MILLIMAN WHITE PAPER

Future of Medicare Star Ratings: The reimagined CMS bonus system

What are the changes and how can plans prepare?

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With significant changes coming to the Medicare Star Ratings, Medicare Advantage organizations need to adapt to maintain or recover current Star Ratings.

Recent methodology changes to the Star Ratings system have generally been cost-neutral to the Centers for Medicare and Medicaid Services (CMS) or favorable to Medicare Advantage organizations (MAOs)[1]. However, health plans recently received their 2024 Star Rating preview, and many were surprised by unexpectedly lower Star Ratings resulting from the Tukey outlier removals on the measure cut points, a change that only marks the beginning of expected shifts to the Medicare Advantage (MA) Star Rating framework. CMS has released several other new Star Ratings methodology changes that are likely to disrupt the status quo in the MA market, and while these changes were created with the intention of improving stability and advancing health equity for all, they are expected to collectively reduce funding to the overall MA program.

This white paper outlines the financial implications these changes are anticipated to have on MA and Medicare Advantage Prescription Drug (MA-PD) contracts[2] for the 2025 payment year (PY 2025) and beyond, along with steps MAOs can take to be successful in this new system.

The key conclusions included in this paper are:

- As shown in Figure 1, CMS expects to realize approximately $2.3 billion in cost savings (reduced MAO revenue) in PY 2028, once all finalized rule changes are implemented. If the proposed rule to increase the hold harmless threshold from 4.0-Stars to 5.0 Stars is finalized, the CMS cost savings would increase to $4.6 billion in PY 2028 and then by approximately 9% to 10% annually thereafter.
- MA contracts with 3.5-, 4.0-, and 4.5-Star Ratings are the only cohorts subject to CMS revenue reductions when their ratings are reduced by half a Star, so the burden of CMS cost saving initiatives falls disproportionately on them.
- As shown in Figure 2 (Page 7), the CMS cost savings in Figure 1 would translate to PY 2028 revenue reductions of approximately $6.60 PMPM (3.5-Star), $11.30 PMPM (4.0-Star) and $9.55 PMPM (4.5-Star) for the finalized rules, by using the annualized 2023 membership[3][4] by Star Rating. If the hold harmless threshold rule change is implemented, then the revenue reductions would increase to $33.30 PMPM (4.0-Star) and $14.10 (4.5-Star). Note that the actual PMPM impact will depend on future enrollment growth and Star Rating changes.
- There will be other non-revenue implications for MA contracts. CMS expects 75% of the total 5.0-Star contracts would shift to 4.5-Stars and lose the marketing and enrollment advantages of being 5.0-Star when the reward system moves to the Health Equity Index (HEI).
- CMS' stated expectation is that these Star Rating methodology changes will absorb most of the CMS cost savings by reducing plan margins, but there are several strategies plans can take to minimize the impact to their revenue.

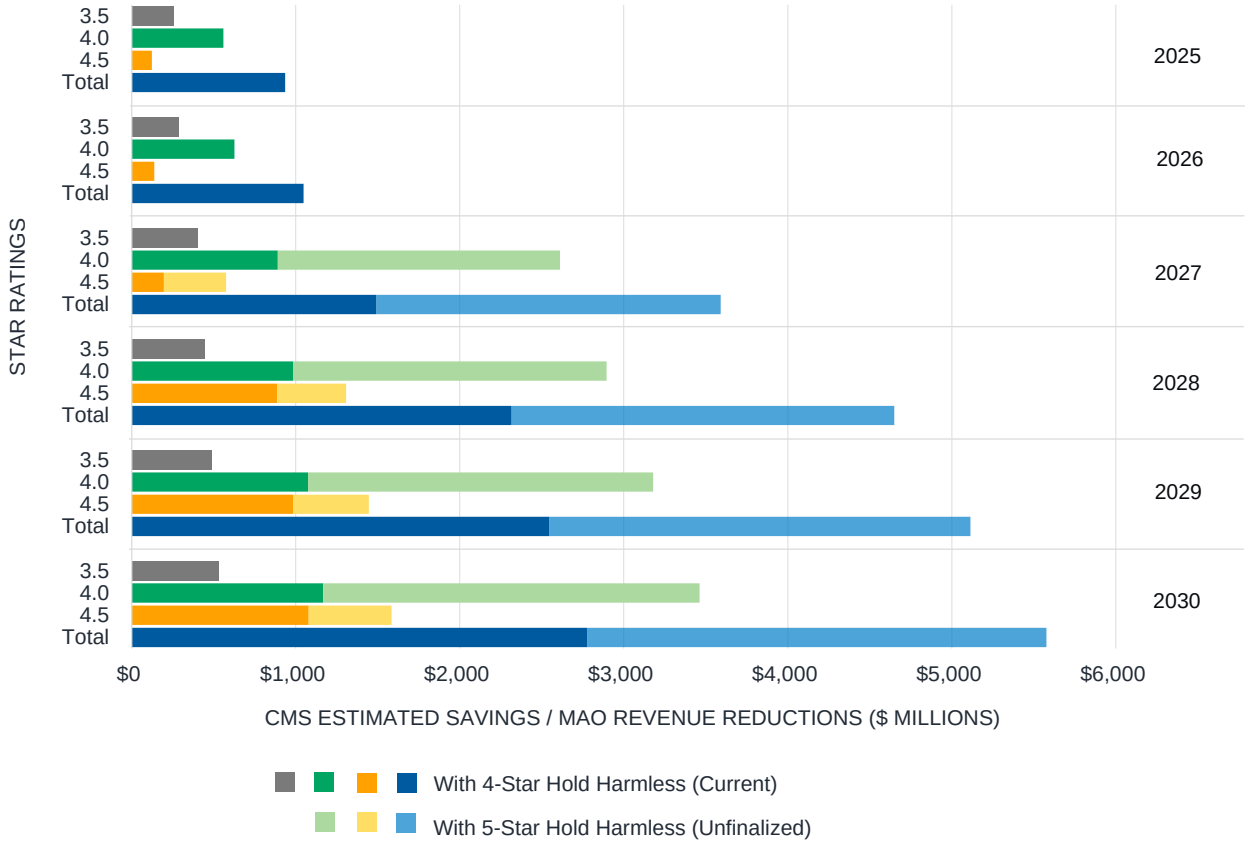
[1] For example, see the "Summary of Cost Benefits" section of the 2020 Final Rule

[2] Prescription drug plans (PDPs), dual demonstrations, National PACE, 1833 Cost, and 1876 Cost contracts are not included in these estimates because their CMS revenue is not directly affected by changes to their Star Ratings.

[3] CMS (March 2023). MA Enrollment by SCC 2023 03. Retrieved October 2, 2023, from https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/monthly-ma/ma-enrollment-scc-2023-03.

[4] CMS (October 4, 2022). 2023 Star Ratings Data Tables. Retrieved October 2, 2023, from https://www.cms.gov/files/zip/2023-star-ratings-data-table.zip (zip file download).

FIGURE 1: CMS COST SAVINGS / MAO REVENUE REDUCTIONS ($000'S) BY PAYMENT YEAR AND STAR RATING[56]



The actual impact of these rule changes on a given contract will depend on many factors, including risk scores, bid-to-benchmark ratios, and the disparities in care between members with and without social risk factors (SRFs). However, all MAOs should evaluate the impact these changes will have on their contracts and consider adjusting their strategies for the upcoming 2024 measurement year.

Tukey Outlier Removal

Starting with the 2024 Star Ratings (PY 2025), CMS is removing Tukey outliers from the calculation of all cut points, except those based on Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures. The stated goal of this change, as discussed in the 2021 Final Rule,[7] is to stabilize cut points and prevent large year-to-year fluctuations in cut points caused by a few low-performing contracts.

[5] Tukey Outlier CMS Cost Savings, Table 12, 2021 Final Rule: https://www.federalregister.gov/documents/2020/06/02/2020-11342/medicare-program-contract-year-2021-policy-and-technical-changes-to-the-medicare-advantage-program

[6] HEI Rewards, weight changes and hold harmless CMS cost savings, Table 1, 2024 Final Rule: https://public-inspection.federalregister.gov/2023-07115.pdf.

[7] CMS, 2021 Final Rule, op cit.

Based on the "guardrails" language in the Final Rules and the coded regulations, many MA stakeholders expected the non-CAHPS cut point thresholds could only move by +/- 5% "from year-to-year". However, rather than applying the thresholds on the actual 2023 values, CMS instead re-calculated the 2023 values with Tukey outliers removed. CMS included its intent to implement this methodology in the 2021 Final Rule, though the description was embedded in the comments sections and was not coded in the regulations.[8,9]

This means the full weight of the Tukey outlier removal will be felt almost immediately, rather than being phased in over multiple years. CMS indicated its intention to remove the "guardrails" in the 2024 Proposed Rule, but that rule change was not finalized until this year's Final Rule.[10]

CMS released a cost impact analysis of Tukey outlier removal in the 2021 Final Rule, which estimated a CMS savings of $935 million for 2025, increasing to $1.5 billion by 2030. Since this analysis was published in February 2020, there have been unforeseen circumstances that suggest CMS' initial savings estimates could be understated:

- CMS' original projections relied on enrollment projections based on 2011 through 2018 base data. Since then, there was an unexpected surge of MA enrollment during the COVID-19 pandemic which increased MA enrollment to 31 million[11] in 2023, 18% higher than the projected 26 million MA enrollees in the original CMS forecast.[12]
- In the 2019 Medicare Trust Fund Report, CMS assumed a 3.6% annual inflation rate.[13] Since that analysis was performed, annual inflation in 2021 and 2022 increased to between 6% and 7%, almost twice the original baseline assumption.[14]

As shown in Table 1, the only one-half Star Rating shifts that result in a revenue reduction are between 4.5- and 4.0-Star Rating, from 4.0- to 3.5-Star Ratings and from 3.5- to 3.0-Star Rating. Because this change will affect the non-CAHPS cut points for all contracts, we expect the financial impact will be primarily felt by those 3.5-Star to 4.5-Star contracts that will face a reduction in revenue due to a one-half star decrease in their rating.

TABLE 1: CMS REVENUE ADJUSTMENT BY STAR RATING

STAR RATING	REBATE PERCENTAGE	QBP %
< 3.5	50%	0.0%
3.5	65%	0.0%
4.0	65%	5.0%
4.5 +	70%	5.0%
New/Low	65%	3.5%

[8] 42 CFR 423.186(a)(2)(i). See https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423#423.186.

[9] Ibid.

[10] The full text of the 2024 Final Rule is available at https://public-inspection.federalregister.gov/2023-07115.pdf.

[11] Ochieng, N., Biniek, J.F., Freed, M. et al. (August 9, 2023). Medicare Advantage in 2023: Enrollment Update and Key Trends. KFF. Retrieved October 2, 2023, from https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends.

[12] 2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, p.4. Retrieved October 2, 2023, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf.

[13] Ibid.

[14] U.S. Inflation Calculator. Current U.S. Inflation Rates: 2000-2023. Retrieved October 2, 2023, from https://www.usinflationcalculator.com/inflation/current-inflation-rates.

To put these CMS cost savings into perspective, the average annual PY 2025 CMS revenue reductions to this group would be $3 million to $5 million per 2023 Star Rating contract,[15] or $3.50 to $4.50 per member per month (PMPM).[16,17,18]

We also note that the actual financial impact of the Tukey outlier deletion will not be fully understood until the 2024 Star Ratings are publicly released later in October. We intend to publish a follow-up white paper shortly after their release.

2024 Final Rule announcement

While the healthcare industry grappled with hardships from the global pandemic and economic lockdowns, CMS paused all significant changes to the MA Star Rating system in the 2022 and 2023 Final Rules. Now that the uncertainty introduced by the COVID-19 pandemic has largely subsided, CMS announced several changes in the 2024 Final Rule that will be implemented in the coming years.

Of the announced changes in the Final Rule, CMS expects the future measure and measure weight changes, as well as the new HEI rewards system, will have a meaningful financial impact on stakeholders. The 2024 Final Rule also finalized the removal of the 60% rule, also known as the disaster adjustment, which excludes contracts with 60% or more of their enrollees in Federal Emergency Management Agency (FEMA) designated Individual Assistance areas at the time of extreme and uncontrollable circumstances from the calculation of Star Ratings for non-CAHPS measures. CMS determined there would be a negligible impact on Star Ratings from this change.

Health Equity Index (HEI) rewards

Starting with the 2027 Star Ratings (PY 2028), the rewards system in the Star Ratings will be replaced by a new system that factors in the HEI, considering social risk factor (SRF) population measures. The current system rewards contracts that achieve high weighted average Star Ratings, with low variability among the individual measures. The HEI system will reward contracts that have meaningful low-income, dual-eligible, and disabled populations and will attain higher Star Rating measure results for this population compared to their peers.

To qualify for the maximum +0.40 reward factor, a contract would need to have an SRF enrollee percentage greater than the median across all contracts (41.65% in the CMS simulation on 2021 Star Ratings[19]), or they could qualify for a +0.20 reward if their percentage was greater than half of the median (20.82% in the same simulation). If a contract's enrollee population does not have an SRF population higher than half the median, it would not qualify for a reward.

In the 2024 Final Rule, CMS shared its simulated impact of replacing the current reward system with the HEI rewards on the 2021 Star Ratings using the 2018 and 2019 measurement periods and included the following key results:

- Under this simulation of the 2021 Star Ratings, seven (1.7%) of MA-PD contracts gained one-half Star and 54 (13.4%) of the MA-PD contracts lost one-half Star on their overall rating.
- Simulations replacing the current reward factor with the HEI reward using data from the 2021 Star Ratings show that no contracts would lose quality bonus payments (QBPs), and 9.4% of contracts would lose rebate dollars.

[15] With 319 total 3.5-, 4.0- and 4.5-Star contracts per the 2023 Star Rating Fact Sheet. See https://www.cms.gov/files/document/2023-medicare-star-ratings-fact-sheet.pdf.

[16] CMS (March 2023). MA Enrollment, op cit.

[17] CMS (October 4, 2022). 2023 Star Ratings by contract, op cit.

[18] CMS (March 31, 2023). Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. Retrieved October 2, 2023, from https://www.cms.gov/files/document/2024-announcement-pdf.pdf.

[19] CMS, 2024 Final Rule, op cit.

In the 2024 Final Rule, CMS estimated that the reward system change would result in program savings of $670 million in 2028, increasing to $1.05 billion in 2033.[20] Because CMS stated no contracts in the simulation would reduce their QBPs, we assume this implies that the only 2021 Star Rating contracts with Star Rating reductions were 5.0-Star and 4.5-Star plans,[21,22] meaning the savings is attributable to the reduction in rebate percentage for 4.5-Star contracts from 70% to 65%.

We estimate that the CMS simulation reduced the total number of 5.0-Star contracts by approximately 75%.[23] Although decreasing to 4.5-Stars would not reduce their payments from CMS, it would impact the marketing and enrollment advantages of a 5.0-Star contract.

Furthermore, we estimate that the CMS simulation reduced the total number of 4.5-Star contracts by approximately 60%, which would lead to CMS cost savings by lowering the rebate percentage when their ratings shift to 4.0-Stars. Assuming all the savings are attributable to 4.5-Star contracts would equate to an average PY 2028 revenue reduction of $10 million to $16 million per 4.5-Star contract in the 2023 Star Rating,[24] or $5.50 PMPM to $7.50 PMPM for this cohort.[25,26,27]

To prepare for the new HEI rewards system, CMS will provide confidential contract-level reports in the Health Plan Management System (HPMS), beginning with the 2024 Star Ratings (2022 measurement period). As the first two-year measurement period begins in 2024, health plans (particularly 5.0-Star and 4.5-Star contracts) should review these reports as soon as they are available so they can implement quality initiatives that target populations experiencing health disparities.

Measure and weight changes

Starting with the 2026 Star Ratings (PY 2027), CMS is decreasing the weight of patient experience, complaints, and access measures from four to two. This rule change will increase the influence of claim-based measures from approximately 30% of the total non-improvement weight in PY 2024 to 53% in PY 2027.[28]

CMS also finalized the following changes to the measures included in the Star Rating program:

- Removal of the Part C “Diabetes Care – Kidney Disease Monitoring” measure
- Addition of the Part C “Kidney Health Evaluation for Patients With Diabetes” measure
- Substantive updates to the Part D “Medication Adherence for Diabetes Medications”, “Medication Adherence for Hypertension (Renin-Angiotensin [RAS] Antagonists)”, and “Medication Adherence for Cholesterol (Statins)” measures

[20] Ibid.

[21] Note that, if a 4.0-Star plan reduced its Star Rating to 3.5-Stars, then its QBP on benchmark rates would reduce from 5% to 0%, so we assume no 4.0-Star contracts lost a rating due to the new HEI rewards system.

[22] To qualify for a reward in the 2021 Star Ratings, a contract needed a pre-reward Star Rating above 3.79. However, in the second plan preview of 2024 Star Ratings technical notes, the minimum reward value was 3.70. It is therefore possible that some number of contracts with pre-reward Star Ratings between 3.70 and 3.75 would lose their reward and miss out on a 4-Star Rating; such an outcome could result in losses beyond those considered in the CMS simulation.

[23] CMS estimated that only 9.4% of contracts would lose rebate dollars, and no contracts would reduce their QBP payments. As the only contracts with simulated revenue reductions were contracts with 4.5-Star Ratings, this means that 38 out of the 63 4.5-Star contracts (approximately 60%) dropped to 4.0-Star contracts. Another 4% of contracts got Star Rating reductions without loss of revenue, dropping from 5.0-Star to 4.5-Star, which we estimate as 16 of the 21 contracts (approximately 75%).

[24] With 67 total 4.5-Star contracts per the 2023 Star Rating Fact Sheet. See https://www.cms.gov/files/document/2023-medicare-star-ratings-fact-sheet.pdf.

[25] CMS (March 2023), MA Enrollment, op cit.

[26] CMS, 2023 Star Ratings by Contract, op cit.

[27] CMS (March 31, 2023), Announcement of Calendar Year (CY) 2024, op cit.

[28] Claim-based measures include HEDIS, HEDIS-HOS, PDE, PDE/MPF and Part C/D Plan reporting data types. Non-claim-based measures include CAHPS, HOS, CTM, MBDSS, IRE and Call Center data types.

In the 2024 Final Rule, CMS estimated this change would result in reduced program expenditures of $330 million in 2027, growing to $580 million in 2033.[29] This rule change should therefore have about half the impact as the new HEI rewards system, and the resulting reduced revenue for the 3.5-Star, 4.0-Star and 4.5-Star contracts.

This rule change may also improve the predictability and stability of the non-CAHPS Star Rating measures if the "guardrails" and Tukey outlier removal rule changes have their desired effect.

Hold harmless threshold and other unfinalized rule changes

Current Star Ratings are calculated for each contract both with and without the Part C and D improvement measures included in its overall score. Because continually improving measure results for contracts with high Star Ratings is difficult, CMS will take the maximum final score if the Star Rating without the improvement measures is over 4.0 Stars.

The original intent of the hold harmless provision was to recognize that higher performing contracts have less room to improve,[30] but CMS indicated in the 2024 Proposed Rule that contracts with 4.0 or 4.5 Stars still have room for improvement.[31] Therefore, CMS proposed to increase the threshold from 4.0-Stars to 5.0-Stars.

The proposed rule would take effect for the 2026 Star Ratings (PY 2027), and CMS estimated net savings of $2.1 billion in 2027, growing to $3.5 billion in 2033. The significant savings for CMS under this proposed rule would be attributable to revenue reductions to 4.5-Star and 4.0-Star contracts. This would equate to an average PY 2027 revenue reduction of $10 million to $17 million per 4.0-/4.5-Star contract in the 2023 Star Rating,[32] or $10 PMPM to $13 PMPM[33,34,35] for this cohort.

While this change was not finalized in the 2024 Final Rule, CMS has stated its intention to implement this proposed change in the future. The following Star Rating provisions will also be considered in the future:

- Removal of the stand-alone Part C "Medication Reconciliation Post-Discharge" measure
- Inclusion of the updated Part C "Colorectal Cancer Screening and Care for Older Adults – Functional Status Assessment" measures
- Addition of the Part D "Concurrent Use of Opioids and Benzodiazepines", "Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults", and "Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults" measures

Total expected financial impact of Star Rating changes

Together, the changes stated in the 2024 Final Rule could add up to program savings of approximately $2.3 billion once they are all implemented in PY 2028, and the hold harmless threshold change could bring the total up to $4.6 billion in PY 2028. The actual total CMS cost savings could be higher or lower, as the changes may interact with each other.

Comparing this value to projected 2024 program revenues of around $430 billion, plans would be looking at nearly a 1% reduction to revenues across all MA contracts.[36] However, because these revenue reductions will be concentrated in contracts with 3.5-Star, 4.0-Star and 4.5-Star contracts, the impact for this cohort will be much higher than 1%.

[29] See p.644 of the 2024 Final Rule at https://public-inspection.federalregister.gov/2023-07115.pdf.

[30] The full text of the 2018 Final Rule is available at https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare.

[31] The full text of the 2024 Proposed Rule is available at https://www.govinfo.gov/content/pkg/FR-2022-12-27/pdf/2022-26956.pdf.

[32] With 203 total 4.0-Star 4.5-Star contracts per the 2023 Star Rating Fact Sheet. See https://www.cms.gov/files/document/2023-medicare-star-ratings-fact-sheet.pdf.

[33] CMS (March 2023), MA Enrollment, op cit.

[34] CMS, 2023 Star Ratings by Contract, op cit.

[35] CMS (March 31, 2023), Announcement of Calendar Year (CY) 2024, op cit.

[36] CMS (March 31, 2023). Fact Sheet: 2024 Medicare Advantage and Part D Rate Announcement. Retrieved October 2, 2023, from https://www.cms.gov/newsroom/fact-sheets/fact-sheet-2024-medicare-advantage-and-part-d-rate-announcement. CMS estimated a change in revenue of 3.32% and $13.8 billion, implying 2023 payments of $415 billion and 2024 payments of $430 billion.

This represents a substantial portion of current MA plans' profitability. As discussed in Milliman's most recent analysis of MAOs' financial results, overall program profit margins ranged from 1.8% to 4.7% of revenue from 2017 through 2021.[37]

It is unclear to what extent plans would reduce benefits, increase premiums, or make other changes in response to these payment reductions, as opposed to reducing plan expenses or margins. This question was discussed in the 2021 Final Rule[38] (see sidebar), where CMS expressed its belief that plans would mostly or entirely elect to reduce expenses or margins, as opposed to deteriorating benefits or raising premiums.

Figure 2 helps put the magnitude of the total CMS cost savings that will be absorbed by the 3.5-, 4.0-, and 4.5-Star contracts into context by using the annualized 2023 membership[39] by Star Rating as a baseline to estimate the PMPM impact. The actual PMPM impact will depend on enrollment growth and Star Rating shifts. However, the implication is the aggregate impact of all future methodology changes will fall disproportionately on these contracts, particularly the 4.0-Star plans.

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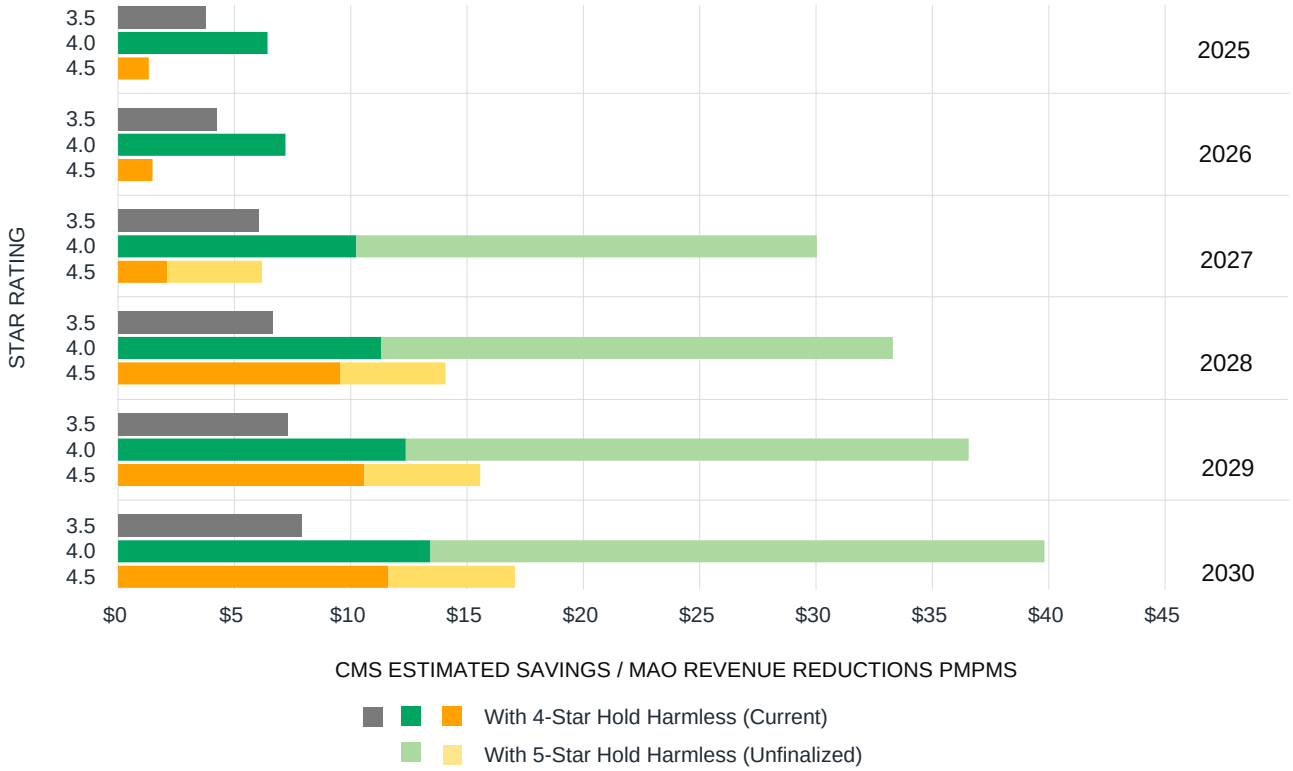
"However, supplemental benefits are only one approach to using the rebate. **The experience of the Social Security Office of the Actuary (OACT) at CMS is that from year-to-year plans prefer to reduce their administrative costs, including profit margins, rather than substantially change their benefit package.**

This is true due to marketing forces; a plan lowering supplemental benefits even one year may lose its enrollees to competing plans that offer these supplemental benefits. Thus, it is advantageous to the plan to temporarily reduce administrative costs, including margins, rather than reduce benefits."

FIGURE 2: CMS COST SAVINGS / MAO REVENUE REDUCTIONS PMPM BY PAYMENT YEAR AND STAR RATING



[37] Ellenberg, P., Kolli, S., Makhija, T., & Sgrosso, G. (November 2022). Medicare Advantage Organizations Financial Results for 2021. Milliman Research Report. Retrieved October 2, 2023, from https://www.milliman.com/en/insight/medicare-advantage-organizations-financial-results-for-2021.

[38] CMS, 2021 Final Rule, op cit.

[39] CMS (March 2023), MA Enrollment, op cit., and CMS, 2023 Star Ratings by Contract, op cit.

What plans can do to succeed

Much of the ability of plans to succeed in Star Ratings boils down to investing time and energy into individual measures, and proactively monitoring performance to identify and affect potential problem areas. With the advent of these new and potential model changes, it can be especially valuable for plans to model the impacts of the new changes on individual Star Ratings measures and line these changes up against their own performance to determine particular points of vulnerability and opportunity. We also envision the following considerations for plans.

TABLE 2: TIMELINE FOR EACH MAJOR STAR RATING METHODOLOGY CHANGE

Methodology	MEASURE	STAR RATING	PAYMENT
Change	Year	Year	Year
Tukey Outliers	2022	2024	2025
Weight Changes	2024	2026	2027
HEI Rewards	2024 & 2025	2027	2028
Hold Harmless	*2024*	*2026*	*2027*

Note: Increasing the hold harmless threshold from 4.0-Stars to 5.0-Stars is currently unfinalized

For reference, we included a timeline in Table 2 for each major Star Rating methodology change discussed below.

HEI REWARDS

The introduction of HEI into rewards may lead plans to re-evaluate traditionally underserved SRF populations (dual-eligible, low-income, and disabled populations). High performance plans may lose their Star Rating reward due to SRF populations that are too small. These plans may want to consider proactive marketing efforts to higher needs populations or service area expansions into underserved communities.

The HEI rewards may also create new opportunities for MAOs that already engage with underserved populations. CMS has noted that seven MA-PD contracts gained a half Star in its simulation of the HEI rewards system, and other 3.5-Star or lower contracts may have an opportunity to improve their Star Ratings by focusing on reducing disparities between SRF and non-SRF populations.

Plans may engage their pharmacy benefit managers (PBMs) to understand what programs may be available to increase patient engagement, particularly with pharmacies located in underserved areas. The goal here would be to reduce, or eliminate, disparities for those beneficiaries with and without SRFs.

TUKEY OUTLIERS

As discussed in cut point simulations released by CMS[40] and the 2024 technical notes, the removal of Tukey outliers has substantially changed the cut points values for multiple measures. Plans should not assume they can maintain their current Star Ratings for these measures just because they are able to maintain current performance levels. Instead, plans should proactively review their historical individual Star Ratings measure performances and compare them to the new cut points released by CMS.

Because competitors may well be taking the same approach on these measures, there could be continued pressure on these measures as they get additional attention across the MA program, and plans should continue to monitor trends in these measures accordingly. If there are any measures where the new cut points approach plans' current performance levels, plans should devote particular attention to improving their performance in these measures to keep up with the market.

Key pharmacy-influenced measures are also subject to Tukey outliers, so plans may wish to consider implementing clinical programs to improve these measures.

[40] CMS. Tukey Outlier Deletion Simulations. Retrieved October 2, 2023, from https://www.cms.gov/files/zip/tukey-outlier-deletion-simulations.zip (zip file download).

HOLD HARMLESS THRESHOLDS

Plans that have historically maintained overall high Star Ratings could also reorder individual priorities, more actively engaging with measures that had previously been protected by hold harmless thresholds. If the new hold harmless thresholds are set to 5.0-Stars, then many plans will lose their protection. Considering in advance the level of effort required to either achieve 5.0-Stars or show sufficient improvement to avoid a penalty could be valuable for plans seeking to maintain or even improve their Star Ratings.

ADDITIONAL EFFORTS

Given the changing environment, plans may find it especially important to proactively track performance earlier in the year to ensure that performance levels are in line with expectations, and where there are deficiencies, make changes while there is still time to affect the next round of Star Rating values.

Plans should consider working with their PBMs to better understand opportunities to increase patient engagement, particularly with pharmacies located in underserved areas, and reduce or eliminate disparities for SRF populations.

Plans may also share quality measure performance with providers and provider groups throughout the year to identify any entities whose performance or disparities in care between SRF and non-SRF populations could affect Star Ratings. Providers can then be engaged in developing quality initiatives or better incentivize performance in targeted areas.

Plans could also potentially use VBID as a tool to support efforts to ameliorate potential Star Ratings impacts. VBID can be used to improve HEI rewards as income/dual status can be a trait to identify participating program members. Plans can also use VBID to offer low or reduced cost sharing to members with chronic conditions, as well as considering rewards and incentives to target improved adherence for selected medications.

Closing remarks

While the revenue reductions discussed in this paper are substantial, we consider it helpful to compare these reductions in plan revenues to those implemented in the Affordable Care Act (ACA), another major reduction to payments for the Medicare Advantage program.

While the cost impact of the ACA's changes on MA cannot be precisely measured, it is reasonable to rely on the 2015 Congressional Budget Office's (CBO) report on the economic effects of repealing the ACA, including the CBO's estimate of $36 billion per year in MA payment reductions, a reduction more than six times larger than the total reductions discussed in this paper.[41]

After the ACA was passed into law, many expected substantial enrollment reductions in the program.[42] Instead, MA has since grown substantially larger, both in terms of total members and in terms of the overall share of Medicare membership (up from 24% in 2010 to 49% in 2023).[43]

Given that the new Star Ratings changes are projected by CMS to be substantially lower than the reductions to MA from the ACA, it is reasonable to expect that the program can continue to thrive despite these material reductions.

While these changes to the Star Ratings may not drive substantial drops in MA's popularity, they may still drive substantial adverse effects for many MAOs and their members. Some plans have already seen these impacts through reductions to their preliminary Star Ratings that CMS recently provided, while others may be impacted by the additional changes that CMS will be implementing in the coming years.

[41] CBO (June 19, 2015). Budgetary and Economic Effects of Repealing the Affordable Care Act. Retrieved October 2, 2023, from https://www.cbo.gov/publication/50252.

[42] Norris, L. Medicare and the Affordable Care Act. MedicareResources.org. Retrieved October 2, 2023, from https://www.medicareresources.org/basic-medicare-information/health-reform-and-medicare.

[43] CMS. MA State/County Penetration. Retrieved October 2, 2023, from https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/ma-state/county-penetration.

It is important for plans to understand these changes and how they may drive financial changes in the coming years, both for individual organizations and the larger markets in which they operate. Important business decisions around benefit and premium targets for 2025 bids will rely on an accurate understanding of the new environment in which all plans must operate, as well as additional changes coming in 2026 and beyond. Understanding the nuances of upcoming Star Rating measure changes is crucial for MAOs, and seeking expert guidance can offer valuable insights into how these changes might impact individual plans.

LIMITATIONS AND DATA RELIANCE

We primarily relied on information and data provided by CMS, including both publicly released membership data and projections for model impacts. We also relied on other information provided by additional sources, primarily relating to policy analysis. Throughout this analysis, Milliman relied on data and other information provided by publicly available data sources. The estimates included in this paper are not predictions of the future; they are estimates based on the assumptions and data analyzed at a point in time. If the underlying data or other listings are inaccurate or incomplete, the results may also be inaccurate or incomplete. Milliman has not audited or verified this data and other information but has reviewed it for reasonableness.

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QUALIFICATIONS

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Hayley Rogers, Matthew Smith, and Mike Yurkovic are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this paper.

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