March 28, 2023

Medicare Advantage FAQs

Risk Model, Plan & Provider Response, TBC, Dual Impact, CMS Vendetta, RADV Audits, Legislation

Relevant Companies

See below for FAQs regarding Medicare Advantage (MA) 2024 rates, RADV, provider impact, legislative activity, and value based care.

If the 2024-risk model is finalized, what types of plans does this impact the most? Beneficiaries?

The biggest negative is likely to the following Medicare Advantage plans: (1) newer plans, (2) smaller plans (3) plans in less mature MA markets. The most socially and medically complex seniors are most negatively impacted. Dual eligibles (Medicare-Medicaid) would also be paid less under the new model.

True that the Medicare Advantage ad during the Superbowl angered the White House?

Yes. Better Medicare Alliance (here) sponsored it. Avalere projects a cut of $540 per MA enrollee on average next year, per a study commissioned by BMA.

What are the (proposed) changes to ’24 risk coding? What is the impact to payer risk scores of premium PMPM?

CMS proposes to move from a HCC model to a demographic model. That means newer to Medicare seniors will obtain higher payments. Diabetics that were previously categorized roughly as healthy, moderate and severe (with those more severe garnering the highest payments in current model) all payments for diabetics would be evenly distributed, not just those with myriad co-morbidities. The -3.12% (payment impact) combination is for risk score and normalization. Wakely Consulting Group described those impacts for AHIP report (see here) and projects a -6.4% cut for duals if the new model is finalized.

Why didn’t CMS address risk score growth via the coding intensity factor (5.91)?

That may have been a better avenue, versus a brand-new complicated risk adjustment system to be implemented in less than one year. CMS saw diagnoses in MA that were not seen in FFS, hence the move to cut the 2,000 codes as a way to even things out. Many argue that there are different motivations for MA vs. FFS re diagnosis collection and there shouldn't be such a blunt comparison.

What can MA plans do to offset premium PMPM and benefits cost PMPM? (if '24 policies are finalized as proposed)?

Benefit reduction is most likely. MA plans may also push back on vendors by asking to lower costs This includes supplemental benefits such as Silver Sneakers, Meals on Wheels or around-the-edges benefits that seniors may not notice as much. MA can also push on providers to lower costs. Payers do not want to increase premiums ($0 premium plans will likely not go to $5 premium because plans would lose enrollees).

How does the '24 proposal flow through to capitated (VBC) providers in terms of their revenue PMPM? What can they do to offset this?

Providers may be hit the hardest because pay is tied to risk scores. This is why APG (here) is raising alarm bells (ATI ran an analysis for APG here). The score for a diabetic is less than it used to be – it would be wider range from least to most severe so when averaged together the least severe are benefitting (avg., higher cost), but higher severity diabetics could see lower payments.

What are the companies (providers) saying?

A few examples, from comment letters:

Oak Street notes for patients who are both full benefit dually eligible and Black or African American, Oak would see a $480 per member per year reduction in risk-adjusted payments compared to the change in payment for Oak Street patients who are non-duals and White. For duals Oak would see a $240 per member per year reduction in risk adjusted payments compared to the change in payment in patients who are non-duals and White.

ChenMed highlighted that revenue per beneficiary would drop by 17% because of which kinds of beneficiaries have the health conditions caught up in the changes, and what diagnostic information an accountable model of primary care proactively captures so that it can manage health.

Does CMS have a vendetta against MA plans? Is this the start of a few years of pain?

With 50% penetration in the program we do not think this is the beginning of the end. Instead, we could see a more thoughtful risk model / coding intensity approach for CMS, not just for '24, but phased-in. CMS (and Congress) can't ignore that seniors love the program, the extras they get like nutrition, transportation and vision benefits. Seniors who love MA are also reliable voters.

Why are MA plans not particularly concerned about the rate notice publicly?

Humana is most vocal in the plan community. All plans are hoping MA sees an improvement in the final rates / risk model. The companies likely do not want to seem like the sky is falling as they work comment letters and visit with lawmakers. AHIP, BMA, SNP Alliance, and ACHP provided pushback on the model in their comments, and may exhibit more concern than corporate public statements / earnings calls.

What has the Hill reaction been from staffers and members to plans and trade associations?

GOP Senators on a key Medicare committee support the MA program (here). There is more of an anti-plan sentiment, and more sympathy towards providers/physicians. From Democrats, there is a feeling that plans are well capitalized and can weather this storm, as they are also buying up provider groups and not sharing savings with the overall system. (Note: this is anecdotal, largely Senate sentiment).

What are the trades – AHIP, BMA, Blue Cross Blue Shield -- saying about the rate notice?

Most groups are asking for a delay or phase-in of the new model. The number of years of phase-in isn't specified but we have seen 2- or three-year phase-ins in other payment situations. That allows CMS to collect more data, etc. Stakeholders are overall concerned with the proposed MA rates as it would increase costs and reduce benefits in 2024. Overall, groups are concerned about the lack of transparency from CMS and data to support their decisions in the new proposed risk model. Groups are concerned that the proposed risk model does not consider the disproportionate impact on certain geographies and populations including dual eligibles.

Can you send comment letters?

Yes. We analyzed recent stakeholder comments on Medicare Advantage, see here: America's Health Insurance Plans (AHIP), Better Medicare Alliance (BMA), Medical Group Management Association (MGMA), America's Physician Groups (APG), BlueCross BlueShield Alliance (BCBSA), Alliance of Community Health Plans (ACHP), and SNP Alliance.

What are the main arguments the plans and providers are messaging against the 24 proposals?

Many (AHIP, Better Medicare Alliance, America's Physician Groups, ACHP, SNP Alliance) have specifically called out the negative effect on dual eligibles and how rates will unintentionally and disproportionately affect this population in addition to those with chronic conditions. Those same organizations concluded that the proposed rates would decrease provider pay and ultimately increase premiums for beneficiaries and/or reduce benefits. Specifically, SNP Alliance members are reporting a negative impact of $700-$800 per member per year. MGMA, America's Physician Groups, and SNP Alliance mention have requested more information on why certain diagnosis codes were cut.

What is the word on RADV?

Many groups note that RADV should be the vehicle to address upcoding. CMS notes in a January 30 final rule that it will not apply the FFSA (as CMS had proposed) which means that the plan community may engage in litigation. We do not think that litigation would ensue until government pay recoupments are requested, which could take some time.

Why did CMS Administrator sound so dug in on the new risk model at AHIP meetings in DC this month?

She has to. Allegations of upcoding indicate fraud & abuse. There is no option not to act in some way. However, the severity of the proposal— slicing 2,000 diagnosis codes in one year — is too much, too soon, in our view.

What do you think they do in the final rule?

We could see a delay or a phase-in of the new model. CMS can easily reduce the # of diagnosis codes to something lower say 1,000 from 2,000+ as an example. IME/GME, growth rate and stars weightings are unlikely to change materially in our view. CMS provided data files to accompany the proposal 17 days into a 30-day comment period. We think that is not ample enough time for plans and providers to analyze, replicate & respond to the agency. Stakeholders have a strong leg to stand on, asking for more time.

What is the TBC for MA and Duals plans for 2024? TBC is total beneficiary cost (or the OOP cap) for beneficiaries.

TBC has not yet been determined for MA and PDPs. We will keep an eye on the final rule for this.

Is there any MA legislative activity here?

Yes, there is a Senate bipartisan Medicare Advantage (MA) upcoding bill in the works that would improve risk adjustment (RA) under MA by using two years of diagnostic data starting in 2024. There would be a provision excluding diagnoses collected from chart reviews and HRAs. The bill would likely be bipartisan and bicameral. It's early days but we could see something move on this front; if it saves dollars and could be packaged with other deficit-reducing provisions (i.e., site neutral policy for hospitals etc).

Anything else to look out for re MA and Part D, providers?

Yes, the final 2024 Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Medicare Cost Plan Programs, Medicare Overpayment Provisions of the Affordable Care Act, and PACE (here) could be any day now. We published an analysis on Dec 15, 2022. The MA star rating (proposed) policy would save $25 B over ten. *Let us know if you need our proposed rule analysis.*

Ipsita Smolinski

Managing Director | Capitol Street

ipsita@capitol-street.com

900 19th Street, NW 6th Fl
Washington DC 20006

202.250.3741

www.capitol-street.com

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