



Viewpoints on the 2024 CMS Final Rate Announcement

On March 31, 2023, the Centers for Medicare & Medicaid Services (CMS) released the Final Rate Announcement for Medicare Advantage (MA) and Part D plan sponsors (“health plans”). The impact to any plan can vary based on specific plan circumstances and will need to be factored into bids and corresponding business plans for 2024. 2024 MA and Part D Bids are due to CMS by Monday, June 5, 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. The Final Rule, codifying many of the proposed Stars programmatic changes, was released on April 5, 2023.

Table of contents

6 key final changes for 2024.....2

Highlights of changes

Part C plan payment 3

Risk adjustment 5

Star Ratings program 7

Part D program changes.... 11

4 things to consider for bid preparation.....13

Optum is here to help14

Meet our experts15

6 key final changes for 2024

- 1 CMS will be phasing in a revised CMS-HCC (hierarchical condition categories) model .** The new model will be phased in over a three-year period. In 2024, the revised model will be given 33% weight while the existing model will be given 67% weight. For 2025, 67% weight will be on the 2024 model and 33% weight on the 2020 model. In 2026, 100% of the 2024 model will be used.
- 2 The CMS-HCC risk model revision and risk score normalization updates are estimated to decrease average plan payments by 2.16%.** When considered against the effective growth rate, CMS says this results in a 0.12% increase in payments. Actual results will vary significantly by county and plan.
- 3 Estimated MA and fee-for-service (FFS) effective growth rate of 2.28% .** The lower growth rate is the result of lower 2022 USPPC costs than CMS estimated last year, and removal of indirect medical education (IME) and direct graduate medical education (DGME) costs from historical and projected expenditures. Similar to the CMS-HCC risk model revision, the removal of the IME and DGME costs will be phased in over a three-year period, at 33% weight in 2024.
- 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. 2025 Stars will introduce several non-substantive changes to CAHPS in an alignment with the focus on the health equity by CMS. CMS is requesting stakeholder input on the proposed concepts when they are formally introduced in future rulemaking.
- 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 .**
- 6 Bid-to-benchmark ratios applied in the employer group waiver plans (EGWPs) payment rates will decrease from 80% to 77% .**



Highlights of final changes

The 0.12% plan payment increase is a national average and does not account for all variables that affect plan payments. It reflects a 2.28% increase due to growth rate and a 2.16% decrease due to risk model revision and normalization factor updates. CMS FFS rebasing is estimated to have no overall impact. The national average plan payment increase does not reflect the impact of Star Rating changes.

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: CMS did provide its methodology for its estimate of 4.44% for plan coding trend, which would help to offset any negative plan payment impacts. This estimate assumes 5% coding trend under the existing risk adjustment model, versus 3.3% coding trend under the revised model.
- 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 2.28% effective growth rate is an expected blend of the total USPCC growth rate of 1.60% and the FFS growth rate of 2.45%. The FFS growth rate is a component of the total USPCC growth rate.



0.12%

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

- 2024 USPCC estimates relative to 2023 Final Rate Announcement estimates:
 - Indirect medical education (IME) and direct graduate medical education (DGME) costs will be removed from historical and projected expenditures over a three year period, with a 33% implementation for 2024. The impact on the effective growth rate for CY 2024 is a 0.78% reduction.
 - 2022 USPCC costs are lower than CMS estimated last year. Specifically, the 2022 total USPCC is 3.4% lower and the 2022 FFS USPCC is 5.0% 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 updating the frailty factors used to calculate frailty scores for beneficiaries enrolled in FIDE SNPs, using the blended CMS-HCC risk adjustment model. No methodology change for PACE beneficiaries.
- The national average for 2024 ESRD growth rate is 2.27%, a decrease from the 2.68% ESRD growth rate published in the 2024 Advance Notice.

CMS 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%.



Highlights of final 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 will be phasing in an update to the CMS-HCC model over three years. In 2024, the new model will be given 33% weight and blended with risk scores from the current 2020 risk adjustment model at 67% weight. For 2025, 67% weight will be on the 2024 model and 33% weight on the 2020 model. In 2026, 100% of the 2024 model will be used.
- Under the revised model, ICD-10 codes will be used instead of ICD-9 codes. In addition, the model is calibrated using 2018 diagnoses and 2019 expenditures. Finally, CMS is removing over 2,200 diagnoses from the risk adjustment model and constrains others.
- The MA coding pattern adjustment factor is to remain at 5.9%, consistent with 2021 (minimum statutory requirement).
- Optum modeling indicates that the New Enrollee cohort will benefit most from the model update, whereas the Full & Partial Aged cohorts will be most negatively impacted.



CMS is estimating the risk model revision and normalization updates to **decrease** average plan payments by 2.16%

Commentary on CMS-HCC model change

CMS is adopting 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 HCCs in the Part C risk adjustment model were renumbered
 - CMS will 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
 - HCCs removed:
 - HCC 47 - Protein Calorie Malnutrition
 - HCC 230 - Angina Pectoris
 - HCC 265 - Atherosclerosis of Arteries of the Extremities with Intermittent Claudication
 - Constrains (holds coefficients of HCCs equal/have the same weight):
 - Diabetes Mellitus (HCCs 36, 37, 38)
 - Congestive Heart Failure (HCCs 224, 225, 226)
 - Blending of two HCC models to apply in payment years 2024 and 2025 to phase in the V28 model changes over a 3-year period.

Commentary on Risk Adjustment Data Validation (RADV) audits

- While not part of the Final Rate Notice, the RADV final rule was released in February and is worth noting in the context of Risk Adjustment regulatory changes.
 - Originally planned for payment year (PY) 2011, the RADV final rule codifies that CMS will extrapolate RADV audit findings beginning with PY 2018 (2017 dates of service).
 - CMS will not apply a fee-for-service (FFS) adjustment factor in RADV audits.
 - Per CMS, the average RADV error rate is 3%, with a median error rate of 1.8%.



Highlights of final 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 2024 Final 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

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
- CAHPS (Part Cand D): Add Web mode of data collection for 2025 Stars
- CAHPS (Part C): Remove 15-minute wait question from the “Getting Appointments and Care Quickly” measure for 2025 Stars
- CAHPS (Part C and D): Question regarding “perceived unfair or insensitive treatment” for 2025 Stars Display page

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 will not be considered for 2024 Display Page or Star ratings at this time
- 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

Potential new measure concepts and methodological enhancements

CMS is requesting that stakeholders provide input on the below proposed concepts when they are formerly introduced in future rulemaking.

- 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

- 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.



Highlights of final 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 final 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 Final 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.

- 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.

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
- Star Ratings
- Service-area mix
- Contracting arrangements



Identify effective cost management strategies to maintain financial viability through 2026



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 and cost of care if they are to produce achievable, competitive bids and provide products that reach stated goals for benefits and member premiums.

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 Revenue Management, Part C and Part D reporting tool and services 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, experiential 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 over 20 years of experience in health care, including 20 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, strategic consulting, 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 regulatory changes.

1-800-765-6807 | empower@optum.com | optum.com

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 Final Notice: [cms.gov/medicare/health-plans/medicareadvtspeccratestats/announcements-and-documents/371979854/2024](https://www.cms.gov/medicare/health-plans/medicareadvtspeccratestats/announcements-and-documents/371979854/2024)

Federal Register: [federalregister.gov/documents/2022/12/27/2022-26956/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program](https://www.federalregister.gov/documents/2022/12/27/2022-26956/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program)



optum.com

Optum is a registered trademark of Optum, Inc. in the U.S. and other jurisdictions. All other brand or product names are the property of their respective owners. Because we are continuously improving our products and services, Optum reserves the right to change specifications without prior notice. Optum is an equal opportunity employer.

© 2023 Optum, Inc. All rights reserved. WF10264404 04/23