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Future Visions of Reform:

Policy Options for the Medicare Advantage Quality Bonus Program and Star Ratings

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OVERVIEW

Arnold Ventures engaged Leavitt Partners (LP), a Health Management Associates, Inc. (HMA), company, to evaluate the Medicare Advantage (MA) Quality Bonus Program (QBP) and the Star Ratings System. The purpose of the study was to identify possible improvements to the MA program for enrollees and contribute to Medicare's fiscal sustainability.

We focused on two major concerns with the QBP and Star Ratings System as it is now structured:

1. The MA QBP is financed with additional Medicare program dollars. As overall bonus payment levels rise, the QBP has the potential to increase financial pressure and negatively affect the long-term fiscal sustainability of Medicare.
2. Some evidence shows that MA Star Ratings are of limited value to MA enrollees seeking to evaluate MA plan quality.[1,2]

Based on this assessment, LP performed a comprehensive literature review to identify existing QBP/Star Ratings reform proposals. For each policy identified, we evaluated the policy's potential to:

1. Decrease QBP spending.
2. Increase utility of the Star Ratings for MA enrollees.
3. Incentivize interventions that hold promise to improve beneficiary health outcomes.

LP also interviewed key opinion leaders (KOLs), including former Administration officials, present and former Republican and Democrat congressional staffers, representatives of the health insurance industry, as well as academics and researchers, to further evaluate the impact and viability of each policy.

Based on our analysis, LP developed a set of policy options to improve the QBP and Star Ratings. LP then worked with HMA and the actuarial firm Wakely Consulting Group to model a set of policy options to evaluate their potential budgetary savings and impact on Medicare sustainability. For some of the policy options included in our report, it was infeasible to model the potential budgetary impact, either because of insufficient publicly available data or for other reasons. Additional details regarding our modeling process are included in our analysis of each policy option.

This report includes a set of eight policy options to improve the QBP/Star Ratings to ensure they have a meaningful impact on MA program enrollees. These policy options also would allow Medicare to better target program resources to areas where they are needed most. Reforming the QBP/Star Ratings has an important role to play in improving the financial stability of Medicare. To ensure the long-term fiscal health of Medicare, additional savings also will have to be found in other parts of the program, and we support a holistic approach to Medicare sustainability efforts.

These policy options encompass a broad scope of potential changes to the QBP/Star Ratings and would address QBP spending growth, the content of the Star Ratings measure set, and an approach for developing performance benchmarks to make it easier to evaluate the quality of MA plans. Should any of these policy options be advanced either on their own or as part of a larger legislative package, consideration should be given to how these policy options can be implemented without disruptions for MA enrollees and while maintaining stability within MA markets.

We estimate that collectively, these policies could produce up to $108 billion in savings for Medicare over a 10-year period and could extend the solvency of the Hospital Insurance (HI) Trust Fund by an entire year.

Reforming the QBP/Star Ratings has an important part to play in improving the financial stability of Medicare. While the potential savings our policy options could produce are significant, Medicare spending is projected to increase to over $1.9 trillion per year by 2032. In order to ensure the long-term fiscal health of Medicare, additional savings will also have to be found in other parts of the program and revenue adjustments may have to be made. These policy options could form one component of a holistic approach to strengthening Medicare and improving its sustainability.

The initial two policy options to address QBP spending growth would require legislative action, whereas the remaining policy options could be implemented through regulatory action.

Policy Options to Reform the Medicare Advantage Quality Bonus Program and Star Ratings

Changes

- Reduce and Tier the Benchmark Bonus
- Incentivize Investment in Innovative, Digitally Supported Measures
- Evaluate Quality at the Local Market Level
- Modify Star Ratings Cut Points to Increase the Predictability of QBP Attainment for Plans
- Eliminate Double Bonuses from MA Benchmarks
- Reduce and Simplify the Existing Measure Set
- Limit the Overall Percentage of Plans that Achieve 4 or 5 Stars
- Stratify Plans with Similar Characteristics to Evaluate Quality

Savings

Anticipated Savings to the Medicare Program

- $108B in cost savings over 10 years
- Reduces Medicare Part A deductibles and Part B premiums
- Extends HI Trust Fund Solvency
- Lowers Medicare Advantage spending per enrollee

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Category	Action Required	Policy Option	Budgetary Impact
Addressing QBP Spending Growth	Legislative	#1: Reduce and Tier the Benchmark Bonus for New Plans and 4 and 4.5 Star Plans	• 1-Year Savings: $5.1 B • 10-Year Savings: $81.8 B • Extends HI Trust Fund Solvency by 1-Year • Reduces Gap Between Medicare Part A Expenditure and Revenues in 2035 by 30% • Reduces the Part A Deductible by $128 and the Part B Premium by $16 • Lowers MA Spending Per Enrollee by $2000 Per Year
		#2: Eliminate Double Bonuses from MA Benchmarks	• 1-Year Savings: $2.5 B • 10-Year Savings: $39.5 B • Reduces Gap Between Medicare Part A Expenditure and Revenues in 2035 by 12% • Reduces the Part A Deductible by $56 and the Part B Premium by $8 • Lowers MA Spending Per Enrollee by $900 Per Year
Changes to the MA Star Ratings	Regulatory	#3: Reduce and Simplify the Star Ratings Measure Set	• 1-Year Savings: $3.4 B • 10-Year Savings: $53.8 B • Extends HI Trust Fund Solvency by 1-Year • Reduces Gap Between Medicare Part A Expenditure and Revenues in 2035 by 20% • Reduces the Part A Deductible by $89 and the Part B Premium by $11 • Lowers MA Spending Per Enrollee by $1,371 Per Year
		#4: Incentivize Investment in Innovative, Digitally Supported Measures	No Modeling Available

Category	Action Required	Policy Option	Budgetary Impact
Performance Benchmarks and Comparisons	Regulatory	#5: Evaluate Quality at the Local Market Level	No Modeling Available
		#6: Limit the Overall Percentage of Plans that Achieve 4 or 5 Stars	No Modeling Available
		#7: Modify Star Rating Cut Points to Increase the Predictability of QBP Attainment for Plans	No Modeling Available
		#8: Stratify Plans with Similar Characteristics to Evaluate Quality	• 1-Year Savings: $370 M • 10-Year Savings: $5.8 B • Reduces Gap Between Medicare Part A Expenditure and Revenues in 2035 by 1% • Reduces the Part A Deductible by $8 and the Part B Premium by $1 • Lowers MA Spending Per Enrollee by $179 Per Year
		Collectively Enacting and Implementing all Policy Options*	• 1-Year Savings: $6.8 B • 10-Year Savings: $108 B • Extends HI Trust Fund Solvency by 1-Year • Reduces Gap Between Medicare Part A Expenditure and Revenues in 2035 by 39% • Reduces the Part A Deductible by $172 and the Part B Premium by $21 • Lowers MA Spending Per Enrollee by $2,700 Per Year

*The budgetary impact of collectively enacting and implementing the policy options as a group does not equal the sum of the individual policy options budgetary impact. Enacting and implementing the policy options as a group would create some overlap in the budgetary savings produced by each individual policy option, which affects the overall budgetary impact of collectively enacting and implementing the policy options as a group.

INTRODUCTION

The Affordable Care Act (ACA) established the MA QBP, which rewards MA plans for achieving a composite 4 Star Rating or better on MA's Star Ratings System. In addition to being the basis for establishing MA plan eligibility for a QBP bonus, the Star Ratings are intended to provide MA enrollees meaningful information on MA plan quality.

Since the ACA's enactment, enrollment in MA has continued to grow rapidly. In 2010, only 25 percent of eligible Medicare beneficiaries were enrolled in MA.[3] By 2023, 51 percent of eligible Medicare beneficiaries were enrolled in MA.[4] This growth is expected to continue, with the Congressional Budget Office (CBO) projecting MA enrollment at 62 percent of all eligible Medicare beneficiaries by 2033.[5]

At the same time, Medicare spending on QBP payments have risen rapidly, with annual payments to plans climbing by nearly $10 billion over eight years.[6] Some of this recent growth is attributable to temporary Star Ratings methodology changes that CMS put in place during the COVID-19 pandemic.[7] However, even with the pandemic's conclusion, QBP payments likely will continue to increase.

Many quality incentive programs in traditional Medicare, such as the Hospital Value-Based Purchasing (VBP) Program or the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program, are budget-neutral. Budget-neutral quality incentive programs typically reward high-performing entities and penalize low-performing entities, with increased payments to high-performers being offset through payment reductions for low-performers.

Unlike budget-neutral incentive programs, the QBP functions as an add-on payment to MA plans and is financed with additional Medicare program dollars. Though the QBP financially rewards MA plans that achieve a qualifying Star Rating, it does not assess a penalty on low-performing MA plans. As the overall level of QBP payments to plans increases, so do the financial pressures on Medicare as a whole.



BACKGROUND ON THE QBP AND STAR RATINGS

The Star Ratings System was created in 2008 to assess quality among MA plans and provide enrollees with information on the quality of those plans.

Under the Star Ratings System, plans are evaluated on a set of measures across several domains, including Health Plan Customer Service and Managing Chronic Conditions.

Plan performance across these measures is then aggregated into a single score of one to five stars, with five stars representing the highest performing plans.

Initially, Star Ratings did not affect payments to plans. This changed in 2012 when the QBP, which rewards MA plans for attaining a specific overall Star Ratings score, took effect. The QBP financially rewards MA plans that score well on the Star Ratings in two ways. First, plans that achieve a 4 Star Rating or higher, receive a 5 percent increase to their benchmark (the benchmark bonus), which translates into higher capitated payments for providing coverage for each enrollee within that plan.[8]

Second, plan rebates—the share of the difference between the plan bid and the benchmark that is awarded to plans—increase when plans achieve a higher Star Rating. The rebate for 4.5 and 5 Star plans is 70 percent of the difference, for 3.5 and 4 Star plans it is 65 percent of the difference, and for plans with 3 or fewer Stars, it is 50 percent of the difference. MA plans located in double-bonus classified counties that have historically low Medicare fee-for-service spending and historically high MA enrollment are eligible for a 10 percent increase to their benchmark when they qualify for a QBP bonus.[9]

Since its inception, the QBP has significantly increased payments to MA plans, reaching an all-time high of at least $12.8 billion total in 2023.[6] QBP bonus payment growth in recent years has been driven by several factors, including growth in the number of MA plans qualifying for bonus payments and growth in enrollment among QBP-qualifying plans.

Recently, CMS has made several changes to the approach used to develop Star Ratings, including the introduction of the Tukey outlier deletion cut point methodology, which is designed to improve predictability and stability, and replacing the current reward factor with a Health Equity Index reward.*

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* The Tukey outlier deletion methodology went into effect with the 2024 Star Ratings and removes outlier contract scores before calculating measure-level cut points. For 2024, it has resulted in cut point increases for many measures and has contributed to a decline in average Star Ratings scores. The Health Equity Index will take effect with the 2027 Star Ratings and is designed to encourage MA and Part D plans to improve care for enrollees with certain social risk factors.



CMS estimates that implementing the Tukey methodology will yield $935 million in savings for 2025, and that replacing the current reward factor with one that is based on the Health Equity Index will result in a net savings of $670 million in 2028.[10,11] Though these savings are significant, MA plans will likely attempt to modify their practices in response to these changes, which could partially mitigate the long-term savings potential of these changes if MA plans continue to qualify for QBP payments in significant numbers. Without further action, QBP payment levels will likely continue to grow. Our policy options to modify the QBP would produce more predictable and steady savings over time by addressing the QBP's level of payment.

The Star Ratings System also has several limitations that prevent it from providing more value to MA enrollees, including:

- An enrollee's ability to assess the quality of a plan may be obfuscated by the number of measures incorporated into the Star Ratings.
- The Star Ratings measure set has some gaps in areas such as behavioral health and post-acute care.
- The Star Ratings measure set does not apply to fee-for-service (FFS) Medicare, which limits its utility to enrollees when deciding between MA and FFS Medicare or to beneficiaries who want to compare quality between the two programs in a specific service area.

The following policy options are designed to help to limit QBP spending growth and increase the utility of the Star Ratings for MA enrollees.

ADDRESSING QBP SPENDING GROWTH

This section offers two policy options that would modify the benchmark payment increases that MA plans receive when they qualify for a QBP bonus. The policy intent is to continue to incentivize and reward MA plans for achieving high quality, while also ensuring that QBP bonus payment growth remains within fiscally sustainable levels and does not negatively affect the Medicare program.

Policy Option #1: Reduce and Tier the Benchmark Bonus for New Plans and 4 and 4.5 Star Plans

This policy would modify the QBP so that new and low enrollment MA plans receive a benchmark bonus of 1.5 percent, 4 and 4.5 Star plans receive a benchmark bonus of 2.5 percent, and 5 Star plans continue to receive a benchmark bonus of 5 percent.

Rationale

As the QBP is currently structured, MA plans that achieve a 4–5 Star Rating all receive the same 5 percent benchmark bonus. New MA plans and those that are without a sufficient number of enrollees to reliably measure performance currently receive a 3.5 percent benchmark bonus.[8] Differentiation between plan quality is meaningful for MA enrollees, and QBP bonuses should be structured so that plans achieving the highest quality performance receive the greatest reward. Though 4 and 4.5-Star MA plans should continue to receive a bonus for achieving high quality, they should be rewarded at a lower rate than plans that achieve 5 Star Ratings to encourage continuous quality improvement.

In 2023, more than 65 percent of MA enrollees were in a 4 or 4.5 Star plan.[12] Reducing benchmark bonuses by 2.5 percent for these plans would provide significant budgetary savings while continuing to incentivize MA plans to engage in quality improvement activities in order to achieve a QBP payment.

New and low enrollment plans typically lack enough data to reliably assess plan quality. Decreasing the benchmark bonus for these plans is not an indication that these plans are of poor quality, but rather that they lack metrics to establish quality. The QBP should be a mechanism to reward quality, and while new and low enrollment plans should not be penalized for low membership or a lack of data, larger benchmark bonus amounts should be awarded to those plans that can demonstrate they provide high-quality care.

Method of Enactment/Implementation

Altering the benchmark bonus system will require legislative action. Upon enactment of this policy, Congress should direct CMS to implement these proposed changes to the benchmark bonus over a period of three years. This will give MA plans enough time to prepare for the policy change, initiate a quality improvement strategy that responds to the impending policy change, and will also minimize any potential impact on MA plan enrollees.

Following the first year of enactment of this policy, no changes would be made to the QBP benchmark bonus. Following the second year of enactment, new and low enrollment MA plans would have their benchmark bonus reduced to 2.5 percent and 4 and 4.5 Star plans would have their bonus reduced to 4 percent. Following the third year of enactment, the policy change would become fully effective. Subsequently, new and low enrollment plans would receive a 1.5 percent benchmark bonus, and 4 and 4.5 Star plans would receive a 2.5 percent benchmark bonus.

Modeling and Impact

We modeled the potential budgetary impact of this policy option utilizing the published 2024 Star Ratings and the 2025 payment year Medicare FFS benchmark rate. Our modeling found that adjusting bonus payment for 4 and 4.5 Star plans from 5 percent to 2.5 percent and new and low enrollment plans from 3.5 percent to 1.5 percent would produce $5.1 billion in QBP savings in a single year.

To project potential savings over a 10-year period consisting of QBP payment years 2026–2035 we used the MA enrollment projections from the CBO's May 2023 Medicare Baseline Projections. The Medicare FFS non-end stage renal disease (ESRD) benchmark growth calculations included in CMS's calendar year (CY) 2024 Advance Notice were trended at the same growth rate and incorporated into our modeling. Lastly, we assumed the QBP eligible distribution of enrollees remained the same as in the last measurement period (measurement year 2022, Star Ratings year 2024, and payment year 2025 = 74% of enrollees in MAPD plans). Based on these assumptions, we estimate a potential savings of up to $81.8 billion over our 10-year projection period. However, the overall savings depend on a number of variables, such as actual MA enrollment and FFS benchmark growth, so a range of potential savings is possible.

We then modeled the impact the savings would have on the HI Trust Fund using data included in the 2023 Medicare Trustees' Report. Our model projects Medicare revenues and savings from 2023 to 2042 and the model's expenditure and revenues, assumptions, and growth rates are consistent with those found in the 2023 Medicare Trustees' Report for years 2022−2033. For years 2034−2042, we projected expenditure and revenue growth using the Trustees Income and Cost growth projections. We estimate that the savings this policy option could produce would add one year of solvency to the HI Trust Fund. In addition, we estimate that the gap between expenditures and revenues in Medicare Part A would be reduced by 30 percent in 2035. Further, the savings yielded could reduce the Part A deductible by $128, reduce the part B premium by $16, and lower MA spending per beneficiary by $2,000 per year.

The policy intent is to continue to incentivize and reward MA plans for achieving high quality, while also ensuring that QBP bonus payment growth remains within fiscally sustainable levels and does not negatively affect the Medicare program.

Policy Option #2: Eliminate Double Bonuses from MA Benchmarks

This policy option would modify the current QBP structure by eliminating the provision of 10 percent benchmark increases for qualifying MA plans located in double bonus counties.

Rationale

When the ACA was enacted, it altered the existing payment methodology for MA plans, and stakeholders were concerned that a significant share of plans would leave specific markets in response to potential payment reductions.[13] Double bonuses were considered an effective means to increase MA plan participation in specific markets that may have otherwise lacked sufficient MA plan competition.

Today, access to MA plans is robust, with one-third of Medicare enrollees living in a county with more than 50 MA plans available in 2024, and less than 1 percent of enrollees living in a county with fewer than four MA plans.[14] For 2024, the average MA enrollee can choose between MA plans offered by eight different companies.[14] Though double bonuses may have been necessary to encourage sufficient MA plan participation in certain markets at the time of the ACA's enactment, that is likely no longer the case. Research on double bonuses has also shown that receipt of a double bonus had a limited effect on MA plan quality.[15]

Eliminating double bonuses would contribute meaningfully to Medicare sustainability. Under this proposed policy change, MA plans would continue to qualify for bonus payments, although none would be eligible for a double bonus, and MA plans would still have an incentive to invest in quality improvement activities to attain an additional QBP payment.

Method of Enactment/Implementation

Eliminating double bonuses from MA benchmarks will require legislative action. Congress should direct CMS to eliminate double bonuses with a three-year phase-out period. This timeline will give MA plans sufficient time to prepare for the policy change and help minimize any potential impact on MA plan enrollees.

Following the first year of enactment, no changes would be made to the calculation of double bonuses. During this period, plans would have time to assess how the cessation of double bonuses might financially affect the plan and adjust internal operations accordingly. Following the second year of enactment, qualifying MA plans located in a double bonus county would have their benchmark bonus increased by an additional 2.5 percent above their applicable benchmark bonus amount. Following the third year of enactment, this policy would become fully effective, and MA plans would no longer qualify for any type of enhanced bonus above their QBP bonus amount.

Modeling and Impact

We modeled the potential budgetary impact of this policy option using the published 2024 Star Ratings and the 2025 payment year Medicare FFS benchmark rate. Our modeling found that eliminating double bonuses would produce approximately $2.5 billion in QBP savings in a single year.

To model the potential savings for this policy option over a 10-year projection period consisting of QBP payment years 2026–2035, we applied MA enrollment projections from the CBO's May 2023 Medicare Baseline Projections. The Medicare FFS Non-ESRD benchmark growth calculations included in the CY 2024 Advance Notice were trended at the same growth rate and incorporated into our modeling. Lastly, we assumed the QBP eligible distribution of enrollees remained the same as in the last measurement period (measurement year 2022, Star Ratings year 2024, and payment year 2025 = 74% of enrollees in MAPD plans). Based on these assumptions, we estimate a potential savings of up to $39.5 billion over the 10-year projection period. Overall savings, however, are dependent on a number of variables, such as actual MA enrollment and FFS benchmark growth, so a range of potential savings is possible.

We then modeled the impact the savings would have on the HI Trust Fund using data from the 2023 Medicare Trustees' Report. Our model projects Medicare revenues and savings in 2023–2042, and the model's expenditure and revenues, assumptions, and growth rates are consistent with those found in the 2023 Medicare Trustees' Report for years 2022–2033. For years 2034–2042, we projected expenditure and revenue growth using the Trustees Income and Cost growth projections. Although the estimated savings produced by this policy option would not affect the projected insolvency date of the HI Trust Fund, we estimate that the gap between expenditures and revenues in Medicare Part A would be reduced by 12 percent in 2035. Further, the savings produced by this policy option could reduce the Part A deductible by $56, decrease the Part B premium by $8, and lower MA spending per beneficiary by $900 per year.

CHANGES TO THE MA STAR RATINGS

This section includes two policy options to improve the content of the Star Ratings and to make them more meaningful to both policymakers and enrollees.

Policy Option #3. Reduce and Simplify the Existing Measure Set

Policy Option #4. Incentivize Investment in Innovative, Digitally Supported Measures

We believe these two policy options are interrelated and thus are including a single rationale section for both. Additional details on enactment/implementation and modeling can be found in separate sections below.

Rationale

Narrowing the Star Ratings measure set will reduce the burden of quality reporting across the healthcare system and make room for selected, high-value measures, particularly those focused on outcomes that matter to patients.

The Star Ratings measure set comprises 42 unique measures, including 30 for Part C and 12 for Part D.[12] Critics have noted that the measures are burdensome to the entire healthcare system because plans depend on healthcare providers and facilities to support their data reporting. Key types of care that are important to enrollees are missing from the current set, such as behavioral health and post-acute care.[16]

Streamlining the Star Ratings measure set today will allow for innovation and investment, particularly in new measure approaches that are based on electronic clinical data and patient-reported outcomes. These data sources can also be a better support for quality monitoring and improvement as well as reporting. Digital measures also provide a common data platform for comparing MA with FFS Medicare.

These proposals amplify an existing CMS strategy. CMS has indicated an intent to align quality incentives around a "Universal Foundation" of performance measures.[17] In addition, the CMS Quality Strategy focuses on a transition to digital measures that will lessen the burden of data collection and build on interoperability standards to improve coordination of care.[18] The strategy includes a specific goal of incorporating more performance measures based on patient-reported data in quality programs. Measures based on electronic clinical data and patient-reported outcomes would also make it more feasible to make comparisons with FFS Medicare.

The CMS Interoperability and Prior Authorization rule finalized in January 2024 paves the way for digital quality measurement by requiring MA plans to implement, by 2027, Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) application programming interfaces (APIs) to support the exchange of healthcare data.[19] Still, moving to innovative, digitally supported measures that are more relevant and readily available for clinical care presents numerous challenges, especially for health plans that do not have a captive provider network. Others have noted the need to incentivize investment in new digital capacities. For example, a national approach to hospital ratings includes an implementation survey to assess implementation of patient-reported outcome tools, including the tools used, the auditing and report process, and how the results translate into healthcare delivery.[20]

The policy intent is to improve the content of the Star Ratings and to make them more meaningful to both policymakers and enrollees.

Policy Option #3: Reduce and Simplify the Star Ratings Measure Set

Method of Enactment/Implementation

Reducing the number of measures in the Star Ratings measurement set could be accomplished through regulatory action. CMS should reduce the total number of measures by eliminating measures that are not aligned with the Universal Foundation. This would remove existing measures that primarily address operational issues and processes of care. In addition, CMS should limit the number of measures per Universal Foundation domain to one or two and use rotation of measures to ensure accountability for diverse clinical conditions, aspects of care, and populations.

This policy option recognizes that the Core set will not remain static over time and affords CMS and MA plans an opportunity to build toward new measures that address key gaps, such as outcomes in behavioral health and post-acute care, and enrollee experiences with plan operations in areas like network adequacy, prior authorization, and denials.

Modeling and Impact

We modeled the impact of a streamlined set by selecting 12 measures, split between clinical quality and care experiences that are in the existing Star Ratings and aligned with the Universal Foundation. We used the measure set and Star Ratings data from 2023 (the most recent year available) and used weights specified for 2025. We were limited in this analysis to existing measures, and it is important to note that some domains, particularly behavioral health and equity, do not have measures in the 2023 Star Ratings.

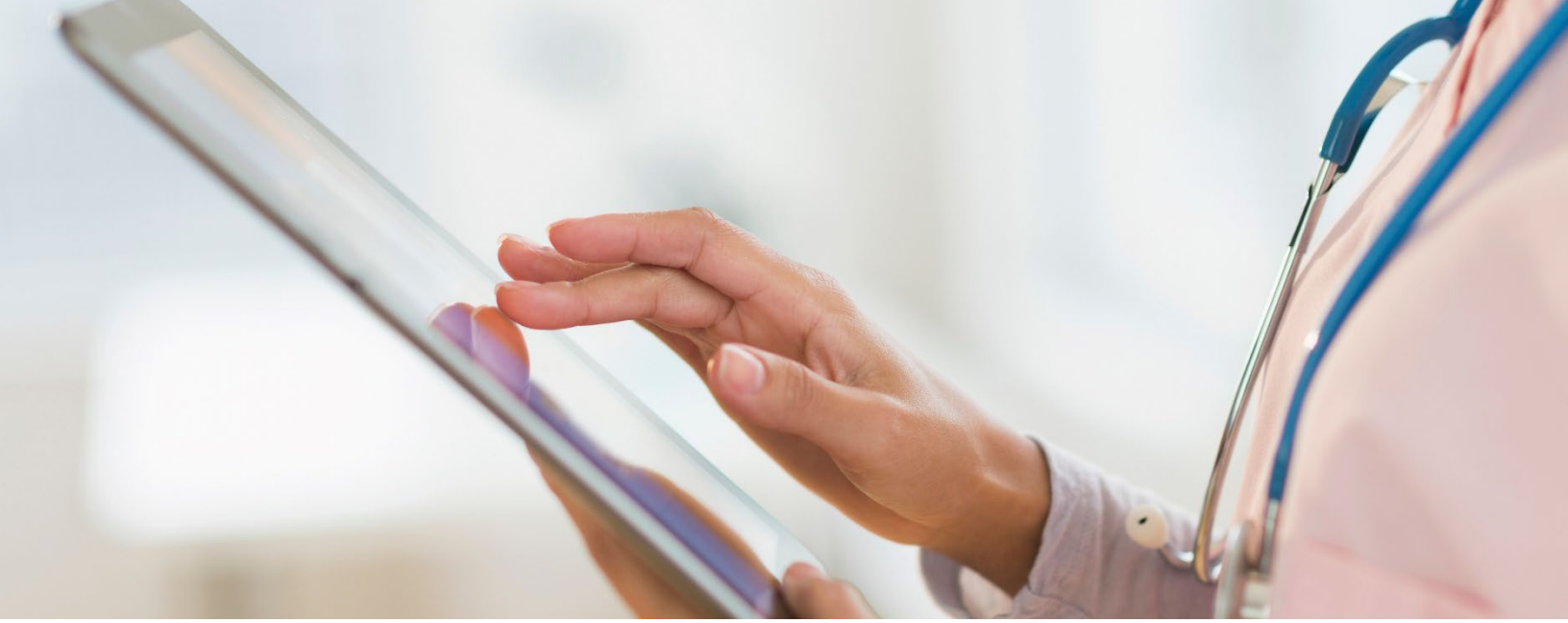
Our modeling found that simplifying the Star Ratings would produce approximately $3.4 billion in QBP savings in a single year. These savings reflect the greater emphasis on clinical quality (HEDIS®) and care experiences (Consumer Assessment of Healthcare Providers and Systems) measures with the removal of operational and access measures that are heavily weighted in the Star Ratings and tend to have higher performance. Under the simplified measure set, the overall ratings will be lower, and fewer health plans will qualify for QBP payments.

Over a 10-year implementation period, the savings are estimated to be approximately $53.8 billion. These savings could be redirected to support bonuses for investment in innovative measures (See Policy Option 4 below).

We then modeled the impact the savings would have on the HI Trust Fund based on data in the 2023 Medicare Trustees' Report. Our model projects Medicare revenues and savings from 2023−2042 and our model's expenditure and revenues, assumptions, and growth rates are consistent with those in the 2023 Medicare Trustees' Report for years 2022−2033. For years 2034−2042, we projected expenditure and revenue growth using the Trustees Income and Cost growth projections. We estimate that the savings produced by this policy option could add one year of solvency to the HI Trust Fund. In addition, we estimate that the gap between expenditures and revenues in Medicare Part A would be reduced by 20 percent in 2035. Further, the savings produced by this policy option have the potential to reduce the Part A deductible by $89, decrease the Part B premium by $11, and lower MA spending per beneficiary by $1,371 per year.

Table 1. Measures Used in Modeling

Universal Foundation Domain	Measure Name	Weight
Wellness & Prevention	Breast Cancer Screening	1
	Colorectal Cancer Screening	1
	Annual Flu Vaccine	1
Chronic Conditions	Diabetes Care – Blood Sugar Controlled	3
	Controlling Blood Pressure	3
Seamless Care Coordination	Plan All-Cause Readmissions	3
Person-Centered Care	Getting Needed Care	2
	Getting Appointments and Care Quickly	2
	Customer Service	2
	Rating of Health Care Quality	2
	Rating of Health Plan	2
	Care Coordination	2



Policy Option #4: Incentivize Investment in Innovative, Digitally Supported Measures

Method of Enactment/Implementation

Adding a bonus for investment in innovative measures to the Star Ratings could be accomplished through regulatory action. CMS should encourage plans to invest not just in their organization's infrastructure, but in supporting data exchange among the providers that serve their members. This infrastructure and collaboration is necessary to move to more meaningful measures that use electronic clinical data and that capture the patient voice. New measures that capture person-centeredness are particularly important given concerns about the weaknesses of currently available CAHPS measures.[21]

Specifically, CMS could create a bonus reward for plans that a) invest in supporting their provider network in digital data capabilities' including capture, visualization, and use of clinical and patient-reported outcome data, and b) increase the volume and representativeness of clinical data that are electronically reported for existing and innovative clinical quality measures, consistent with existing rules for interoperability from CMS and ONC. This reward should focus on improvement in infrastructure and electronic reporting, in order to support plans with fewer resources in developing capabilities. CMS should assess and adjust benchmarking to account for potential lower rates of performance in early years as data capture matures.

Modeling and Impact

Incentivizing plans to invest and demonstrate progress in their ability to report on digital measures using electronic clinical data and patient-reported outcomes would pave the way for a more meaningful Star Ratings measure set. As a new bonus reward, this would increase spending but could be tied to the savings in simplifying the core set. This action would lower burden and cost for providers supporting plan reporting. Given the lack of publicly available data on the current status of investment and infrastructure for measures based on electronic clinical data and patient-reported outcomes, we were unable to model the budgetary impact of this policy option.

PERFORMANCE BENCHMARKS AND MA PLAN COMPARISONS

This section includes four policy options that would enable better measurement and evaluation of MA plan quality. This would not only allow potential MA enrollees to better assess plan quality and more efficiently compare MA plans within their market when selecting coverage, but also would allow MA plans to better gauge their own quality performance in comparison to their peer organizations before Star Ratings are assigned and QBP payments are made.

Policy Option #5: Evaluate Quality at the Local Market Level

Under this policy, the Star Ratings methodology would be modified so that quality is evaluated at the MA plan level within a local market, such as an individual county, state, or region, rather than evaluated at the MA contract level.

Rationale

Medicare Advantage Organizations (MAOs) contract with CMS to provide MA plans to Medicare enrollees. An MA contract is typically comprised of a number of individual MA plans which can be located in separate markets, and contracts can include MA plans in entirely different, noncontiguous states. CMS averages the Star Ratings measure performance of the MA plans comprising a contract and assigns an overall Star Rating to the contract based on this average. Bonuses for qualifying contracts also are assigned at the contract level.

All plans that comprise an MA contract receive the same overall Star Rating that the contract receives and if the contract receives a 4 Star Rating or above, all plans included under the contract also receive a bonus payment. Under this methodology, low and average quality plans are still able to receive a high overall Star Rating and bonus payment if they are included in a contract that has a high overall Star Rating. A flaw with this approach is that assigning Star Ratings at the contract level does not provide a meaningful indicator of plan quality to enrollees seeking to evaluate plans within their local market.

A potential MA enrollee evaluating an MA plan providing coverage within a specific county can view the Star Rating for the overall MA contract that the plan is a part of. However, the enrollee would be unable to easily discern what other plans are included in that contract, the Star Ratings of the individual plans that comprise the contract, or the geographic location of the other MA plans included in the contract. This could lead to a scenario in which a consumer selects a plan based on the high overall Star Rating of the contract, but the individual plan selected is of average or low quality. Evaluating quality at the plan level within a local market would provide consumers more meaningful information to inform their plan selection.



Method of Enactment/Implementation

Modifying the Star Ratings methodology so that Star Ratings are no longer assigned at the contract level and are instead assigned at the plan level within a local market could be accomplished through regulatory action.

Assigning Star Ratings at a local geographic level such as a county, state, or other regional geographic area would allow consumers to make a more meaningful comparison of plan quality when considering enrolling in a specific health plan. However, determining the appropriateness of the local market at which to evaluate plan quality should be determined through an analysis undertaken by CMS.

Evaluating plan performance on certain Star Ratings measures may be infeasible because of inadequate data availability in specific geographic regions as the result of inadequate MA market penetration or insufficient MA plan participation. Given these potential constraints, CMS should first evaluate and determine the most appropriate geographic region at which to assign Star Ratings.

After determining the appropriate geographic region at which to evaluate quality, CMS should phase in this policy over a three-year period. During the first two years of implementation, CMS would continue to assign and publicly display Star Ratings at the contract level. However, CMS would also calculate and provide MA plans private information on their Star Ratings performance at the determined local level. In the third year of implementation, CMS would fully implement the policy change. Star Ratings would no longer be assigned at the contract level and would henceforth be assigned at the local geographic level determined by CMS. This local geographic Star Ratings information would be made publicly available to consumers though display on the Medicare plan finder.

Modeling and Impact

Evaluating MA plan quality at the local level would have a positive impact on MA enrollees, as it would provide more meaningful information to enrollees on which to base their plan selection. Due to insufficient publicly available MA Star Ratings data at the local plan level, we were unable to model the budgetary impact of this policy option.

Policy Option #6: Limit the Overall Percentage of Plans that Achieve 4 or 5 Stars

Under this policy, the existing Star Ratings methodology would be modified so that only a set percentage of plans achieve a 4 or 5 Star Rating.

Rationale

Under the current Star Ratings methodology, most MA enrollees are enrolled in a 4 Star or better plan.[12] Though enrollees should be encouraged to enroll in a high-quality plan that best meets their coverage needs, it can be difficult for enrollees to evaluate individual plan performance, due to Star Ratings representing the average performance of separate plans included under an overall contract.

Under this policy change, only excellent and truly exceptional MA plans would be assigned a 4 Star Rating or higher, providing enrollees with more meaningful information on which to base their enrollment decision.

Method of Enactment/Implementation

Modifying the Star Ratings methodology so that only a set percentage of MA plans achieve a 4 or 5 Star Rating could be accomplished through regulatory action. CMS should assess what the appropriate distribution should be for plans across the 5 Star levels. To provide meaningful distinction between plan quality, a larger percentage of plans should be assigned 3 Stars, a lower percentage of plans assigned 4 Stars, and only the highest quality plans assigned a 5 Star ranking.

After determining the appropriate distribution for each Star level, CMS should phase in this policy change over a three-year period. During the initial three years, CMS should annually model the impact this policy change would have on MA plan Star Ratings performance and provide this information privately to plans, granting them sufficient time to prepare for the policy change. After a three-year period, this policy change would go fully into effect, with a set distribution for MA plans across the Star Ratings levels.

Modeling and Impact

Limiting the overall percentage of plans that achieve 4 or 5 Stars will have a positive impact on enrollees by producing a more meaningful differentiation of plan quality, allowing MA enrollees to make more informed decisions when selecting a plan. Due to insufficient publicly available data, modeling the budgetary impact of this policy option was not possible.

The policy intent is to enable better measurement and evaluation of MA plan quality. This would not only allow potential MA enrollees to better assess plan quality and more efficiently compare MA plans within their market when selecting coverage, but also would allow MA plans to better gauge their own quality performance in comparison to their peer organizations before Star Ratings are assigned and QBP payments are made.

Policy Option #7: Modify Star Ratings Cut Points to Increase the Predictability of QBP Attainment for Plans

Under this policy, CMS would modify the cut point methodology for assigning ratings to measures, while retaining the 1–5 Star Ratings System for public reporting.

Rationale

The current Star Ratings methodology is characterized by steep cut points that can make it difficult for MA plans to evaluate whether they will achieve a 4 or 5 Star Rating in advance of CMS publishing the information. This lack of insight has made it difficult for MA plans to forecast expected financial performance and develop future performance goals and strategy, and it also creates an incentive for plans to engage in intense efforts that sometimes only result in narrow improvements in quality performance.

Method of Enactment/Implementation

Modifying the cut point methodology for assigning ratings to measures could be accomplished through regulatory action. CMS should incorporate new approaches for setting benchmarks that give MA plans increased insight into how to achieve high performance. Specific mechanisms include:

1. Implementing smoother, sloped cut points, giving MA plans increased insight into whether they will achieve bonus status in any given year. This change could be done by adding measure performance rates to create a total performance score, rather than scoring each measure and summarizing the Star Ratings. This approach would mean that plans performing near a cut point on a specific measure would not be penalized for falling short of the measure.

2. Instead of using current performance as the cut point, CMS could set in advance absolute cut points, rather than basing cut points on relative performance in a given year. Blue Cross Blue Shield of Massachusetts used this approach to develop its Alternative Quality Contract with accountable care organizations, which generated improvements in quality and, over time, net savings in quality.[22,23]

Modeling and Impact

Adopting new approaches for setting benchmarks would encourage plans to compete on quality rather than on points. Due to insufficient publicly available data, modeling the budgetary impact of this policy option was not possible.

Policy Option # 8: Stratify Plans with Similar Characteristics to Evaluate Quality

Under this policy, MA plans would be stratified and evaluated for quality performance against other MA plans that have similar characteristics nationally, such as the percentage of enrollees who are dual-eligible.

Rationale

The Star Ratings System compares plans with significantly different enrollee populations, which can put plans with a higher number of low-income subsidy (LIS) or dual eligible enrollees and rural members at a disadvantage.[24] Stratifying and evaluating quality of plans with similar characteristics puts plans on a more level playing field when being evaluated and provides a more meaningful indicator of plan quality to enrollees when selecting an MA plan. CMS has introduced the Health Equity Index as a way to encourage plans to focus on reducing gaps in care for historically disadvantaged groups,[25] but the index is a bonus rather than embedded throughout measure scoring.

In the end, addressing the differences in populations served by plans requires attention to two considerations: 1) how to make fair comparisons when plans serve different populations, and 2) how to avoid normalizing poorer performance for populations that are at a disadvantage in accessing high quality care.

Researchers at RAND described an approach that calls for 1) specifying groups of interest, and 2) adjusting the weight of their performance in quality calculations based on policy goals.[26] This approach avoids the shortcomings of standard approaches (which might encourage organizations to focus only on larger groups) and disparity-based approaches that might encourage organizations to avoid more challenging populations or decrease care for advantaged groups.

Method of Enactment/Implementation

CMS should consider methods to incentivize MA plans to enroll vulnerable and at-risk populations and provide quality coverage, benchmarked against national performance. CMS already has several ways to identify groups at risk, including dual eligibility, low-income subsidies, disability, and rurality (based on address). CMS could incorporate an intentional, measure-based approach (rather than a bonus) to encourage plans to seek higher performance for groups at risk of disparities, and to reward them for keeping/enrolling members of these groups.



Modeling and Impact

Our modeling of this policy option is based on existing data available from CMS files. To define the populations at risk of disparities in care, we used definitions employed in the Categorial Adjustment Index that are based on whether MA participants are categorized as having a disability, have dual eligibility for both Medicare and Medicaid, or are eligible for a low-income subsidy for Part B.[27] We used the Final Adjustment Category levels from the Categorical Adjustment Index to group the contracts into Low, Average, and High Risk groups, based on their social risk population prevalence and calculated their Star Rating based on the performance of each of these groups.

As expected for this policy option, which is designed primarily to improve the fairness of the QBP, our modeling found that revising cut points and scoring in this manner had limited impact on savings (about $370 million in a single year, with an estimated savings of $5.8 billion over 10 years).

We then modeled the impact the savings would have on the HI Trust Fund utilizing data included in the 2023 Medicare Trustees' Report. Our model projects Medicare revenues and savings from 2023 to 2042 and our model's expenditure and revenues, assumptions, and growth rates are consistent with those found in the 2023 Medicare Trustees' Report for years 2022 to 2033. For years 2034 to 2042, we projected expenditure and revenue growth using the Trustees Income and Cost growth projections. Although the estimated savings produced by this policy option would not affect the projected insolvency date of the HI Trust Fund, we estimate that the gap between expenditures and revenues in Medicare Part A would be reduced by 1 percent in 2035. Further, the savings produced by this policy option have the potential to reduce the Part A deductible by $8, reduce the part B premium by $1, and lower MA spending per beneficiary by $179 per year.

CONCLUSION

The policy options in this report would meaningfully contribute to the sustainability of Medicare and improve MA for enrollees. In total, we found our policy options have the potential to produce a collective savings of $108 billion over a 10-year period, which could extend the solvency of the HI Trust Fund by an entire year. These policy options have the potential to reduce the gap between expenditures and revenues in Medicare Part A by 39 percent in 2035, reduce the Part A deductible by $172, and reduce the Part B premium by $21. In addition, collectively these policy options could lower MA spending per beneficiary by as much as $2,700 per year.

As enrollment in MA continues to increase, promoting high-value, quality care within the program is vital. MA plans should be incentivized and rewarded for improving quality for enrollees. The policy options included in this report would support that goal. These policy options would also improve MA for enrollees by modifying the Star Ratings System, further incentivizing interventions that have the potential to improve patient outcomes. In addition, these policy options would allow for a more meaningful evaluation of MA plan quality and would provide MA enrollees additional information on which they can base their coverage decisions. This will ensure that MA enrollees are in the best position to elect coverage that meets their unique healthcare needs.



APPENDIX

LP analyzed and incorporated certain aspects of the following QBP reform proposals into our policy options. For each proposal, we have noted which portions were included, and whether the included portions were modified.

MedPAC MA-VIP[24]

The Medicare Payment Advisory Commission (MedPAC) recommended that Congress replace the current MA QBP with a MedPAC-developed MA Value Incentive Program (MA-VIP). The MA-VIP was designed to be budget neutral and financed by MA plan contributions. Key components of the MA-VIP include:

- Scoring a small set of population-based measures tied to clinical outcomes and patient/enrollee experience.
- Evaluating quality at the local market level.
- Using a peer-grouping mechanism to account for differences in enrollees' social risk factors.
- Establishing a system for distributing rewards with no "cliff" effects.
- Distributing plan-financed rewards and penalties at the local market level.

Of the above components, LP incorporated the following into this document:

- Scoring a small set of population-based measures as **Policy Option #3: Reduce and Simplify the Existing Measure Set.** However, LP chose to focus its measure set on measures in the Universal Foundation, with the goal of increasing alignment between the Star Ratings measure set and measures in other CMS programs.
- Evaluating quality at the local market level as **Policy Option #5: Evaluate Quality at the Local Market Level.** LP added a three-year phase-in and noted that CMS would need to assess the most appropriate level of evaluation (e.g., county or state) given the current Star Ratings methodology.
- Using a peer-grouping mechanism to account for differences in social risk factors as **Policy Option #8: Stratify Plans with Similar Characteristics to Evaluate Quality.** LPs policy option aligned with MedPAC's proposal.
- Establishing a system for distributing rewards with no "cliff" effects" as **Policy Option #7: Modify Star Ratings Cut Points to Increase the Predictability of QBP Attainment for Plans.** LP incorporated the spirit of this proposal but provided two options for this policy option that differ from the MA-VIP component.

ACHP Raising the Bar on Quality[28]

The Alliance of Community Health Plans (ACHP), a trade association representing non-profit health plans, released a set of recommendations in 2023 to reform the QBP. Key components of the proposal include:

- Retiring many Star Ratings process measures and increasing weights for patient experience and outcomes measures.
- Improving measure collection to accurately reflect patient experience and outcomes.
- Establishing the number of MA plans that achieve high quality.

Of the above components, LP incorporated the following into this document:

- Retiring Star Ratings process measures as **Policy Option #3: Reduce and Simplify the Existing Measure Set.** However, LP chose not to focus purely on retiring process measures but also focused on alignment with other CMS programs by cutting out all measures that are not in the Universal Foundation.
- Establishing the number of MA plans that achieve high quality as **Policy Option #6: Limit the Overall Percentage of Plans that Achieve 4 or 5 Stars.** Our policy option is aligned with this recommendation and our policy option includes additional details concerning potential implementation.

Urban Institute Framework[16]

In 2023, the Urban Institute released a report examining the MA QBP, which evaluated MedPAC's MA-VIP and included its own set of recommendations to reform the MA QBP. Key components of the proposal include:

- Shifting the focus of the QBP from rewarding MA contract quality to protecting beneficiaries from substandard plans.
- Publicly reporting measures of administrative effectiveness, such as disenrollment among high-need beneficiaries, serious illness care, access to post-acute care, improper prior authorization denials, and network adequacy.
- Modifying Star Ratings so that they emphasize improvement rather than attainment.
- Updating Star Ratings so that scores would not be based on multi-state contracts, but instead be assigned based on performance relative to other contracts in the local market.

Of the above components, LP incorporated the following into this document:

- Update Star Ratings to base scores relative to other contracts in the local market as **Policy Option #5: Evaluate Quality at the Local Market Level.** However, while Urban recommended basing the scores for contracts within a local market *relative to other contracts in that same local market,* LP does not make that recommendation.

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ABOUT LEAVITT PARTNERS

Leavitt Partners (LP) has been at the forefront of health policy development for more than three decades. The firm is comprised of professionals whose experience spans the executive and legislative branches of government. As former congressional staff and executive branch political appointees, its team members know the regulatory and legislative processes firsthand and are respected for integrity, expertise, and a record of success. LP helps clients understand and navigate the legislative and regulatory environments to create opportunities, resolve problems, direct action, and build and maintain positive interactions with key federal policymakers.

Our team in Washington, D.C. has deep federal policy expertise, having helped write significant health care legislation and regulation during their time in public service. We have been involved in developing most of the major health care legislation over that time, including Medicare Part D, the Affordable Care Act, the Drug Supply Chain Security Act, the Medicare Access and CHIP Reauthorization Act (MACRA), the Comprehensive Addiction and Recovery Act, the 21st Century Cures Act, the Mental Health Reform Act of 2016, the Bipartisan Budget Act of 2018, multiple FDA User Fee Acts, the SUPPORT Act in 2018, the Pandemic and All-Hazards Preparedness Act and its reauthorizations, multiple COVID-19 relief packages, and the health care provisions of the Consolidated Appropriations Acts of 2021, 2022, and 2023, including the major provisions related to mental health, substance use disorder, and pandemic preparedness.

Additionally, Leavitt Partners is home to expert conveners with decades of experience in the private sector and government who have spent years fine-tuning the process for building successful alliances that bring multi-sector stakeholders to the table with a commitment to reaching consensus, real-world solutions. Leavitt Center experts have helped more than 50 alliances achieve impactful outcomes, including the Dual Eligible Coalition, the CARIN Alliance FHIR accelerator, the Helios FHIR accelerator for Public Health Data Modernization, the Pharmaceutical Distribution Security Alliance (PDSA), the COVID Patient Recovery Alliance, and the National Alliance to Impact the Social Determinants of Health (NASDOH).

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