Viewpoints on the 2024 CMS Advance Notice

On February 1, 2023, the Centers for Medicare & Medicaid Services (CMS) released the 2024 Advance Notice for Medicare Advantage (MA) and Part D plan sponsors ("health plans"). As always, these changes contain a mix of both opportunities and challenges that plans will need to assess and develop strategies to address. Most importantly, commentary about general impact can vary greatly based on specific plan circumstances. Comments on the 2024 MA and Part D Advance Notice issued on February 1 are due by Monday, March 6, 2023.

Please keep in mind that rates and other information contained in this guide are preliminary and subject to change. Final rates are expected by April 3, 2023.

On December 14, 2022, CMS released the 2024 Medicare Advantage and Part D Proposed Rule (CMS-4201-P). The proposed rule serves as a context for many of the changes noted for the Star Ratings program in the Advance Notice as well as reinforces the health equity concepts outlined in the proposed rule. Comments on the policy and technical changes published December 14 were due by February 13, 2023.

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6 key proposed changes for 2024

1 **CMS is proposing to update the CMS-HCC (hierarchical condition categories) model.** While the new model would add HCCs, the underlying diagnoses codes would shift from an ICD-9 basis to a lower volume of ICD-10 codes.

See risk adjustment →

2 **Estimated MA and fee-for-service (FFS) effective growth rate of 2.09%.** The lower-than-normal growth rate is driven by indirect medical education (IME) and direct graduate medical education (DGME) costs being removed from historical and projected expenditures, along with 2022 USPCC costs emerging lower than CMS estimated last year.

See Part C plan payment →

3 **The CMS-HCC risk model revision and risk score normalization updates are estimated to decrease average plan payments by 3.12%**. When considered against the effective growth rate, this results in a 1.03% decrease in payments. Actual results will vary significantly by county and plan.

See Part C plan payment →

4 **The key theme for the 2024 Star Ratings update is promoting a whole-person care model** with equity as a core component of this model as noted in the "Display Measures" and "Potential New Measure Concepts" sections. CMS is requesting stakeholder input on the proposed concepts to further engage in the rulemaking process. The rulemaking will formally introduce these concepts in Star Ratings program.

See Star Ratings program →

5 Changes to the Part D program include those signed into law by the Inflation Reduction Act (IRA) of 2022. This includes the **elimination of beneficiary out-of-pocket costs in the catastrophic phase in CY 2024.**

See Part D program changes →

6 Bid-to-benchmark ratios applied in the employer group waiver plans (EGWPs) payment rates proposed to **decrease from 80% to 77%.**

See Part C plan payment →

Part C plan payment

Highlights of proposed changes

The 1.03% plan payment decrease is a national average and does not account for all variables that affect plan payments. It reflects a 2.09% increase due to growth rate and a 3.12% decrease due to risk model revision and normalization factor updates. The national average plan payment decrease does not reflect a CMS FFS rebasing, which will be provided with the Final Rate Announcement or impact of Star Rating changes. CMS did provide an estimate of 3.3% for plan coding trend, which would help to offset the 1.03% plan payment decrease. Plans should consider how the following may vary from the national averages.

- Potential impact of FFS rate rebasing, including county-level impacts of adding 2021 FFS data and removing 2016 data from AGA calculation; FFS repricing for the most current geographic price cost indices; durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program changes; and Center for Medicare & Medicaid Innovation (CMMI) program impact:
  - Variances from average -1.24% Star Ratings change impact
  - Plan-specific coding trend
- 2024 applicable ("quartile") percentages have been updated based on 2023 FFS per-capita rates.
- CMS United States per capita costs (USPCC)-projected cost estimates reflect the expected impact of COVID-19. This is an estimate of the average across all state and county codes in the country. The 2.09% effective growth rate is an expected blend of the total USPCC growth rate of 1.81% and the FFS growth rate of 2.15%. The FFS growth rate is a component of the total USPCC growth rate.
- 2024 USPCC estimates relative to 2023 Final Rate Announcement estimates:

1.03%

plan payment decrease is a national average and does not account for all variables that affect plan payments

  - Indirect medical education (IME) and direct graduate medical education (DGME) costs were removed from historical and projected expenditures. The impact is the 2024 total USPCC is 1.06% lower and 2024 FFS USPCC is 2.13% lower.
  - 2022 USPCC costs are lower than CMS estimated last year. Specifically, the 2022 total USPCC is 2.7% lower and the 2022 FFS USPCC is 5.4% lower.
  - The 2023 and 2024 USPCC costs are projected to increase at a higher rate than CMS projected in 2022, which marginally mitigates the negative restatements noted.

- CMS is proposing to include the historical experience of Advanced Alternative Payment Models (APM) incentive payments disbursed in years 2019 through 2021 in the ratebook.
- CMS is proposing to update the frailty factors used to calculate frailty scores for beneficiaries enrolled in FIDE SNPs, using the proposed 2024 CMS-HCC model. No proposed methodology change for PACE beneficiaries.
- The national average for 2024 ESRD growth rate is estimated to be 2.68%, a decrease from the 2023 9.59% ESRD growth rate.

CMS once again considered developing ESRD rates based on core-based statistical areas (CBSAs) to better align differences in rates between rural and urban areas. Furthering their approach, CMS also studied the CBSA-developed rates based on the area deprivation index (ADI). On average, this approach would result in increased rates for CBSAs with a low ADI (or low level of socioeconomic deprivation), and decreased rates for CBSAs with a high ADI. Considering these findings, CMS will continue to use statewide MA ESRD rates for 2024.

The basis of the EGWP payment rates is the average individual market bid-to-benchmark ratio by applicable percentage for the prior-year bid submission. As a result of continued increase in competition in the individual market and expansion of supplemental benefits, the individual bid-to-benchmark has declined from 2022 to 2023 by roughly 3 percentage points from 80% to 77%, which is estimated to reduce EGWP revenue by roughly 1%.

Risk adjustment

Highlights of proposed changes

Risk scores will continue to be weighted 100% using Encounter Data System (EDS) submissions for non-PACE (Program of All-inclusive Care for the Elderly) MA plan risk score calculations.

- CMS is proposing to update to the CMS-HCC model for 2024. While the new model would add HCCs, the underlying diagnoses codes would shift from an ICD-9 basis to lower volume of ICD-10 codes.
- The MA coding pattern adjustment factor is to remain at 5.9%, consistent with 2021 (minimum statutory requirement).
- The proposed 2024 CMS-HCC model normalization factor is 1.015.
- The 2020 CMS-HCC model normalization factor would have increased from 1.127 to 1.146.
- The 2017 CMS-HCC model normalization factor is to increase from 1.140 to 1.159 (applicable for PACE plans).
- Optum modeling indicates that the New Enrollee cohort would benefit from the model update, whereas the Full & Partial Aged cohorts would be most negatively impacted.

CMS is estimating the risk model revision and normalization updates to decrease average plan payments by 3.12%

Commentary on ESRD dialysis model change

CMS is proposing several changes to the CMS-HCC model

- Clinical version updated from V24 to V28
- Update the data years used to calibrate the model
  - The underlying data would use 2018 diagnoses data to predict 2019 expenditures
  - Reflects more current trends in utilization and spending
- The 2024 model has 115 payment HCCs
  - The previous model has 86 payment HCCs
  - Changes to some of the HCCs are due to changes in the transition from ICD-9 to ICD-10-CM (Clinical Modification)
- Renumbering HCCs
  - Some of the Part C risk adjustment model were renumbered
  - CMS is to incorporate a series of gaps in the numbering of the HCCs between disease groups to help avoid a comprehensive renumbering due to any future model changes
- Principle 10 rule applied
  - Removes discretionary diagnosis categories from the payment model where coding variations are not clinically or empirically credible cost predictors
  - Removes:
    - HCC 47 Protein Calorie Malnutrition
    - HCC 230 – Angina Pectoris
    - HCC 265 – Atherosclerosis of Arteries of the Extremities with Intermittent Claudicaution
  - Constrains (holds coefficients of HCCs equal/have the same weight):
    - Diabetes Mellitus (HCCs 36, 37, 38)
    - Congestive Heart Failure (HCCs 224,225, 226)

Commentary on Risk Adjustment Data Validation (RADV) audits

- While not part of the Advanced Notice, the RADV final rule was also released in February and is worth noting in the context of Risk Adjustment regulatory changes.
  - The final rule announces certain policies to improve program integrity and payment accuracy in the Medicare Advantage (MA program.
  - Originally planned for payment year (PY) 2011, the rule codifies that CMS will extrapolate RADV audit findings beginning with PY 2018 (2017 dates of service).
  - CMS is finalizing a policy that will not apply a fee-for-service (FFS) adjustment factor in RADV audits.
  - Codifying regulations that MA organizations (MAOs) must remit improper payments identified during RADV audits in a manner specified by CMS.
  - Per CMS, the average RADV error rate is 3%, with a median error rate of 1.8%.

Star Ratings program

Highlights of proposed changes

Key theme: Integrating health equity as a core component of the whole-person model of care.

2024 Star Ratings update

The following updates are from the CY 2024 Medicare Advantage and Part D Proposed Rule (CMS-4201-P), and the 2024 Advance Notice Announcement.

- Deadline is June 30, 2023, for the Complaints Tracking Module (CTM) and Independent Review Entity (IRE) data review by CMS
- Tukey outlier deletion will be applied for non-CAHPS measures to deduce measure cut points resulting in minimizing threshold volatility
- Transitions of Care (Part C) measure at weight of 1
- Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions (Part C) at weight of 1
- Plan All-Cause Readmissions (Part C) measure returning at weight of 1
- Medication Reconciliation Post-Discharge (Part C) standalone measure at weight of 1
- Controlling Blood Pressure (CBP) in Part C at a weight of 3
- CMS proposes creation of a building block called “Universal Foundation” consisting of a core set of quality measures aligned across all CMS quality programs. This “Universal Foundation” will consist of measures that span across 6 meaningful measure domains: Wellness and Prevention, Chronic Conditions, Behavioral Health, Seamless Care Coordination, Person-Centered Care, and Equity.

The key theme for the 2024 Star Ratings update is promoting a whole-person care model with equity as a core component

1. CAHPS® – The acronym “CAHPS” is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)
2. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

2025 Star Ratings and beyond update

Non-substantive changes to Star Ratings measures

- Optional exclusions for select HEDIS measures (Part C)
  - Controlling Blood Pressure: Optional exclusions for pregnancy, end-stage renal disease/dialysis/nephrectomy/kidney transplant, and non-acute inpatient admissions now required
  - Colorectal Cancer Screening: Optional exclusions for colorectal cancer and total colectomy now required
  - Kidney Health Evaluation for Patients with Diabetes: Optional exclusions for polycystic ovary syndrome, gestational diabetes, and steroid-induced diabetes now required
  - Enrollees who died during the measurement year became a required exclusion for measurement year 2023
- Diabetes Care measure: Update specifications
  - Eye Exam (Part C)
  - Blood Sugar Controlled (Part C), could be renamed *Glycemic Status Assessment for Patients With Diabetes*
  - Kidney Health Evaluation for Patients with Diabetes (Part C)
- Breast Cancer Screening (Part C): Updated specifications to be more "inclusive" of individuals at risk of breast cancer
- Statin Use in Persons with Diabetes (SUPD) (Part D): Updated specifications to align with measure steward, PQA specifications
- Medication Adherence for Diabetes Medication, Medication Adherence for Hypertension (RAS Antagonists), Medication Adherence for Cholesterol (Statins) (Part D): Updated specifications to align with measure steward, PQA specifications
- MTM Program Completion Rate MTM Program Completion Rate for Comprehensive Medication Review (CMR) (Part D): Updated specifications to identify beneficiaries in hospice

Substantive changes to Star Rating measures

- Care for Older Adults (Part C):
  - Pain Assessment – proposed for retirement by the measure steward, NCQA
  - Functional Status Assessment and Medication Review – proposed for retirement by the measure steward, NCQA while simultaneously exploring development of new measure to replace current measure

Display measures:

- Depression Screening and Follow-Up (Part C): Proposed for inclusion for 2026 Stars Display Page
- Initiation and Engagement of Substance Use Disorder (SUD) Treatment (Part C): Specification update and considered for adding to future Star Ratings
- Timely Follow-up After Acute Exacerbations of Chronic Conditions (Part C): New clinical quality measure by measure steward, IMPAQ International for 2024 Star Ratings display page; considered for potential inclusion in future Star Ratings in Part C
- Adult Immunization Status (Part C and D): Inclusion for 2026 Stars Display Page
- Concurrent Use of Opioids and Benzodiazepines (COB), Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH), and Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults (Poly-CNS) (Part D): Align with measure steward, PQA specifications
- Initial Opioid Prescribing – Long Duration (IOP-LD) (Part D): Update measure specifications for 2025 Stars display page
- Antipsychotic Use in Persons with Dementia, Overall (APD), Antipsychotic Use in Persons with Dementia, in Long-Term Nursing Home Residents (APD-LTNH), Medication Adherence for HIV/AIDs (Antiretrovirals) (ADH-ARV), Use of Opioids at High Dosage in Persons without Cancer (OHD), Use of Opioids from Multiple Providers in Persons without Cancer (OMP), Initial Opioid Prescribing – Long Duration (IOP-LD) (Part D): Align with measure steward, PQA measure specifications
- CAHPS (Part C and D): Question regarding “perceived unfair or insensitive treatment”

Potential new measure concepts and methodological enhancements

CMS is requesting stakeholder input on the proposed concepts to further engage in the rulemaking process. The rulemaking will formally introduce these concepts in Star Ratings program.

- Health Equity Index (Part C and D): Replacement for categorical adjustment index (CAI) to drive health equity for 2027 Stars
- Chronic Pain Assessment and Follow-up (Part C): Assess chronic pain and follow-up in Medicare enrollees age 65 and older
- Cross-Cutting: Sexual Orientation and Gender Identity for HEDIS Measures (Part C): To be inclusive and gender-affirming while aligning with the measure intent
- Cross-Cutting: Identifying Chronic Conditions in HEDIS Measures (Part C): Simplifying identification of chronic conditions

Star Ratings program (continued)

- Blood Pressure Control Measures (Part C): To replace existing blood pressure measure
- Kidney Health (Part C): New measure concept from NCQA for kidney health management
- Social Connection Screening and Intervention (Part C): Focused on members age 65 and older
- Broadening the Mental Health Conditions Assessed by Health Outcomes Survey (HOS) (Part C): Addition of Generalized Anxiety Disorder (GAD-2) for identify and address mental health in beneficiaries
- Measuring Access to Mental Health Care on HOS (Part C): Understanding access and barriers to access to mental health care and its impact
- Addressing Unmet Health-Related Social Needs on HOS (Part C): CMS developed survey-based measure potentially included in HOS to gain insights in member's perception of help received from the health plan
- CAHPS (Part C and D): Additional questions and web-based response modality

Part D program changes

Highlights of proposed changes

- Part D benefit parameter increases consistent with changes in the annual percentage increase (API) in Part D expenditures are as follows:
  - 8.01% API for 2024 reflects a 6.42% for 2023 trend and multiplicative update of 1.50% adjustment for prior periods
  - Deductible is increasing from $505 to $545
  - Initial coverage limit is increasing from $4,660 to $5,030
  - Minimum cost sharing in catastrophic coverage portion of the benefit is removed from 2024 Part D benefit

Highlights of proposed changes on benefit designs

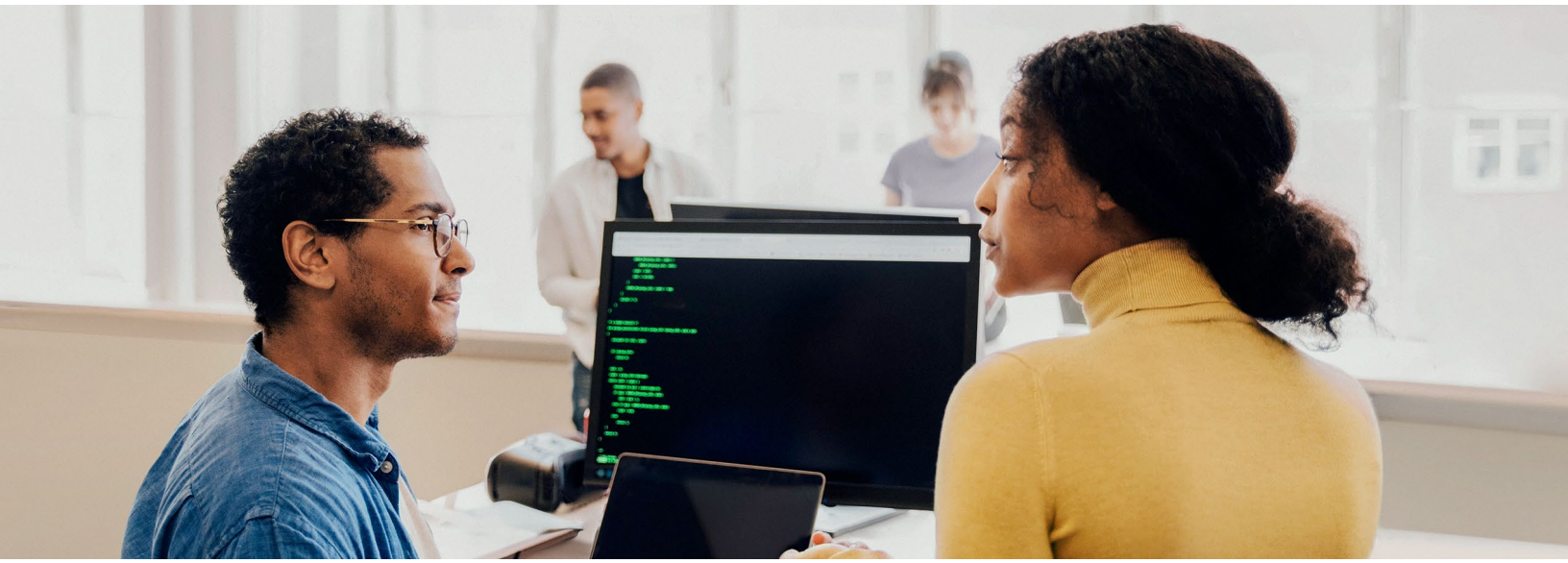
In August 2022, President Biden signed into law the Inflation Reduction Act (IRA) of 2022, which includes provisions aiming to lower health care and energy costs. The law includes several amendments and additions to the standard Part D drug benefit defined in the Social Security Act. The Part D benefit-related IRA updates that will be in place for CY 2024 and that are described in the Advance Notice include:

1. **Elimination of beneficiary out-of-pocket costs in the catastrophic phase in CY 2024.** Starting 2024, cost sharing for covered Part D drugs will be eliminated for beneficiaries in the catastrophic phase of coverage.

Part D program changes (continued)

2. **Expansion of full LIS and sunset of partial LIS as of January 1, 2024.** Beginning in CY 2024, the Low-Income Subsidy program (LIS) under Part D will be expanded so that beneficiaries who earn between 135% and 150% of the federal poverty level and meet statutory resource limit requirements will receive the full LIS subsidies that prior to 2024 were only available to beneficiaries earning less than 135% of the federal poverty level.
3. **Insulin Copay Cap.** During CY 2024, Part D plans must NOT apply the deductible to any Part D covered insulin product and must charge no more than $35 per month's supply of a covered insulin product in the initial coverage phase and the coverage gap phase.
4. **ACIP-recommended vaccine $0 cost sharing.** During CY 2024, Part D plans must NOT apply the deductible to an adult vaccine recommended by the Advisory Committee on Immunization Practices and must charge no cost sharing at any point in the benefit for such vaccines.
5. **Part D premium stabilization.** Beginning in CY 2024, the growth in the Base Beneficiary Premium will be capped at 6%. The Base Beneficiary Premium for Part D is limited to the lesser of a 6% annual increase, or the amount that would otherwise apply under the prior methodology had the IRA not been enacted.

Other announcements



Highlights of 2024 Medicare Advantage and Part D Proposed Rule

On December 14, 2022, CMS released the 2024 Medicare Advantage and Part D Proposed Rule (CMS-4201-P). CMS is proposing several changes that could have a significant impact on health plan benefits, member premiums and health plan operations. The comment period for the proposed rule ended February 13, 2023.

There is no indication when a Final Rule will be issued by CMS. There is no indication that the rule will be finalized to support health plans in their CY 2024 bid development. For example, the CY 2022 Final Rule for Medicare Advantage and Part D was issued on June 2, 2021. Stakeholders should work closely with CMS for guidance on how any potential impact on CY 2023 pricing should be included in the bid pricing process that is due on June 5, 2023.

Major proposal items discussed

1. Pharmacy DIR and redefining the negotiated price: CMS is proposing to redefine the negotiated price to be the lowest possible a pharmacy could receive inclusive of quality-based payments known as pharmacy direct and indirect renumeration.
2. Maximum out-of-pocket (MOOP) policy for dually eligible beneficiaries: Current guidance on the MOOP calculation allows plans to only count those amounts individual enrollees are responsible for paying, after state responsibility. The proposed rule would require health plans to attribute all member cost sharing toward the MOOP, regardless of payer. This would result in reducing state Medicaid liability for Medicare cost sharing and increase health plan liability for costs once the member hits the MOOP.

Other announcements (continued)

3. Marketing and communications oversight: CMS is proposing to strengthen oversight of third-party marketing organizations to detect and prevent deceptive marketing and sales tactics.
4. Network adequacy at time of application submission: CMS is proposing health plans comply with network adequacy standards as part of the application process.
5. Star Rating calculation for 3 CY 2024 HEDIS measures collected through HOS data: CMS is proposing a technical change to allow them to calculate Star Ratings for HOS metrics. Without this change, CMS would be unable to calculate the 2024 Star Ratings since all contracts qualify for the extreme and uncontrollable circumstances adjustment for COVID-19.

4 things to consider for bid preparation

Financial impact may vary from plan to plan based on a combination of:

- Benchmark changes
- Risk adjustment changes
- Cost sharing and benefit design requirements
- Star Ratings
- Service-area mix
- Contracting arrangements

Continue to review COVID-19 impact on base period claims costs, trend and risk scores

Review plan-specific impact of CMS-HCC model changes

Understand plan-specific impact of Part D program changes

Continue to address health disparities of complex populations with a holistic approach toward health equity and inclusivity

Optum is here to help

More than ever, Medicare Advantage plans must continue to execute effectively. They need to address quality, risk adjustment and cost of care if they are to produce achievable, competitive bids and provide products that reach stated goals for benefits, member premiums and margins. Integrating initiatives across each of these functions may improve results, improve the member and provider experience, and reduce program costs.

Optum is unique in its alignment and delivery of the critical combination of actuarial, care management and operational consulting expertise. In an environment where there are often an increasing number of issues to address, we have helped our clients achieve the balanced approach they need to manage the challenges of the Medicare Advantage market.

Optum is unique in its combination of:

- Actuarial
- Care management
- Operations
- Technology

Actuarial services and performance reporting: We have the experience and tools to assist in developing strategic bid pricing to help align with a plan sponsor's operational and strategic goals. We offer both Parts C and D reporting tools to help plan sponsors monitor their performance during the plan year. This includes leveraging social determinants of health within analytics to understand gaps or barriers in care and help inform operational activities to advance health equity.

Risk score accuracy: We offer clinical and operational insight and delivery support to improve the accuracy and completeness of risk scores, combined with the analytics to illustrate the revenue impacts and critical path for such initiatives.

Star Ratings program and performance management: We offer projections, assessments and targeted solutions such as Part D performance improvement, advanced analytics and other critical components to improve Star Ratings performance. Optum also offers consulting and solutions for member-reported "experience" measures, including CAHPS and Health Outcomes Survey (HOS) measure sets.

Population health management: We have deep experience in care management and network management to minimize risk.

Enabling risk-based reimbursement: We bring hands-on experience in creating transformational provider risk-sharing arrangements.

Meet our experts

Gregory J. Backus, ASA, MAAA

Senior Director, Optum Government Programs Actuarial Series

Greg is an accomplished actuary with over 20 years of experience working at several health plans. He has held multiple actuarial leadership roles in payer organizations with both Medicare and Medicaid product lines.

Alex Balmes

Vice President, Optum Government Programs Actuarial Services

Alex has 20 years of experience in health care, including 16 years providing actuarial services within Optum Advisory Service. His current focus is on Medicare Advantage, Medicaid and the ACA lines of business. His experience includes MA and Part D bid development, reserving, provider contracting, RA valuation, M&A management, actuarial recruiting and analytical systems development.

Rose A. Bernards, MBA

Practice Lead, Risk Adjustment, Optum Advisory Services

Rose brings over 25 years of health care experience to her role as part of Optum Advisory Services. Rose's career spans a combination of ambulatory clinic, hospital, insurance and vendor roles providing unique, integrated perspectives across the health care landscape. She currently helps support both payers and providers seeking to improve accurate and complete documentation and coding for their risk-adjusted contracts across Medicare, Medicaid and commercial lines of business.

Tejaswita Karve, PhD

Practice Lead, Star Ratings, Optum Advisory Services

Tejaswita's expertise includes leveraging population health management strategies to maximize performance on quality ratings programs, specifically, on the Medicare Star Ratings program. Tejaswita has over a decade of experience across several Fortune 100 organizations and renowned integrated delivery and finance systems. She has led the lifecycle of Star Ratings program from developing data-driven strategies, to building reporting and analytics capabilities as well as driving execution efforts. She is experienced in promoting advocacy positions with the state and federal agencies (CMS, Defense Health Agency) in support of whole-person care models and integrating social determinants of health in care delivery to help achieve better quality outcomes while delivering a seamless member experience.

Let’s talk about how we can help you assess and address 2024 proposed regulatory changes.

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This document includes guidelines within our definition of the 2024 CMS Rate Announcement and other regulatory changes. All information contained herein is provided solely as commentary and should not be misunderstood as constituting legal or compliance advice. Plans should consult their own legal and/or compliance advisors as to recommended next steps.

Sources

2024 Advance Notice:.cms.gov/medicare/health-plans/medicareadvtgspecratestats/announcements-and-documents/2024-advance-notice

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