OOPS, LET'S DO IT AGAIN: CMS ANNOUNCES CHANGES TO 2025 MEDICARE ADVANTAGE QUALITY BONUS PAYMENTS

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Changes to 2025 Quality Bonus Payments Lead to Bid Season 2.0

On June 13, 2024, the Center for Medicare and Medicaid Services (CMS) announced that they will recalculate the 2024 Star Ratings for the purpose of determining 2025 Quality Bonus Payments (QBPs), following recent court rulings in favor of SCAN Health Plan and Elevance Health, Inc. As a consequence of this decision, many Medicare Advantage (MA) plans will undergo an expedited bidding process, updating their bids to reflect higher QBPs. The new bids must be submitted to CMS by June 28, 2024. These recent and ever-evolving developments introduce considerable uncertainty and raise new questions about market dynamics for the year 2025.

Wakely performed an analysis of the Overall Star Rating changes for all contracts. The discussion that follows summarizes the results of our calculations. See Appendix A for details on the methodology and assumptions used to recalculate all Star Ratings.

Wakely's analysis finds that 2025 bonus payments will increase for 53 contracts currently enrolling 1.46 million Medicare Advantage members.

Summary of QBP Changes

In the recalculation of 2024 Star Ratings, CMS used the published 2023 Star Rating cut points to determine the guardrails for the 2024 Star Ratings. They then applied a hold harmless provision, allowing only for Overall Star Rating increases that would lead to higher plan revenue. While the change had the potential to impact all contracts, this paper focuses on the contracts that benefitted from a higher QBP or rebate percentage[1]. This includes contracts increasing from 3 to 3.5, 3.5 to 4.0, and 4.0 to 4.5.

Wakely's analysis indicates QBP increases for 53 contracts, which currently enroll 1.46 million MA members. This indicates a large potential change to plan revenue and potentially significant benefit changes in the new bids to be submitted. Table 1 summarizes current plan enrollment (as of June 2024) in plans with a QBP change. In total, 4.4% of current membership is enrolled in a plan that will now receive a higher QBP in 2025.

[1] Throughout this paper, the term "QBP" is used to encompass bonus payments and rebate percentages

Table 1

Medicare Advantage Enrollment in Changing QBP Contracts, by Plan Type

	All Plans	General Enrollment	Dual-Eligible SNP	C-SNP	I-SNP
Total Members	33,453,427	26,806,539	5,810,159	744,098	92,631
Members with QBP Change	1,462,990	1,091,723	345,927	19,720	5,620
Percent of Membership with QBP Change	4.4%	4.1%	6.0%	2.7%	6.1%

Note that the table above includes only plans that receive a QBP. Plans that do not receive Star Ratings, such as Medicare-Medicaid Plans (MMPs) and Part D Plans (PDPs) have been excluded from this analysis.

Regional Changes in Bonus Payments

The plans eligible to submit new bids with higher QBPs are primarily concentrated in a select few states. This discussion will specifically delve into General Enrollment and Dual-Eligible Special Needs Plans (SNPs), which represent the Medicare Advantage (MA) plan types with the highest enrollment figures.

Figure 1 underscores the counties where a significant portion of enrollment is held by plans that are increasing their QBPs. Notably, Los Angeles, California, stands out with over 100,000 enrollees in general enrollment plans increasing QBPs, the highest of any county. This statistic highlights the substantial impact and localized nature of the Star Rating recalculations.

In terms of general enrollment plans, the states with the highest percentage of enrollment impacted are (in descending order) Iowa, South Dakota, North Carolina, Michigan, New Jersey, and California. These states have a higher concentration of plans that will be resubmitting bids with higher QBPs. This suggests a significant potential shift in the competitive dynamics and benefit offerings within these healthcare markets for the upcoming year.

Figure 1

Percent of County Enrollment in Plans with QBP Increases, General Enrollment Plans

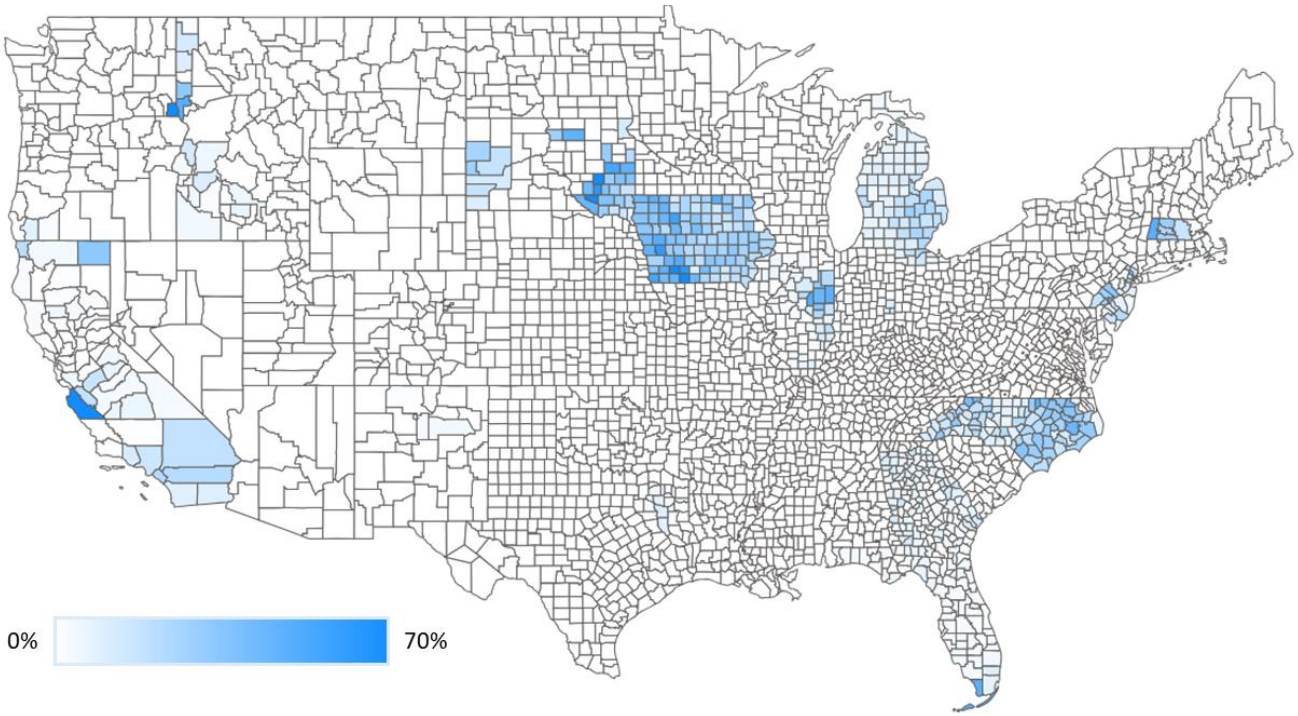
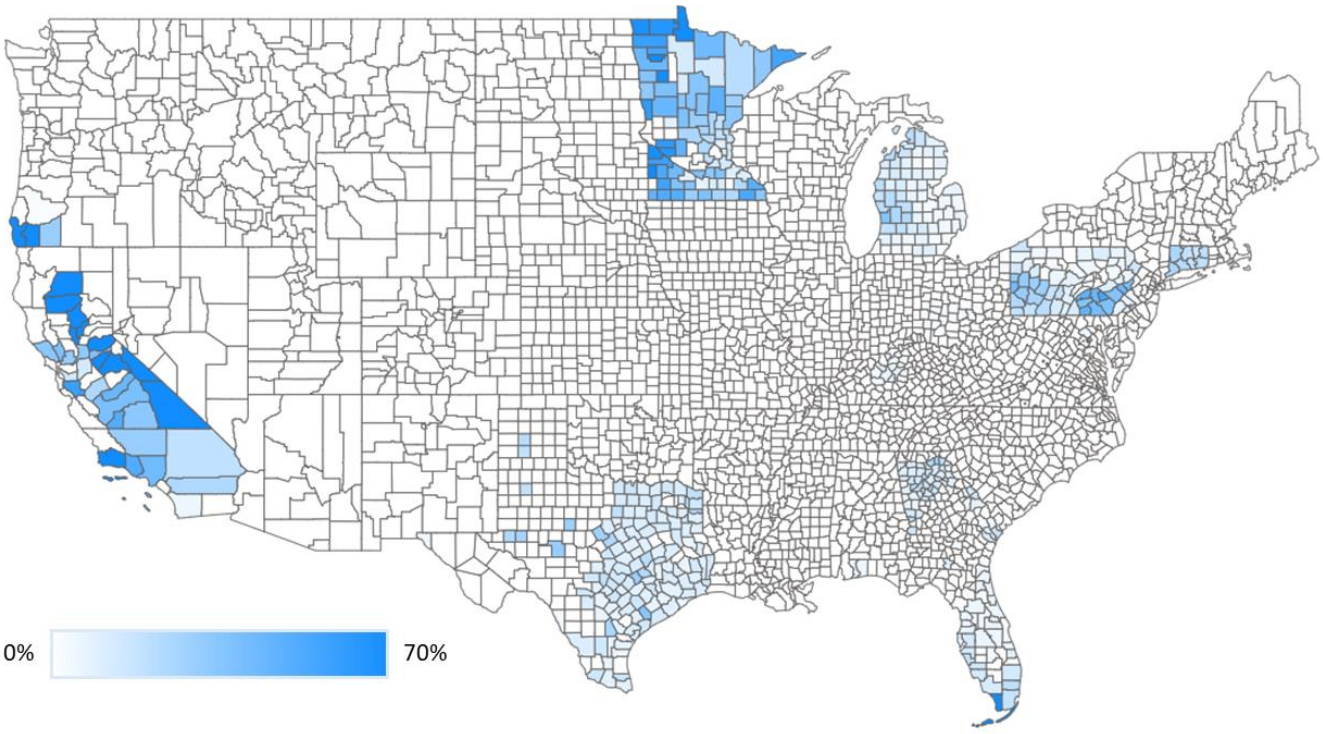


Figure 2 emphasizes the counties where a substantial portion of enrollment in Dual-Eligible Special Needs Plans (D-SNPs) is linked to plans that are increasing QBPs. Notably, California emerges prominently due to the significant enrollment of SCAN Health Plan members. Again, Los Angeles County stands out with over 50,000 enrollees in D-SNP plans increasing QBPs.

The distribution of plans experiencing QBP increases differs markedly from that of general enrollment plans. In this case, there is a heightened concentration of enrollment in California, Connecticut, Pennsylvania, Minnesota, and Florida (listed in descending order). This regional focus underscores the varied impact of CMS's recalculations on different plans.

Figure 2

Percent of County Enrollment in Plans with QBP Increases, Dual-Eligible Special Needs Plans



Parent Organization Changes

Wakely's analysis reveals that the changes in Quality Bonus Payments (QBP) are highly concentrated, primarily benefiting several parent organizations. The table below summarizes the 2024 enrollment figures by parent organization, highlighting the top 10 organizations in terms of plan membership experiencing QBP increases. Note that this table includes membership in newly established plans, which benefit from an increasing average Star Rating for their parent organizations.

As expected, SCAN and Elevance emerge as major beneficiaries of these changes, boasting 270,000 and 173,000 members respectively in plans with increased QBPs. These plans filed the initial lawsuits that triggered the recalculation of all Star Ratings. CVS Health rounds out the top three with 210,000 members experiencing QBP increases.

Table 2

Total Enrollment with QBP Changes, by Parent Organization

Parent Organization	Total Enrollment	Enrollment with QBP Change	Percent Enrollment with QBP Change
SCAN Group	277,975	273,622	98.4%
CVS Health Corporation	4,275,902	210,447	4.9%
Elevance Health, Inc.	2,029,692	173,799	8.6%
Blue Cross Blue Shield of Michigan Mutual Ins. Co.	709,396	119,904	16.9%
Blue Cross and Blue Shield of North Carolina	129,399	94,782	73.2%
Independence Health Group, Inc.	137,465	78,861	57.4%
Clover Health Holdings, Inc.	80,094	76,517	95.5%
Henry Ford Health System	83,358	67,684	81.2%
Centene Corporation	1,140,398	50,219	4.4%
Highmark Health	421,249	38,621	9.2%

Additional Findings

While this brief focuses on QBP changes, it's important to note additional Star Rating adjustments that don't affect plan revenue and thus don't necessitate filing new bids. Specifically, several plans are slated to improve from 4.5 to 5.0 Stars. CMS permits 5-Star plans to market to and enroll new members year-round. It remains uncertain if CMS will extend this benefit to plans reaching 5 Stars post-recalculation, although CMS has explicitly indicated the intent to update Medicare Plan Finder to align with the updated calculations. Our analysis identifies 58 plans set to attain 5 Stars through this recalculation, bringing the total of 5-Star rated plans to 488. Currently, these plans enroll 200,000 members.

Conclusion

As illustrated throughout this brief, CMS's decision to recalculate Star Ratings, adjust QBPs, and allow plans to submit new bids has a profound impact on a significant number of Medicare Advantage enrollees. Plans eligible to submit new bids must decide how to allocate additional revenue, whether towards higher margins or enhanced benefits, while satisfying Total Beneficiary Cost (TBC) requirements, which may be materially adjusted as a result of a QBP improvement. It is likely that updated bids will involve a combination of higher margins and enhanced benefits.

While this change promises enhanced benefits for some enrollees, many plans that cannot adjust their bids were originally guided by competitor Star Ratings that have since changed. This informational imbalance may prompt further pushback on CMS.

Looking ahead, it remains uncertain whether CMS will appeal these rulings to revert to the initial guardrail application or continue with this approach in future Star Ratings beyond 2025. This uncertainty has created a sense of ambiguity in the industry that is unlikely to be resolved soon.

Please contact Suzanna-Grace Tritt at suzannagrace.tritt@wakely.com or Tim Murray at tim.murray@wakely.com with any questions or to follow up on any of the concepts presented here.

OUR STORY

Wakely's Expertise

We move fast to keep our clients ahead of the healthcare curve.

Broad healthcare knowledge. Wakely is experienced in all facets of the healthcare industry, from carriers to providers to governmental agencies. Our employees excel at providing solutions to parties across the spectrum.

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Appendix A – Updated Star Rating Calculation Methodology

CMS implemented the Tukey Outlier Deletion method in the 2024 Star Ratings. The initial published 2024 Star Ratings reflect "Tukey" cut points after applying guardrails. To apply the guardrails in the original published results, CMS simulated 2023 cut points with Tukey, then limited the movement by 5% in either direction.

To recalculate the Overall Star Ratings using different cut points, CMS applied 5% guardrails to the *actual* 2023 cut points rather than the *simulated* Tukey 2023 cut points. Wakely recalculated all contract Overall Star Ratings using the new cut points published by CMS on June 19, 2024 to determine new measure-level Star Ratings. We also adjusted the Reward Factor mean and variance thresholds based on the new cut points. We did not make any changes to the Categorical Adjustment Index, or CAI.

All other Star Rating calculations, including measure weights, cut points, and calculations follow the methodology outlined in the 2024 Star Rating Technical Notes. This information may be subject to change in future CMS updates.