a measurement year. Because of the outsized impact of performance that just meets a threshold,[44] MA organizations may direct resources toward predictive modeling and other techniques to determine potential measure cut points.[45] Similarly, they may be incentivized to direct outsized resources toward influencing a few marginal cases to reach a cut point associated with a significant increase in payments.

Large Contracts and Impact on Beneficiary Decision-Making

Because Star Ratings are determined at the contract level, larger, multistate contracts may obscure meaningful beneficiary information. There is a risk that beneficiaries may misinterpret Star Ratings as a localized indicator and predictor of quality, plan performance, and access to care.[46,47]

Potential to Game Star Ratings Measures

MA organizations could selectively misreport some plan-reported measures, particularly by manipulating which beneficiaries are included in the numerator or denominator of Healthcare Effectiveness Data and Information Set (HEDIS) measures. To illustrate, a validation study of the HEDIS quality readmission measure using MA encounter data found that readmission rates were statistically significantly higher in encounter data than in HEDIS data, and this difference was associated with the underreporting of index admissions in HEDIS.[48] This finding demonstrates that there is a risk for misreporting HEDIS measures.

Fragmented oversight and variation in requirements applied to different Star Rating data sources (e.g., CAHPS and the Health Outcomes Survey [HOS]) creates a risk for plans to engage in strategies to influence the data that are reported, particularly enrollee survey data results. For example, insurers may attempt to influence enrollee selection for and responses to the CAHPS survey instrument via Do Not Survey lists, pre-CAHPS communication, and preconditioning strategies to influence survey results while circumventing oversight rules.[49,50,51] Coding intensity practices could also help MA organizations game certain measures (see also the section on coding intensity). For example, diagnosing additional marginal cases of diabetes could positively influence performance on the measure of blood sugar control among enrollees with diabetes.

Mitigation Approaches

Increase and align oversight of Star Rating operations. Different components of the Star Ratings system are subject to varying requirements and oversight methodologies, which leads to inconsistencies that may create opportunities for FWA. All health plans submit HEDIS data to the National Committee for Quality Assurance (NCQA) and must undergo a HEDIS Compliance Audit, which may only be performed by licensed organizations and certified auditors.[52] CMS uses a designation assigned by the HEDIS auditor to determine ratings. An audit designation of "biased rate" is assigned to a measure when "the individual measure score is materially biased (e.g., the auditor informs the contract that the data cannot be reported to the NCQA or to CMS)."[53] When the HEDIS auditor designates a "biased rate" to a HEDIS measure, the contract receives 1 star for the measure and the measure score is set to "CMS identified issues with this plan's data."[54] If the HEDIS summary-level data value varies substantially from the value in the patient-level data, the measure is reduced to a rating of 1 star.[55] Although this is likely a significant disincentive, additional civil monetary penalties for plans that receive "biased rate" designations from the HEDIS auditor could also be considered.

CMS-approved Health Outcomes Survey (HOS) vendors must adhere to requirements in the *Medicare Health Outcomes Survey (HOS) Quality Assurance Guidelines and Technical Specifications*.[56] CAHPS survey vendors and MA plans must adhere to requirements in the *Medicare Advantage & Prescription Drug Plan (MA & PDP) CAHPS® Survey Quality Assurance Protocols & Technical Specifications Version 16.0.*[57] Both sets of requirements include prohibitions on activities to influence or incentivize positive survey responses. For example, health plans are permitted to conduct focus groups during MA & PDP CAHPS Survey administration but "the MA & PDP CAHPS Survey Project Team strongly discourages health plans from asking any questions contained in the MA & PDP CAHPS Survey."[58] Contracts or their agents are strongly discouraged from fielding other surveys of enrollees 4 weeks prior to, during, and 4 weeks after the 2026 Medicare CAHPS Survey administration.[59] NCQA prohibits survey vendors, MA organizations, and their agents from asking HOS-related questions of

members 8 weeks prior to and during the HOS administration.[60] In contrast, the HOS Quality Assurance Guidelines do not address use of focus groups. Aligning requirements relating to communication with MA members about surveys and increasing oversight of such requirements may reduce the FWA risk opportunities for MA organizations to inappropriately influence enrollee survey responses.

Requirements and oversight activities related to the ability of plans to influence the enrollee sample drawn for surveying by CMS also could be improved. For example, MA organizations may provide their "Do Not Survey" list to supplement their MA & PDP CAHPS survey vendor's list.[61] If an enrollee named in the survey vendor's or MA organization's "Do Not Survey" list appears in the sample drawn by CMS and data collection has not been initiated, the enrollee can be removed from the sample and excluded from the survey.[62] If an enrollee named in the survey vendor's or MA organization's "Do Not Survey" list appears in the sample drawn by CMS and data collection has been initiated, the vendors are instructed to assign the enrollee a Final Disposition Code of "32 – Refusal." Enrollees who refuse participation in future surveys may be added to a survey vendor's "Do Not Survey" list.[63] Increased examination and oversight of MA organizations' Do Not Survey lists could reduce any incentive they may have to motivate enrollees who they expect to give low ratings to join such lists.

Apply budget neutrality to the QBP program. Savings to the government is often highlighted as the primary benefit of transforming the QBP into a budget-neutral program; doing so could save the federal government an estimated $6 to $10 billion annually.[64] This option could be structured in such a way that it would also result in smaller quality-adjusted rebates, thereby reducing incentives to engage in fraudulent, abusive, or wasteful actions to increase Star Ratings. However, applying budget neutrality presents significant implementation challenges as it requires changes to statute and would likely be opposed by MA organizations. A variant of this option is to eliminate entirely benchmark increases tied to Star Rating performance. However, this option would also reduce incentives to invest in activities and infrastructure that may lead to better consumer experience and higher quality care.

Assess quality at the local level. Assigning Star Ratings based on performance relative to other contracts in local markets (i.e., evaluating quality at the local market level and/or plan level instead of the contract level) may reduce opportunities for waste and abuse through contract consolidation and lead to more accurate information about MA quality.[65,66,67] When beneficiaries currently view a contract's Star Rating, they can't readily identify how many plans comprise the contract, how many service areas are covered, or what share of a contract's enrollment each plan represents.[68] For example, Employer Group Waiver Plans (EGWPs) and Dual Eligible Special Needs Plans (D-SNPs) are included in a contract's overall rating.[69] EGWPs are retiree health insurance plans originating from a waiver provision in the Medicare statute

promoting employer group plans.[70] It has been observed that "contracts with larger shares of EGWP enrollment have higher average Star Ratings," which may be attributed to demographic characteristics of EGWP enrollees, such as income.[71] Similarly, D-SNPs can have quite different benefits than other plans under a given contract, suggesting that the contract-level Star Ratings may not generalize to D-SNPs. The option of assessing quality at a local or plan level preserves the potential for financial bonuses while changing data submission and measure calculation methodology and therefore may be more palatable to MA organizations. However, this approach may not be feasible given that there are no standardized geographic regions in MA, and many existing measures could not be calculated at the plan level due to small sample sizes. Any change to the level at which measures are calculated would preserve many of the existing incentives for gaming Star Ratings measures. A related option could be adding to the Star Ratings a more limited scorecard containing some plan-level measures that are feasible with smaller samples, thereby providing additional transparency to beneficiaries without having an impact on Star Ratings bonuses.[72]

Change or reweight the measure set. Changing the impact of certain measure types used to assign Star Ratings may reduce the risk of waste and gaming by reorienting the incentive structure faced by plans when deciding how to allocate resources and by providing beneficiaries with a more accurate picture of plan performance. However, preferred approaches differ. One avenue prioritizes administrative effectiveness measures that may protect beneficiaries against substandard plans and aid in decision-making such as "rates of prior authorization and claim denials, network adequacy and access to care, and reported negative experiences with plans."[73,74] As an implementation consideration, this option acknowledges the lack of association between higher Star Ratings and enhanced clinical quality.

Other variants of this option include removing and/or de-emphasizing (by reducing assigned weights) measures that may be inflated due to upcoding practices, retiring topped-out measures, and removing certain process measures. For example, the Alliance of Community Health Plans (ACHP) recommends prioritizing patient experience and health outcome measures in computing Star Ratings and immediately retiring 10 of 17 current process measures, arguing that most insurers are adept at conducting administrative tasks and therefore score well.[75] ACHP identified the following five process measures for immediate retirement, indicating that the "majority of plans are clustered together on process measures, showing no meaningful difference between plans and distorting consumers' ability to distinguish high and low performers:" (1) Care for Older Adults – One Pain Assessment in a Year, (2) Accuracy of Prices on Medicare Plan Finder, (3) Kidney Disease Monitoring for Consumers who Needed Medical Attention for Nephropathy, (4) Care for Older Adults - One Medication Review in a Year, and (5) Medication Therapy Management Comprehensive Review.[76] Removal of these measures could improve the ability of Star Ratings to distinguish among plans and reduce waste associated with

reporting these measures; however, it would also reduce the amount of information available to beneficiaries for decision-making.

Over the years, CMS has added and removed Star Rating measures and used its discretion to increase Star Ratings required for bonuses, signaling the feasibility of this approach as a FWA mitigation option.[77] Notably, CMS's priorities regarding the characteristics of an ideal Star Ratings measure set are evolving. CMS has recently sought to "simplify and refocus the measure set on clinical care, outcomes, and patient experience of care measures where performance is not topped out and where there is more variation in performance across contracts" by removing several measures focused on operational and administrative performance, process of care, and patient experience of care.[78] More specifically, the administrative process measures confirmed for removal are related to review and timeliness of appeals, call center operations, enrollee complaints about their health plan, customer service and rating of health care quality, and member choice to leave a plan.[79] Similar to the ACHP proposal, this change could reduce waste associated with reporting these measures but it would do so at the cost of reducing information available to beneficiaries.

One option to sever ties between administrative, plan operations measures and process measure performance and potentially wasteful or fraudulent financial incentives, as described by Fowler et al., is to "move those measures outside of the Star Ratings program altogether without sacrificing oversight" by introducing a CMS-created "MA Transparency Scorecard, a complementary tool that would increase visibility into plan behavior without creating new financial incentives."[80] The authors note that this option "aligns with CMS's goals of reducing administrative burden in Star Ratings while maintaining visibility into important plan operations."[81] That is, it could reduce waste while retaining or improving the quality and accessibility of information beneficiaries can use for decision-making.

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