2024 MA Rates Proposed -2.27%

Growth Rate Grim, Risk Model Revamped; Likely Improvement Final '24 Print

- **CMS released 2024 proposed Medicare Advantage (MA) plan rates here.** As a reminder, this is a proposal. CMS will take comments and release a final 2024 Rate Release by April 3.

- **MA rates are lower than we anticipated (-2.27%) for 2024, though the final pay update typically will only improve between now and April 3.** Congress would love to take the savings from Medicare Advantage plan cuts to offset other legislation. We said rates would be +2-4% versus prior years of uber healthy +5-8% updates.

- **We think that the rates will improve because Congress likes to use savings for other priorities.** We could see an improvement for 2024 final rates. Then, Congress may take $10 B+ from plans to fund other priorities, as Congress gets into balanced budget mode.

- **The big puts & takes:** The growth rate falls to 2.09% from 4%+ in prior years. Star ratings at -1.24% also is a reduction not seen over the past several rate cycles. The risk model is a significant negative that we unpack in the text of this note.

- **The risk model eliminates 2,000 diagnosis codes and is, frankly, transformative**. The proposed new risk adjustment model reflects more current costs associated with various diseases, conditions, and demographic characteristics considers the ICD-10 diagnostic classification system that has been in use for medical payment since 2015 and includes revisions designed to reduce the sensitivity of the model to coding variation.

- **The overall update looks to be negative for plans (HUM, UNH, ELV, CNC, others) and VBC co's (OSH, AGL, CMAX, others).**

Impact	2024 Advance Notice
Effective Growth Rate	**+2.09%**
Rebasing/Re-pricing	**TBD**
Change in Star Ratings	**-1.24%**
MA Coding Pattern Adjustment	**0%**
Risk Model Revision & Normalization	**-3.12%**
MA risk score trend	**+3.30%**
Expected Average Change in Revenue	**+-2.27**
SOURCE: CMS & Capitol Street, 2/1/23	

- **Other**: **Part D rules incorporate recent *Inflation Reduction Act* changes.**
  - CATASTROPHIC PHASE Beginning in 2024, cost-sharing for Part D drugs will be eliminated for beneficiaries in the catastrophic phase of coverage.
  - LIS The Low-Income Subsidy program (LIS) under Part D will be expanded so that beneficiaries who earn between 135 and 150 percent of the federal poverty level and meet statutory resource limit requirements will receive the full LIS subsidies that were prior to 2024 only available to beneficiaries earning less than 135 percent of the federal poverty level.

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- INSULIN During 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.
- VACCINES 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.
- PREMIUM CAP 6% Beginning in 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.

- **NEXT UP: This is a proposal for 2024, and likely improves between proposed and final rates**. Comments are due March 3.

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Background

See more detail below.

Risk Model Revision

- For 2024, the proposed model incorporates a clinical revision of the HCCs, using ICD-10 codes to create the HCCs for the first time. Previous versions of the CMS-HCC model used ICD-9 codes to create the HCCs. In addition to using more recent data and denominator year in recalibrating the model, the new CMS-HCC model will reflect a reclassification by which CMS, in consultation with a panel of outside clinicians, rebuilt the condition categories to reflect diagnosis coding under the ICD-10-CM diagnosis classification system. The new categories reflect more clinical specificity and validity (i.e., greater level of detail that allows more precision in the identification of specific conditions) available through ICD-10 coding. The new categories and updated HCCs will also reflect possible changes to physician coding patterns that have developed because of the transition to ICD-10 that the current model does not.
- Currently, the HCC diagnostic classification system classifies over 72,000 ICD-10-CM diagnosis codes into approximately 1,500 diagnostic groups (DXGs). Each ICD-10-CM code maps to exactly one DXG, which represents a well-specified medical condition. DXGs are further aggregated into 204 condition categories. Condition categories describe a broader set of similar diseases. Consistent with prior model calibrations, hierarchies are imposed by CMS among related condition categories, so that a beneficiary's risk score includes only the most severe manifestation among related diseases. After imposing hierarchies, condition categories become Hierarchical Condition Categories, or HCCs. In developing risk models, CMS imposes hierarchies in all model calibrations so that if a person has more than one condition category in a hierarchy, only the highest (most severe) condition category in the hierarchy will be assigned as the HCC for calculating the risk score.
- Changes to the condition categories – including additions, deletions, and revisions – are based on each condition category's ability to predict costs for Medicare Parts A and B benefits. Condition categories that do not predict costs well or the condition does not have well-specified diagnostic coding – are not included in the model.

See below for our takeaways from CMS's 2024 MA and Part D proposed rule. The "CY 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program" here is an annual rule with guidance on all aspects of the MA & Part D programs for the following year.

MA STARS – PATIENT EXPERIENCE DOWNGRADE & NEW EQUITY MEASURES

- **The impact of all of the Star Ratings provisions is $25 B in savings over ten years accounting for under 1% (0.37%) of the private health baseline.**

- **CMS proposes reducing the weight of patient experience/complaints and access measures, which plans embrace.** The weight would be reduced by half (from four to two), to better align with other CMS quality programs and the current CMS Quality Strategy that promote quality outcomes. CMS proposes removing the bidirectional caps that restrict movement of a measure's cut points compared to the prior year. CMS proposes, for measure-specific-thresholds for non-Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, modifying the Improvement Measure hold harmless policy, removing Star Ratings measures on a sub-regulatory level, and removing the 60% rule that is part of the adjustment for extreme/uncontrollable circumstances.

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- **For the first time, the Star Ratings program could have a health equity measure (2027) which financially rewards plans.** CMS proposes a tiered health equity index (HEI), beginning 2027 Star Ratings, using data from 2024 and 2025 years. The goal is to encourage MA and Part D plans to improve care for individuals with dual eligibility, low-income subsidies, and disability, etc. The HEI reward provision, which would replace the current reward factor, is expected to result in net savings of between $680 M in 2028 and $1.05 B in 2033, resulting in a ten-year savings estimate of $5.13 B.

- **Commitment to promoting health literacy – calculating the HEI reward.** CMS clarifies the populations that MA plans are required to provide services in a culturally competent manner. This would include populations (1) with limited English proficiency or reading skills, (2) of ethnic, cultural, racial, or religious minority groups, (3) with disabilities; (4) who identify as LGBTQIA+ (5) who live in rural areas, and (6) adversely affected by poverty. The rule would also require MA plans to develop procedures to offer digital health education to enrollees to help close gaps in telehealth care. Contracts with percentages of enrollees with any of the specified social risk factors (SRFs) each year that are greater than or equal to one-half of the contract-level median % of enrollees with the specified SRFs up to, but not including, the contract-level median would qualify for one-half of the HEI reward. Contracts that have % of enrollees with any of the specified SRFs greater than or equal to the contract-level median would qualify for the full HEI reward.

TOUGHER MARKETING PLAN RULES

- **As we expected, CMS cracks down on MA advertising & marketing.** Marketing practices, including television ads, have been a longstanding concern. CMS proposes adding bans and guardrails on MA plans.

    - CMS proposes to *limit* the requirement to record calls between third-party marketing organizations (TPMOs) and beneficiaries to marketing (sales) and enrollment calls. See CMS final rule that instated this requirement here. The went into effect October 1, 2022.
    - CMS proposes banning ads that (1) do not mention a specific plan name, (2) use words or imagery, such as the Medicare name/logo that may mislead or confuse beneficiaries or misrepresent the plan.
    - CMS proposes codifying past guidance that (1) increases enrollee protections against high-pressure/misleading marketing, (2) ensures enrollees are not pressured into enrolling in plans or attending events, (3) prevents predatory marketing, (4) strengthens the role of plans in monitoring agent and broker activity.
    - CMS bans (not limited to the following): (1) on sales presentations that immediately follow an educational event, (2) on agent distribution/collection of Scope of Appointment and Business Reply Cards at educational events, (3) agents conducting a sales and/or enrollment meeting with a beneficiary within 48 hours after a beneficiary's consent (4) use of Medicare language or logos in advertisements that mislead Medicare enrollees into believing these advertisements are from the government.
    - CMS required plans to (1) report agents who fail to adhere to CMS requirements to CMS, and (2) work with state Departments of Insurance (DOI) to address any issues.

- **CMS adds guardrails to protect beneficiary access to accurate information on Medicare coverage by agents/brokers.** They include, but are not limited to, requiring agents to (1) inform beneficiaries that they can access Medicare options/information from 1-800-MEDICARE, SHIPs, or Medicare.gov, (2) ask standardized questions about a beneficiary's health care needs, providers, and prescriptions, before enrolling them into a plan, (3) provide a pre-enrollment checklist to

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prospective enrollees, that includes effect on current coverage they change plans, and (4) fully review the pre-enrollment checklist with beneficiaries prior to completing enrollments if conducting telephonic enrollments.

PART D - HIV/AIDS ADDED, LOWER # PART D DRUGS, INTERCHANGEABLES

- **HIV/AIDS added to Part D chronic disease list, and lower max # drugs offered (to 5 from 8)** CMS proposes (1) adding HIV/AIDS to the list of chronic diseases, and requiring plans to include all 10 chronic diseases in targeting criteria*, (2) lowering the maximum number of covered Part D drugs a sponsor may require from 8 to 5 drugs and requiring inclusion of all Part D maintenance drugs in targeting criteria, and (3) revising the methodology for calculating the cost threshold ($4,935 in 2023) to be proportionate to the average annual cost of five generic drugs ($1,004 in 2020). *Core chronic diseases include: diabetes, hypertension, dyslipidemia, chronic congestive heart failure, Alzheimer's disease, end-stage renal disease (ESRD), respiratory disease (including asthma, COPD, and other chronic lung disorders), bone disease-arthritis (osteoporosis, osteoarthritis, and rheumatoid arthritis), and mental health (depression, schizophrenia, bipolar disorder, and other chronic/disabling mental health conditions.

- **Interchangeable biological products and generics would be immediately substitutable in Part D.** Currently, Part D drugs are allowed to immediately switch a newly released generic version with the brand name drug. CMS proposes to allow Part D sponsors to immediately substitute (1) a new interchangeable biological product, (2) a new unbranded biological product, and (3) a new authorized generic for their corresponding brand name equivalents.

- **Parts of the *Consolidated Appropriations Act, 2021* (*CAA*) and the Inflation Reduction Act of 2022 (*IRA*) would be implemented.**

    - *CAA*: The Limited Income Newly Eligible Transition (LI NET) program is made a permanent part of Medicare Part D. Projected drug costs of $95 M from 2024-2033.
    - *IRA*: 11404 of the *IRA*, which expands eligibility under the low-income subsidy (LIS) program is implemented. individuals with incomes up to 150% of the federal poverty level (FPL) will qualify for the full low-income subsidy beginning January 1, 2024. Those who currently qualify for the partial subsidy would be able to get the full subsidy. Projected costs for expanding LIS of $2.32 B from 2024-2033.

PRIOR AUTH & BEHAVIORAL HEALTH

- **Behavioral health policies adds clinician types, removes PA for mental health emergencies and maintains parity with physical health benefits .** CMS proposes to: (1) add Clinical Psychologists, Licensed Clinical Social Workers, and Prescribers of Medication for Opioid Use Disorder as specialty types for which specific minimum standards are set for and MA networks are evaluated for, and make the specialty types eligible for the existing 10% telehealth credit, (2) change general access to services standards to cover behavioral health services, (3) codify appointment wait times standards for both primary care & behavioral health services, (4) clarify that mental health services that evaluate/stabilize emergency medical conditions are not subject to PA, (5) require that MA plans notify enrollees when their behavioral health/primary care provider(s) are dropped from networks; (6) require MA networks to have care coordination programs to move towards pay parity between behavioral and physical health.

- **More from CMS on prior authorization (PA), clearly a priority.** This rule adds continuity of care requirements and requires that once a beneficiary receives prior authorization approval, it is valid for the entire course of treatment. CMS proposes that (1) PA policies for coordinated care plans can

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only be used to determine the presence of diagnoses and/or ensure that a procedure is medically necessary, (2) plans must provide a 90-day minimum transition period when a beneficiary currently under treatment switches MA plans, and (3) all plans must establish a Utilization Management Committee that ensures that policies are consistent with Traditional Medicare guidelines to ensure that PA is not being misused. See our memo from 12-07-2022 for our thoughts on the E-Prior Auth proposed rule. See the PA rule here.

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