2023 Medicare Advantage Rates +8%

Coding Intensity Stays Same at +5.9%, Insanely Positive Pro MA Release

- **CMS released the 2023 proposed Medicare Advantage (MA) plan rates here.** As a reminder this is a proposal. CMS will take comments and release a final 2023 Rate Release on April 4.

- **Rate update of this magnitude (may) set up plans for cuts later, as we have not see one of this magnitude.** Congress would love to take the savings from Medicare Advantage plan cuts to offset other legislation. However, we are in an election year. We see no negative updates here – HRA, coding intensity, risk adjustment, etc.

- **The overall update looks to be extremely positive for plans (HUM, UNH, ANTM, CNC, others) with an expected average change in revenue of 7.98%.**

Impact	2023 Advance Notice
Effective Growth Rate	4.75%
Rebasing/Re-pricing	TBD
Change in Star Ratings	0.54%
Medicare Advantage Coding Pattern Adjustment	0%
Risk Model Revision	0%
Normalization	-0.81%
MA risk score trend	3.50%
Expected Average Change in Revenue	7.98%

SOURCE: CMS, 2/2/22

- **Other**: **Coding Intensity, Risk scores, ESRD**. The '23 factor will remain at the minimum, or 5.9%. CMS continually reviews MA coding patterns and continues to assess how we calculate the MA coding pattern adjustment, how best to apply it, and what the appropriate level of the adjustment should be. CMS will continue the 2022 policy to calculate 100% of the risk score using the 2020 CMS-HCC model, which was phased in from CY 2020 to 2022,as amended by the *21st Century Cures Act*. CMS will also continue calculating risk scores using diagnoses exclusively from MA encounter data submissions and fee-for-service (FFS) claims. CMS uses a separate model to calculate the risk scores applied in payment for the Part A and Part B benefits provided to beneficiaries in ESRD status when enrolled in MA plans.

- **NEXT UP: This is a proposal for 2023, and an insanely positive pro-plan one at that**. Comments are due March 4. We expect Progressives to be angry with the healthy bump, asking Congress to reduce pay given their assertion plans are growing risk scores over time to garner additional (government) pay. It's an election year, so Congressional cuts appear unlikely unless dollars are needed, and then reductions would not kick in until 2024 at the soonest. We had said that we expect nothing major in the proposed 2023 rates, and expect them to be plain vanilla, with

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few surprises. The final rule is due by April 4. We will also see CMS decide DIR policies (impact PBM, Pharmacy, Plans) in a final rule later this year.

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Background

Recall that the CMS released the Technical rules of the Road in January. DIR was the major unexpected proposal. See below for details.

- **CMS will address Risk Score growth, and potential upcoding by the plans, as criticized by MedPAC**, MA risk score trend is +3.50%. The agency will continue policy of calculating risk scores using diagnoses exclusively from MA encounter data submissions and FFS claims.

- **On Star Ratings, CMS said it finalized an increase in the weight of patient experience/complaints and access measures from 2 to 4 for 2023.** CMS announced a deadline of June 30, 2022 for all contracts to make their requests for review of the 2023 Star Rating appeals and CTM measure data. Recall that CMS noted in Jan 6, 2022 technical rulemaking that Star Ratings would account for COVID. CMS will calculate 2023 Star Ratings for 3 HEDIS measures that are based on the Health Outcomes Survey. Without this technical change, CMS would be unable to calculate 2023 Star Ratings for these measures for any MA contract since all contracts qualify for the extreme and uncontrollable circumstances adjustment for COVID-19.

    - Monitoring Physical Activity,
    - Reducing the Risk of Falling, and
    - Improving Bladder Control.

- **MA plan network adequacy requirements are stronger, and helps with bid pricing tool.** This came from the Jan Technical rule. CMS is proposing that plans demonstrate they have a sufficient network of providers to care for beneficiaries before CMS approves an application for a new or expanded MA plan.

- **MLR reporting requirements in effect for contract years 2014 – 17 are back & CMS wants supplemental & social determinant info (dental, hearing, housing, transpo, food security) reported.** Current regulations require that MA and Part D plans report to CMS the % of revenue spent on patient care and quality and the amount of any remittance that must be paid to CMS for failure to meet the 85% (minimum) MLR requirement. MA and Part D plans would have to report the underlying cost and revenue information needed to calculate and verify the MLR % and remittance amount, if any. MA organizations will report the amounts they spend on various types of supplemental benefits not available under original Medicare (e.g., dental, vision, hearing, transportation).

- **Special Needs Plans (SNPs) and Social Determinants/Health Equity**. Building on CMS's experience with other programs and model tests, we propose to require that all SNPs include standardized questions on housing stability, food security, and access to transportation as part of their health risk assessments (HRAs).

- **Pharmacy DIR is baccckkk in 2023…CMS notes it saves beneficiaries $21 B and impacts PBMs and plans (negatively).** We highlighted in our 2022 healthcare outlook that CMS announced its intention last fall to address PBM DIR. The agency is proposing Part D plans apply all price concessions they receive from pharmacies to the point of sale, so that the beneficiary can also share in the savings. CMS is proposing to redefine the negotiated price as the baseline, or lowest possible, payment to a pharmacy, effective January 1, 2023. This policy would reduce beneficiary out-of-pocket costs and improve price transparency and market competition in the Part D program.

- **DIR**: **This policy was in Grassley-Wyden or *Prescription Drug Pricing Reduction Act of 2019* (here).** The negotiated plan-pharmacy price is frequently higher than the final payment to pharmacies, making bene cost-sharing higher, advancing through the Part D benefit more quickly. More Part D plans have entered into arrangements with pharmacies that may pay less money for dispensed drugs if pharmacies do not meet certain criteria. The negotiated price for a drug is the price reported to CMS at the point of sale (POS), which is used to calculate beneficiary cost-sharing and generally adjudicate the Part D benefit. With the emergence of these payment arrangements, the negotiated price is frequently higher than the final payment to pharmacies. Higher negotiated prices lead to higher beneficiary cost-sharing and faster beneficiary advancement through the Part D benefit.