Wakely
An HMA Company

Summary of Advance Notice of Methodological Changes

Calendar Year 2024
Medicare Advantage Capitation Rates and Part C and Part D Payment Policies

February 13, 2023

Prepared by:

Wakely Consulting Group, LLC, an HMA Company

Table of Contents

Executive Summary

On February 1, 2023, CMS released the 2024 Advance Notice, which details planned changes to the Part C and Part D capitation and risk adjustment methodology for calendar year (CY) 2024. The comment period for the Advance Notice ends March 3, 2023, and the final rating provisions will be announced no later than April 3, 2023.

The CY2024 fee-for-service (FFS) Growth Rate, which is the major driver of Part C benchmark rates, is estimated at 2.15%.

CMS has proposed changes to the non-ESRD Part C risk model but is not proposing to revise the RxHCC model despite changes to the Part D benefit parameters. Associated to the new non-ESRD Part C risk model is a revised CY2024 FFS normalization factor of 1.015, which compares with 1.127 for CY2023. The proposed coding intensity adjustment factor remains at the statutory minimum of 5.9%.

Following is a brief summary of the key changes and proposals in the Advance Notice.

Part C Growth Rates

The table below shows the estimated growth rates for 2024.

Table 1: Estimated 2024 Growth Rates

Growth Rate	Percentage
FFS – Non-ESRD	2.15%
MA Growth Percentage (including FFS and MA) – Non-ESRD	1.81%
Dialysis-only ESRD	2.68%

For the non-ESRD rates, CMS has made a technical revision to remove the MA-related Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) from the USPCC calculations which has lowered the FFS Growth rate by 2.13 percent and the MA growth percentage by 1.06 percent.

Part C Risk Scores

No changes are expected to the Part C risk models used for payment in CY2024 for ESRD populations.

For non-ESRD, the Part C risk model for aged and disabled beneficiaries is proposed to be updated for:

- more recent calibration and denominator year data,

- a clinical reclassification of the Hierarchical Condition Categories (HCCs) using ICD-10-CM, and
- additional constraints and the removal of HCCs,

Associated to the new CY2024 non-ESRD model, the FFS normalization factor for Part C models[1] is proposed to be 1.015 (compared with the CY2023 normalization factor of 1.127 for the 2020 CMS-HCC model, which has a denominator year of 2015), and now reflects four years of trend. In determining this trend, CMS used normalization factors from 2018 through 2022, but dropped 2021 due to the impact of the COVID-19 pandemic.

CMS followed a similar method to calculate the FFS normalization factors for the the 2023 ESRD CMS-HCC Models for non-PACE.

For PACE risk adjustment models, the normalization factors are estimated based on 2016 through 2020 normalization factors, trended to 2024, which reflects nine years of trend since these models have a denominator year of 2015.

The CY2024 coding pattern adjustment is set at the statutory minimum of 5.90%, which represents no change compared with CY2022.

Part D Risk Scores

CMS is not proposing any new RxHCC models for CY2024, and will continue to use the 2023 RxHCC model for non-PACE plans. The non-PACE RxHCC FFS normalization factor for CY2024 is proposed to be 1.063, which compares with 1.050 for payment year 2023.

For PACE organizations, CMS proposes to continue using the CY2020 RxHCC model, which has a denominator year of 2015. The PACE RxHCC FFS normalization factor for CY2024 is proposed to be 1.084 (up from 1.073 in CY2023).

Both RxHCC models use 2016 through 2020 normalization factors, trended to 2024. This reflects four years of trend for the 2023 RxHCC model and nine years for the 2020 RxHCC model

EGWPs

Plans will not need to file EGWP bid pricing tools (BPTs) for CY2024, as was the case in CY2023.

CMS proposes to continue calculating separate HMO and PPO bid-to-benchmark ratios based on individual 2023 bids and then re-weighted with February 2023 EGWP enrollment. The preliminary 2024 bid-to-benchmark ratios compared to the 2023 rates are as follows:

[1] For community, institutional, new enrollee, and C-SNP new enrollee models.

Table 2: Estimated Bid-to-Benchmark Ratios

Applicable Percentage	2023 Ratios	2024 Estimates
0.95	80.7%	78.5%
1.00	79.8%	77.2%
1.075	79.7%	76.7%
1.15	79.8%	76.9%

TBC Threshold

CMS has not yet published requirements for MA and PD benefits related to the Total Beneficiary Cost (TBC) threshold.

Part D Defined Standard Benefit Changes

Several changes to the Defined Standard Benefit resulting from the Inflation Reduction Act (IRA) of 2022[2] will apply for CY2024. Unlike most other provisions in the Advance Notice, these changes are not proposed, but are final. The key IRA changes for 2024 are as follows:

- No cost-sharing for any beneficiaries in the catastrophic phase of coverage
- Expansion of the LIS program where more beneficiaries will be eligible for full low-income premium and cost-sharing subsidies.
- Insulin prescriptions will not be subject to the deductible and will be limited to $35 cost-sharing for a month's supply.
- The base beneficiary premium growth will be held to no more than 6%.

Part D Parameters and Risk Sharing

Preliminary updates to the Part D parameters were announced. The annual percentage increases in average expenditures and the consumer price index were announced as 8.01% (up from 5.08% in 2023) and 7.83% (up from 7.44% in 2023) respectively.

No changes are expected to the risk sharing corridors.

[2] H.R.5376 - 117th Congress (2021-2022): Inflation Reduction Act of 2022 | Congress.gov | Library of Congress

Star Rating Changes

Various updates for the Star Rating measures are proposed. New measures concepts and methodological enhancements for future years are also introduced.

New areas related to "Extreme and Uncontrollable Circumstances" include New Mexico (wildfires), Kentucky (severe storms), Puerto Rico (Hurricane Fiona), Florida and South Carolina (related to Hurricane Ian). Plans in these regions qualify for "higher of" current or prior Star Ratings years if more than 25% of their service area is Summary of 2024 Advance Notice

The "higher of" methodology related to Covid no longer applies for 2024 Star ratings.

Overall MA Payment Impact

Wakely estimates that, on average, 2024 Part C standardized benchmarks will increase 1.26% over 2023 nationwide. This reflects the impact of the growth rate, change in star ratings and changes to applicable percentages (i.e. quartile rankings). We also estimate that the change in MA plan payment revenue for 2024 versus 2023 is expected to decrease by 1.90%. This takes into account changes in Part C risk score adjustments, including the FFS normalization factor and the MA Coding Pattern adjustment. It assumes no change for plan-specific risk scores, so the change in the Part C risk adjustment model and FFS normalization factor compared with 2023 causes a decrease.

Plans should be aware that the changes in the benchmarks can be considerably different (and typically are greater in magnitude) than the change in CMS revenue to the plan. Plans are paid 100% of their Part C basic bid (assuming they bid below the benchmark), which is unaffected by the benchmark for most plans, plus a percentage of the remaining difference of the excess of the benchmark above the bid. Therefore, a change in the benchmark will impact plans differently based on the disparity of the plan's bid compared to the benchmark (i.e. the "savings") and the star-based percentage of the savings retained by the plan (i.e. Part C "rebate").

Our analysis of county specific benchmarks and plan revenue was aggregated using January 2023 CMS published MA enrollment and star ratings for payment year 2024.

Details regarding our calculations and assumptions are provided in Appendix A at the end of this summary.

The remainder of this summary includes many details discussed at length in the Notice.

Wakely Analysis - Wakely Estimated Impact of Growth Rates Combined with Payment Reform

Wakely estimates that, on a nationwide average basis, and as compared with 2023, 2024 Part C benchmarks will:

- Increase by 1.26% on a standardized (i.e. 1.00) risk score basis. This incorporates the FFS growth rate, changes in applicable percentage by county, average change in star ratings and quality bonus, the impact of benchmark cap and the proposed methodology change to IME and DGME cost removal. It does not include changes at the county level, which include IME/DGME , VA and DoD adjustment factors, credibility factors, or county rebasing and repricing.
- Decrease by 1.90% on a risk-adjusted basis. The risk-adjusted increase incorporates the year-over-year impact of FFS normalization factors, MA Coding Pattern adjustment and the risk model revision.

The Wakely risk-adjusted estimate is based on the following components:

- Change in 1.00 benchmarks
- Impact of change in fee-for-service normalization factor
- Assumption of no trend in raw risk scores
- Average change in star ratings based on January 2023 Medicare Advantage enrollment.

Table 3 shows our estimates of the components that make up this change:

Table 3: Change in Blended Risk-Adjusted Benchmarks [1]

2023 to 2024	
Growth Rate [2]	2.15%
Applicable %	-0.02%
Star Rating/Quality Bonus	-0.95%
Benchmark Cap	0.01%
Total Benchmark Change	**1.26%**
FFS Normalization & Risk Model Revision	-3.12%
MA Coding Pattern	0.00%
Total Risk Score Change	**-3.12%**
TOTAL	**-1.90%**

1] Based on January 2023 MA enrollment and Fall 2022 Star Ratings
2] Includes -2.13% adjustment for the removal of MA-related IME and DGME costs

Below is a brief definition of each of the elements in Table 3.

Growth Rate. This is the impact of the FFS (+2.15%) growth rate.

Applicable %. Average nationwide change in applicable percentage, based on the enrollment by Medicare Advantage contract and county.

Star Rating/Quality Bonus. Difference in quality bonus impact on benchmarks due to star rating changes between 2023 and 2024.

Benchmark Cap. The ACA formula requires that the final blended benchmark can be no greater than the pre-ACA benchmark. The impact of this cap can year-to-year as plans change star ratings, and as the MA trend differs from the FFS trend. Note, in years when the FFS growth rate is less than the MA growth rate, the impact of the benchmark cap is more prevalent.

Part C Fee-for-Service (FFS) Normalization Factor and Risk Model Revision. The 2024 Part C FFS normalization was 1.127. For 2024, CMS is proposing a new Part C Risk Adjustment Model which uses a 2020 denominator year. It is unclear what the exact impact will be and will likely vary significantly from plan to plan. Based on the Fact Sheet, CMS estimates the overall change to both the risk adjustment model and FFS normalization will be -3.12%.

Change in Coding Pattern Adjustment. The coding pattern adjustment for 2024 will be - 5.90%, which is the minimum adjustment required by the Affordable Care Act. The adjustment is the same 2023.

Change in Bid and Rebate Amounts

The actual revenue change for individual Medicare Advantage plans will depend on the trend in bids, and will further vary depending on star rating, counties served, risk score trends, population changes, and many other factors.

If we assume that both 2023 and 2024 bids are 77% of the benchmark then we estimate the change in Part C payments from 2023 to 2024 to be a decrease of -2.30% (see Table 4).

In order to properly estimate the impact of the various MA payment components addressed in the Advance Notice, Medicare Advantage plans must consider the aggregate effect on actual payments from CMS, which is not necessarily the same as the change in benchmarks. As noted above, we estimate the change in risk-adjusted benchmarks to be -1.90%. If we include estimated changes in bid and rebate levels, then the impact to Part C revenue is -2.30%. This estimate is based on the following assumptions:

- Plans bid at 77% of the benchmark in 2024. This is based on the published bid-to-benchmark ratios in the 2024 Advance Notice.
- Bid trend from 2023 to 2024 will be 1% assuming a static population
- Annual risk score coding trend is 0% for a static population
- Nationwide average star ratings, which result in an average rebate percentage of 67.4% in 2023 and 65.7% for 2024
    - No consideration for sequestration or insurer fee Table 4 shows the calculations underlying our estimates.

Table 4: Estimated 2023 to 2024 Nationwide Revenue Change

Item	2023	2024	2024/2023
1.0 MA Benchmark *[1]*	$1,163.23	$1,177.85	1.26%
Raw Risk Adjustment Factor *[2]*	1.0000	1.0000	0.00%
Risk Score Model and Normalization Change	1.0000	0.9588	-3.12%
MA Coding Pattern Adjustment	0.9410	0.9410	0.00%
Total RAF Adjustments	**0.8350**	**0.8089**	**-3.12%**
Risk-Adjusted Benchmark	$971.25	$952.78	-1.90%
Assumed Risk-Adjusted Bid [4]	**$747.86**	**$733.64**	-1.90%
Savings (Benchmark less bid)[3]	$223.39	$219.14	-1.90%
Rebate	**$150.52**	**$144.06**	-4.29%
Risk-Adjusted Bid + Rebate	**$898.38**	**$877.70**	**-2.30%**
[1] Based on nationwide average MA enrollment by county as of January 2023			
[2] Assumed no trend in risk scores			
[3] Bid set at 77% of risk-adjusted benchmark			
[4] 67.3% for 2023 and 67.4% for 2024			

As in past years, CMS did not release county-specific benchmarks that reflect re-basing. The re-basing that CMS intends to perform prior to the Final Rate Announcement may result in dramatically difference changes in FFS benchmarks by county.

Attachment I: Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for CY2024

Section A. Data and Assumptions Supporting USPCC's

Proposed Technical Update: CMS is proposing a technical update to remove additional Medical Education Payments in the Non-ESRD USPCC Baseline.

BACKGROUND

Section 1886(d)(11) of the Affordable Care Act (Act) directs the Secretary to provide inpatient prospective payment system hospitals with an additional payment amount for indirect medical education (IME) costs for discharges of Medicare Advantage (MA) enrollees, and section 1886(h)(3)(D) of the Act directs the Secretary to provide hospitals with an additional payment

amount for direct graduate medical education (DGME) costs associated with services furnished to MA enrollees.

CMS states that prior non-ESRD United States per Capita Cost (USPCC) estimates have included IME and DGME costs attributable to MA enrollees because the supporting data did not separately identify these payments from those made on behalf of FFS enrollees. This implies that MA organizations (MAOs) had been effectively paid for these admission-related costs, even though CMS, and not MAOs, had been paying these costs associated with MA enrollees directly to hospitals.

CMS is proposing to remove the MA-related IME and DGME costs from the historical and projected non-ESRD USPCCs. According to CMS:

- The proposed adjustment lowers the 2024 non-ESRD FFS USPCC and FFS growth rate by 2.13%.
- The proposed change also reduces the 2024 non-ESRD Total USPCC and Total growth rate by 1.06%. This total growth rate impacts the Pre-ACA benchmark cap.

In prior years CMS has removed IME and DGME costs from FFS rates at the county level, and CMS does not propose to change these county care out adjustments for 2024. Details on these adjustments are explained in Section II of the notice. Based on the comments above regarding the baseline data not separately identifying IME and DGME costs separately for FFS and MA, it is unclear whether the historical county level adjustments also included a carve out for the costs attributable to MA enrollees. Note, in the 2023 rates the nationwide average IME cost removal was 1.7% and the average DGME cost removal was 0.5%.

Section B 2023 Growth Percentage Estimates

The preliminary estimate of the MA growth rate is +1.81% (last year the rate was +4.75%).

The non-ESRD fee-for-service growth rate is estimated at +2.15% (last year the rate was +4.89%).

Section C USPCC Estimates

In the Notice, CMS noted that the estimates for the USPCCs include consideration for the impact of COVID in 2020 and beyond. Specifically, CMS noted that estimates of the following COVID-related costs were considered:

- COVID-19 vaccine
- Utilization of services (presumably both deferred services and pent-up demand)
- Changes to MA coverage created by COVID-related legislation

- Cost sharing in excess of Medicare FFS cost sharing
- Specified testing-related services
- Prohibition on utilization management requirements related to COVID lab testing and testing-related services

CMS also explains the USPCCs for 2022 and subsequent years reflect the projected cost impacts related to the provisions of the Inflation Reduction Act (IRA). They specifically noted the following adjustments were considered:

- Part B manufacturer rebates
- Shifts in beneficiary coinsurance
- Exclusion of the Part B deductible for insulin furnished through durable medical equipment (DME)
- Cap of $35 beneficiary cost share for one month supply of insulin

Note, CMS states the IRA adjustments are projected to increase Part B FFS expenditures for 2023 and subsequent years. However, it is unclear what the impact is in the USPCCs and growth rate.

CMS also notes that the CY2024 Rate Announcement will reflect the provisions of the Consolidated Appropriations Act, 2023. Due to timing restraints, adjustments were not included in the published USPCCs or growth rates in the Advance Notice. It is unclear whether this will have a positive or negative impact.

The restatements in CMS's FFS USPCC estimates from the prior estimates in the CY2022 Final Announcement are summarized in Table 5. Note, all years (2010 – 2025) are restating down.

Table 5: FFS USPCC Estimate Restatement Impact

Year	Current/Prior
2025	-2.6%
2024	-2.7%
2023	-3.0%
2022	-5.4%
2021	-1.1%

CMS has not yet provided specifics on the causes of the restatement. The negative direction is most likely driven by the technical change for IME/DGME. We suspect a portion of the 2022 restatement is also driven by an over projection of cost expenditures for pent up demand due to COVID-19.

Wakely estimates that the nationwide average change in blended standardized (non-risk adjusted) MA Benchmarks from 2023 to 2024 will be 1.26% and the nationwide average change in the blended risk adjusted benchmark will be -1.90%. See the Wakely analysis at the start of this summary for additional detail.

As has been the case in past years, the change in benchmarks can vary significantly depending on geographic area, plan star rating and applicable percentage. While CMS will not publish the final geographic relativities (aka Average Geographic Adjustment, or AGA, factors) until the Final Announcement, we can still estimate the impact of changing county quartiles, average star ratings, and a minor change in how CMS will develop the costs exclusions for kidney acquisition costs and direct graduate medical equipment.

Table 6 shows the top five and bottom five growth rates by State (these changes include changes due to star rating, double bonus status, applicable percentage, benchmark cap, and kidney acquisition costs).

Table 6: States with Highest and Lowest Benchmark Change

Rank	State	Change
1	MI	3.5%
2	UT	3.2%
3	WA	3.2%
4	LA	3.1%
5	NJ	2.7%
46	NE	1.4%
47	CT	1.4%
48	NY	1.2%
49	GA	1.1%
50	NH	1.0%

Section D Loading for Claims Processing Costs.

Consistent with last year CMS is proposing to adjust the USPCC to include administrative costs incurred by the Medicare Administration Contractors (MAC's) as described in the ACA. For PY 2024, the adjustment is based on FY 2022 expenses. Part A MAC expenses for FY2022 totaled about $220,000 for an adjustment factor of 0.000582. And Part B MAC expenses for FY2022 totaled about $600,000 for an adjustment factor of about 0.001310.

Attachment II: Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2024

Section A. MA Benchmark, Quality Bonus Payments, and Rebate

CMS intends to rebase county FFS rates in 2024 (which is the basis of the "Specified Amount", defined below) using FFS claims data from 2017 through 2021. This is consistent with prior years as CMS has rebased the rates every year since 2012 and anticipates continuing this in the future.

County benchmark rates are capped at the Applicable Amount (defined below). CMS interprets that the comparison occurs after the Quality Bonus Payment Percentage ("QBP") has been included. CMS acknowledged stakeholders' concerns that the benchmark cap may diminish incentives for MA plans to continuously improve care; however, CMS believes that "section 1853(n)(4) of the Act prevents elimination of the rate cap or excluding the bonus payment from the cap calculation."

Below are the key components of the Part C benchmark calculation:

- 2024 "Applicable Amount" (pre-ACA amount): The greater of a county's 2024 FFS cost and the 2023 Applicable Amount increased by the CY 2024 National Per Capita MA Growth Percentage.
- 2023 "Specified Amount" (FFS benchmark): 2024 FFS Cost less IME phase-out less kidney acquisition costs all multiplied by the "Applicable Percentage" plus the QBP.
- "Applicable Percentage": Varies by county and is based on the county's rank of 2023 per capita FFS rate, assigned by quartiles, as shown in Table 7.

Table 7: FFS Quartile Assignment

Quartile	Applicable Percentage
4th (highest)	95.0%
3rd	100.0%
2nd	107.5%
1st (lowest)	115.0%

If a county's quartile changed from last year, the Applicable Percentage is the average of the current and prior year's applicable percentage. The applicable percentages for CY 2024 county rates will use 2023 rankings and will continue to be adjusted to exclude the IME phase out and payments for kidney acquisition costs.

Quality Bonus Percentage (QBP), or "applicable percentage quality increase": The QBP is 5% for 4, 4.5 and 5 star MAOs, and is 0% for plans with a star rating below 4. For new plans under a new parent organization and low enrollment plans, a 3.5% QBP applies.

For consolidations of two or more contracts of the same plan type and legal entity approved on or after January 1, 2019, the QBP rating for the first year following consolidation is determined by the enrollment weighted average of what would have been the QBPs of both contracts using November enrollment from the year the Star Ratings were released. ***Example:*** for two contracts consolidating for January 2024, the 2023 QBP rating is based on 2023 Star Ratings released in 2022, using November 2021 enrollment of the two contracts.

Double QBP percentages are awarded to "qualifying plans" located in qualifying or "double bonus" counties. Double bonus counties must:

1. Have a population of over 250,000 (as of 2004).
2. Have at least 25% of MA-eligible beneficiaries enrolled in MA plans (as of December 2009).
3. Have 2024 per capita FFS spending lower than the national average.

The final 2024 rate notice will contain a list of all double bonus counties, as the third criterion above is not yet known.

- Cap on Benchmarks: The QBP-adjusted benchmark for a county cannot exceed the applicable amount.
- Rebates: Rebate levels are based on plan Star Ratings as follows in Table 8:

Table 8: MA Rebate Percentages

Star Rating	2024
4.5+ Stars	70%
3.5 to < 4.5 Stars	65%
< 3.5 Stars	50%

The percentage is applied to the amount by which the risk-adjusted service area benchmark exceeds the risk-adjusted bid. New MA contracts under a new parent organization and low enrollment plans are treated as having 3.5 Stars.

Section B. Calculation of Fee for Service Cost

2024 FFS COUNTY COST

The FFS county cost for CY2024 is calculated as the USPCC x AGA, where:

USPCC = the national average FFS cost, called the U.S. per capita cost

AGA = County-level geographic index, called the average geographic adjustment

With the Advance Notice, CMS is releasing county-level 2021 FFS cost data used to develop 2024 rates, available at:

https://www.cms.gov/Medicare/Health- Plans/MedicareAdvtgSpecRateStats/FFS-Data

AGA DEVELOPMENT OVERVIEW:

- A five-year average of FFS costs from 2017 to 2021 is initially calculated (last year was 2016 to 2020) and is then adjusted.
- Costs for hospice and Cost plans are excluded.
- CMS will re-price 2017 to 2021 claims to the most current (i.e., FY2023) wage and geographic practice cost indices and adjust historical FFS claims for legislative changes.
    - This includes the repricing of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims to reflect updated methodologies in accordance with the final rule which appeared on the Federal Register on 12/28/2021. https://www.federalregister.gov/d/2021-27763/

There are two additional adjustments included in the development of the AGAs:

Adjustments for Medicare Shared Savings Program and Innovation Center Models and Demonstrations, and Advanced Alternative Payment Models

The first adjustment incorporates shared savings and losses or episode savings and loses experienced under the Medicare Shared Savings Program and Innovation Center models and demonstrations into historical FFS experience. CMS is proposing to use more recent experience years to calculate this adjustment. A similar adjustment has been applied in prior years.

CMS is proposing to incorporate the Advanced Alternative Payment Models (APM) incentive payments made in 2019 through 2021 into the historical ratebook experience Qualifying APM participants receive an incentive payment equal to 5% of their estimated aggregate payments for covered professional services furnished during the base year. Payments are made in the year after the base year, beginning in 2019.

Additional Adjustment to FFS per Capita Costs in Puerto Rico

An additional adjustment is being considered for Puerto Rico. Puerto Rico data only includes beneficiaries with Part A & B for all five years of the base period. (Puerto Ricans are not auto- enrolled into Part B, they must opt in). CMS is considering whether to

apply an adjustment to Puerto Rico FFS costs to reflect Puerto Rico's high proportion of zero-claimant members versus the national average. Such an adjustment has been applied in prior years.

After the AGA has been calculated, the following additional adjustments are made:

- DGME and IME costs are removed.
- Counties with less than 1,000 members are blended with other counties in the market area for credibility.
- Adjustments are made for beneficiaries who are dually enrolled in Veteran Affairs and/or the Department of Defense health programs.
- Organ acquisition costs for kidney transplants.

Attachment II: Changes in the Part C Payment Methodology for Medicare Advantage and PACE for CY2024

Section C. Adjustments to the AGAs

SECTION C1. DIRECT GRADUATE MEDICAL EDUCATION

Direct Graduate Medical Education (DGME or GME) costs must be excluded from FFS per capita costs used to develop MA capitation rates. Prior to 2023, these costs have been carved out by tabulating estimated "pass-through" payments to hospitals, which are inclusive of DGME costs, and using DGME estimates from these reports to reduce FFS payments. For 2024, the same process as 2023 will be used. CMS is proposing to again use the provider specific file (PSF) as the source for the development of the DGME exclusion. The 2024 DGME carve-out factors will be published with the 2024 rate announcement.

SECTION C2. ORGAN ACQUISITION COSTS FOR KIDNEY TRANSPLANTS

Kidney acquisition costs (KAC), first removed in 2021, will continue to be carved out for non-PACE plans in 2024. Similar to the DGME exclusion, CMS changed the KAC calculation methodology in 2023 and will continue to use the new methodology in 2024 which once again uses the PSF as the source for carve-out percentage development. The 2024 KAC carve-out factors will be published with the 2024 rate announcement.

SECTION C3. IME PHASE OUT

Indirect Medical Education (IME) costs are being phased out of MA capitation rates. For 2024, CMS will first calculate FFS rates including IME. The maximum reduction for any county in 2024 is 9.0% of the FFS rate. As in prior years, CMS will publish rates with and without the 2024 IME reduction. In the Economic Information section of the Notice, CMS notes that in 2024 there are no counties that are affected by more than the 2023 maximum of 8.4%.

Section D. MA ESRD Rates

ESRD Rates = [2017-2021 FFS ESRD dialysis USPCC] x [trend to 2024] x [State AGA] x [DGME and IME removal factor] x [kidney acquisition cost removal factor].

- State AGA is the weighted average of state ESRD FFS dialysis costs for 2017 to 2021 divided by the national average for the same timeframe normalized for risk score.
- CMS intends to reprice historical inpatient, outpatient, SNF, and ESRD PPS claims for 2017 to 2021 to reflect the most recent wage indices (in this case FY2023) and reprice physician claims with the most recent Geographic Practice Cost Indices (CY2023). This is a continuation of an enhancement introduced last year.
- ESRD state rates for PACE plans will include kidney acquisition costs.

CMS also notes that they are aware of MAO concerns regarding ESRD payment adequacy in light of the 21st Century Cures Act, which allows ESRD beneficiaries to enroll in MA plans. One suggestion, which was analyzed for CY2023, was to develop ESRD rates at a geographic level smaller than state. The analysis suggested that rural and underserved urban areas would see rate decreases relative to the current state level. CMS continued their analysis by studying the proposed rate changes based on area deprivation index (ADI) by county compared to the published state rates for CY2022 and found that areas with low ADI saw an increase in rates while high ADI areas experienced a decrease. Given their findings, CMS is not proposing any further change to methodology for 2024 and will continue to use statewide MA ESRD rates.

Section E. Location of Network Areas for PFFS Plans in Plan Year 2023

Non-employer MA PFFS plans offered in a network area must meet certain access standards. Network area is defined as an area that the Secretary identifies as having at least two network-based plans. CMS will include the list of network areas for plan year 2025 with the CY2024 Rate Announcement.

Section F. Employer Group Waiver Plans

For 2024, CMS intends to continue to waive bid pricing tool requirements.

CMS is also proposing to continue to use the same methodology that was used for 2023 in establishing MA EGWP payment amounts, which is to use 2023 bid-to-benchmark ratios weighted by February 2023 enrollment.

For 2024, CMS has published preliminary bid-to-benchmark ratios for EGWPs. These preliminary ratios are not final and are based on January 2023 enrollment instead of the intended February 2023 enrollment.

Table 9: EGWP Bid to Benchmark Ratios

Applicable Percentage	Proposed 2024 Bid to Benchmark Ratio	2023 Bid to Benchmark Ratio	Percent Change
0.95	78.5%	80.8%	-2.8%
1	77.2%	79.9%	-3.4%
1.075	76.7%	79.9%	-4.0%
1.15	76.9%	79.9%	-3.8%

CMS will continue to allow MA EGWPs to use a portion of Part C payment to buy down enrollee Part B premium. CMS will continue to collect Part B premium buy-down amounts in the EGWP PBP submission. EGWPs that choose to use a portion of their payment to buy- down Part B premium will have that amount reduced from their capitated payment. The Part B buy-down amount cannot vary among beneficiaries within a plan and is subject to the same maximum Part B buy-down amount as non-EGWP plans.

Attachment II: Changes in the Part C Payment Methodology for Medicare Advantage and PACE for CY2024

Section G. CMS-HCC Risk Adjustment Model for CY2024

CMS is proposing to implement a revised version of the CMS-HCC risk adjustment for the aged/disabled population. CMS is not proposing any model change for the ESRD population or PACE plans. The proposed risk adjustment model will incorporate two primary updates:

1. Updated data for model calibration and determining average expenditures.
2. HCC reclassification

Updated data for model calibration: The current model uses 2014 diagnosis and 2015 expenditures to formulate the coefficients used in the risk score model, which at that time utilized ICD-9 classification codes for documenting diagnosis. CMS evaluated if the ICD-10 classification system was stable enough to utilize more recent data where ICD-10 codes were being used in documenting diagnosis. CMS found the system to be stable and has proposed using 2018

diagnosis and 2019 expenditures to calibrate the coefficients. This regression coefficients are calculated by using 2018 ICD-10 diagnosis codes to predict 2019 expenditures.

The denominator year predicted expenditures used to normalize coefficients to a 1.0 basis was also updated to utilize the 2020 prediction period (2019 diagnosis for 2020 cohort of beneficiaries). All predicted costs are normalized to the average per member per year costs of $10,402.34.

HCC reclassification: CMS is proposing a change in the ICD-10 codes that map to risk adjustable HCCs. The change in ICD-10 codes is due to:

- CMS utilizing ICD-10 codes in its model calibration rather than ICD-9 codes in the prior model and,
- Specific ICD-10 codes that CMS deemed as having discretionary coding. More specifically, CMS notes that the reclassification included consideration for conditions that are coded more frequently in MA relative to FFS.

The specific ICD-10 codes that were removed from being risk adjustable were based on CMS observing that discretionary coding occurred for these codes in MA when compared to the FFS population. They believe that this indicates that these codes are likely not consistent across the industry since the MA population has a much higher prevalence of those ICD-10 codes when compared to the FFS population. According to a December 2000 Report[3], the concept of reducing or eliminating the impact of discretionary coding on risk scores is a core foundation for a risk adjustment model and CMS utilized this core principle for eliminating these ICD-10 codes from the proposed risk adjustment model. Table 10 compares the key differences between the 2020 HCC risk adjustment model and the 2024 model.

Table 10: HCC Risk Model Differences

	2020 Model	2024 Model
Number of HCCs	86	115
ICD Model Version used in regression	ICD-9	ICD-10
Dx to HCC Mapping	V24	V28
Number of ICD-10 codes that are risk adjustable	9,797	7,770
Data Year for Regression (diagnosis period/expenditure period)	2014/2015	2018/2019

Table II-4 in the advanced notice compares the specific HCC changes in the new model. Some potentially impactful changes include:

[3] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/pope_2000_2.pdf

- HCC 36, 37, and 38 (diabetes HCCs) have the same coefficients.
- HCC 224, 225, and 225 (congestive heart failure HCCs) have the same coefficients
- Additional specificity added to most groups (i.e. more cancer HCCs)
- Removal of the Protein-Calorie Malnutrition, Angina Pectoris, and Atherosclerosis of Arteries of the Extremities, with Intermittent Claudication HCCs

Section H. End Stage Renal Disease (ESRD) Risk Adjustment Models for CY 2024

In CY 2024, CMS will continue to use the updated 2023 ESRD risk adjustment models for dialysis, transplant, and post-graft beneficiaries. The 2019 ESRD risk adjustment models will continue to be used for PACE organizations.

Section I. Frailty Adjustment for PACE Organizations and FIDE SNPs

For FIDE SNPs in CY 2024, CMS is proposing to update the frailty factors used to calculate frailty score to be consistent with the updated CY 2024 CMS-HCC model. CMS has created a preliminary set of factors using updated ADL (activities of daily living) data from the 2018 Medicare FFS Consumer Assessment of Health Providers & Systems (CAHPS) survey. The previous frailty model used ADL data from the same survey in 2014.

Table 11: Frailty Factors Associated With The 2024 CMS-HCC Model – FIDE SNPs

Activities of Daily Living (ADL)	Non-Medicaid	Partial Medicaid	Full Medicaid
0	-0.067	-0.095	0.000
1-2	0.105	0.102	0.155
3-4	0.182	0.102	0.155
5-6	0.182	0.315	0.275

For PACE organizations, CMS is proposing to continue use of the 2017 CMS-HCC model to calculate risk scores used to pay for Part A and B services in CY 2024. CMS will use the frailty factors associated with the 2017 CMS-HCC model to calculate frailty scores for PACE organizations in CY 2024.

Table 12: Frailty Factors Associated with the 2017 CMS-HCC Model – PACE Organizations

Activities of Daily Living (ADL)	Non-Medicaid	Medicaid
0	-0.083	-0.093
1-2	0.124	0.105
3-4	0.248	0.243
5-6	0.248	0.420

Section J. Medicare Advantage Coding Pattern Adjustment

CMS is proposing the coding pattern adjustment for CY2024 is the statutory minimum of 5.90%.

Section K. Normalization Factors

CMS is proposing the following normalization factors for CY2023:

Table 13: Normalization Factors

Program	Population	Model	Denominator Year	Years Used	Proposed CY2024 FFS Normalization	CY2023 FFS Normalization	Year-to-Year Impact
Part C	Non-ESRD	2024 CMS-HCC v28	2020	2018-2022, excluding 2021	1.015	NA	NA
Part C	ESRD	2023 ESRD Dialysis	2019	2018-2022, excluding 2021	1.022	1.034	1.2%
Part C	ESRD	2023 ESRD Functioning Graft	2019	2018-2022, excluding 2021	1.028	1.048	2.0%
Part C	PACE	2017 CMS-HCC	2015	2016-2020	1.159	1.140	-1.6%
Part C	PACE ESRD	2019 ESRD Dialysis	2015	2016-2020	1.100	1.088	-1.1%
Part C	PACE ESRD	2019 ESRD Functioning Graft	2015	2016-2020	1.159	1.138	-1.8%
Part D	Non-PACE	2023 RxHCC	2019	2016-2020	1.063	1.050	-1.2%
Part D	PACE	2020 RxHCC	2015	2016-2020	1.084	1.073	-1.0%

Please note that the year-to-year impact values reflect the fact that the factors are applied by dividing the risk score by the normalization factor. For example, the 2023 to 2024 impact on Part D risk scores for non-PACE members will be to reduce scores by 1.2%, all other factors being equal.

For CY2024, CMS is proposing to use the same linear slope projection method as has been used in prior years to calculate the normalization factors, but with different time periods depending on the denominator year of the model. The 2024 Part C CMS-HCC and the 2023 ESRD CMS-HCC models (2020 and 2019 denominator years, respectively) would use risk scores from 2018 through 2022, with 2021 risk scores excluded. The PACE Part C and ESRD risk adjustment models (2015 denominator year) would use risk scores from 2016 through 2020, excluding 2021 and 2022. CMS notes that using risk scores from 2018 through 2022, with 2021 excluded for the models with a 2015 denominator year results in normalization factors lower than the actual 2022 FFS risk score, which implies a projected 2024 FFS risk score lower than the average 2022 FFS

risk score. One potential reason cited is that 2015 denominator year models require 9 years of projection versus 4 or 5 in the models with 2019 or 2020 denominator years.

For the RxHCC model, MA and FFS risk scores are included to calculate the normalization factor and 2022 MA risk scores are not available for consideration yet. CMS is proposing to use the same methodology as prior years, using the five-year linear slope for 2016-2020, and excluding 2021, consistent with the models described above.

Section L. Sources of Diagnoses for Risk Score Calculation for CY 2024

For non-PACE organizations CMS will continue the policy adopted in the CY 2023 Rate Announcement, calculating risk scores for payment to MA organizations and certain demonstrations using only risk adjustment-eligible diagnoses from encounter data and FFS claims.

For PACE organizations, CMS will also continue the same method used in prior years to calculate risk scores. Encounter data, RAPS data and FFS claims are pooled with no weighting to calculate a single risk score.

Attachment III. Benefit Parameters for the Defined Standard Benefit and Changes in the Payment Methodology for Medicare Part D for CY 2024

Section A. RxHCC Risk Adjustment Model

CMS will not update the RxHCC model for CY2024 and will continue using the 2023 RxHCC risk adjustment model. This model will not incorporate any adjustments due to the Inflation Reduction Act (IRA). CMS will recalibrate the RxHCC model and incorporate the updated benefit structure from the IRA, along with any other proposed changes, for CY 2025.

Section B. Source of Diagnoses for Part D Risk Score Calculation for CY 2024

CMS will continue calculation of CY2024 risk score based on diagnoses from encounter data (EDS) and fee-for-service (FFS) claims exclusively. For PACE, CMS proposes to continue the same method for CY2022 that has been in place since CY2015.

Section C. Inflation Reduction Act of 2022 Part D Benefit Design Changes

IRA policies in place for 2024 include:

- Cost sharing for covered Part D drugs will be eliminated for all beneficiaries in the catastrophic phase of the benefit. The federal reinsurance liability will remain at 80% of allowable costs in the catastrophic phase. Therefore, the elimination of cost sharing for all beneficiaries in the catastrophic phase results in a slightly greater than 5% increase in plan liability in the catastrophic phase.
- The income threshold for the full LIS and LICS benefit increases from 135% of the FPL to 150% of the FPL. This change eliminates the Partial Dual low-income copay category (category 4) and moves all Partial Dual members to the Full Dual Above 100% of the FPL category (category 1).
- There is a maximum copay of $35 for all Part D covered insulin products for all phases of the benefit except for the catastrophic phase, where member cost sharing has been eliminated for all drugs.
- There is a $0 copay for all adult vaccines recommended by ACIP in all phases of the benefit. Part D sponsors will be required to provide this coverage as a basic benefit and reflect the cost of coverage appropriately in the CY 2024 bid.
- The Base Beneficiary Premium (BBP) is limited to a 6% increase for CY 2024. If the BBP without the IRA provision would be calculated to be more than 6% above the CY 2023 BBP, then the CY2024 BBP will be set at 106% of the 2023 BBP ($32.74 as published by CMS on July 29, 2022), with the excess being added to the direct subsidy. Note that this cap will be applied only at a national level and not on a plan-specific basis.

Section D. Annual Adjustments to Medicare Part D Benefit Parameters in CY 2024

SECTION D1. UPDATING THE MEDICARE PART D BENEFIT PARAMETERS

For CY2024, the annual percentage increase (API) applied to the CMS Defined Standard Part D parameters is 8.01%, reflecting a 6.42% increase in the CY 2023 annual percentage trend and a multiplicative adjustment of 1.50% for prior year revisions.

The calculation of the API is based on Part D PDE data. The year-over-year change in annual average per capita Part D costs from August to July is the annual percentage trend. For the CY2024 year, the calculation is: (August 2022 – July 2023) / (August 2021 – July 2022) =

$4,916.80 / $4,620.25 = 1.064. Note, actual Part D PDEs for January 2023 – July 2023 did not exist at the time of the calculation, so January – July costs are based on projections. This methodology can create significant prior-year revisions once the full year of data is available.

CY2024 Part D Defined Standard benefit changes:

- $545 deductible ($505 in 2023)
- $5,030 ICL ($4,660 in 2023)
- $8,000 TrOOP ($7,400 in 2023)
- $1.55/$4.50 copays for full subsidy full benefit duals ($1.45/$4.15 in 2023)

Table 14: Part D Benefit Parameters

Part D Benefit Parameters	2023	2024
Standard Benefit		
Deductible	$505	$545
Initial Coverage Limit	$4,660	$5,030
Out-of-Pocket Threshold	$7,400	$8,000
Total Covered Part D Spending at Out-of-Pocket Threshold for Non-Applicable Beneficiaries	$10,516.25	$12,159.21
Estimated Total Covered Part D Spending for Applicable Beneficiaries	$11,206.28	$13,172.18
Minimum Cost-Sharing in Catastrophic Coverage Portion of the Benefit		
Generic/Preferred Multi-Source Drug	$4.15	Not Applicable
Other	$10.35	Not Applicable
Full Subsidy-Full Benefit Dual Eligible (FBDE) Individuals		
Deductible	$0.00	$0.00
Copayments for Institutionalized Beneficiaries [category code 3]	$0.00	$0.00
Copayments for Beneficiaries Receiving Home and Community-Based Services [category code 3]	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL [category code 2]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$1.45	$1.55
Other	$4.30	$4.60
Above Out-of-Pocket Threshold	$0.00	Not Applicable
Over 100% FPL [category code 1]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$4.15	$4.50
Other	$10.35	$11.20
Above Out-of-Pocket Threshold	$0.00	$0.00

Full Subsidy-Non-FBDE Individuals		
Applied or eligible for QMB/SLMB/QI or SSI and income at or below 135% FPL and resources ≤ $9,900 (individuals) or ≤ $15,600 (couples) [category code 1]		
Deductible	$0.00	$0.00
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$4.15	$4.50
Other	$10.35	$11.20
Maximum Copayments above Out-of-Pocket Threshold	$0.00	Not Applicable
Partial Subsidy		
Applied and income below 150% FPL and resources below $15,510 (individual) or $30,950 (couples) [category code 4]		
Deductible	$104.00	Not Applicable
Coinsurance up to Out-of-Pocket Threshold	15%	Not Applicable
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$4.15	Not Applicable
Other	$10.35	Not Applicable
Retiree Drug Subsidy Amounts		
Cost Threshold	$505.00	$545.00
Cost Limit	$10,350.00	$11,200.00

SECTION D2. CALCULATION METHODOLOGIES FOR THE ANNUAL PERCENTAGE INCREASE (API) AND CONSUMER PRICE INDEX (CPI)

For the CY2024 benefit parameters, Part D program data will be used to calculate the annual percentage trend of 6.4% by comparing the ratio of the average per capita cost for August 2022 – July 2023 (use PDE through December 2022 projected through July 2023) and the average per capita cost for August 2021 – July 2022. An adjustment of 1.5% is applied to reflect the impact of prior year revisions, for a total annual percentage increase for 2024 of 8.01%.

The annual percentage increase in consumer price index (CPI) for September 2024 is the combination of the projected trend for September 2023 (3.81%) and a multiplicative prior year revision of 3.87% for a total annual percentage increase of 7.83%.

SECTION D3. ANNUAL ADJUSTMENTS FOR PART D BENEFIT PARAMETERS IN CY 2024

See Table 14 above for the annual benefit parameters, which are derived by multiplying the CY2023 parameters by the CY 2024 API and rounding.

SECTION D4. INSULIN COPAY CAP

As noted in section C of this attachment, an insulin copay cap of #5 for a one month supply of each covered insulin product was implemented through the IRA. Note that, for low-income subsidy-eligible beneficiaries in the coverage gap in 2024,the low-income cost-sharing subsidy will continue to cover the cost of a covered insulin product up to the nominal copayment amount for said product.

Section D5. ACIP-recommended Vaccine $0 cost sharing

As noted in section C of this attachment, adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) will be exempt from any co-insurance or other cost sharing for beneficiaries in all phases, including for any dispensing fee or vaccine administration fee.

Section E. Reduced Coinsurance for Applicable Beneficiaries in the Coverage Gap

The Medicare coverage gap for non-LIS members was effectively closed for applicable (mainly brand) drugs in CY 2019 and for non-applicable (mainly generic) drugs in CY2020; therefore, the following coverage gap coinsurance provisions continue to apply for CY2024:

- Non-LIS 25% coinsurance for applicable and non-applicable drugs in the gap (same as 2022).
- Non-LIS 95% coinsurance for non-applicable drugs (mainly brand) in the gap (same as 2022). Note that member liability is approximately 25% after 70% manufacturer discount. This is the same cost sharing scheme used in CY2023.

Section F. Part D Calendar Year Employer Group Waiver Plans

CMS makes prospective payments for Part D federal reinsurance for calendar year Employer Group Waiver Plans (EGWPs) offering Part D. Consistent with Part D non-EGWPs, the prospective payment will be reconciled with actual expenses several months after the conclusion of the plan year. The payment will be based on the average reinsurance amount paid to CY2021 EGWPs. This amount is $71.09 PMPM (versus $67.56 PMPM in CY2020).

Section G. Part D Risk Sharing

There are no changes to the Part D risk corridor calculations for CY2024.

Section H. Retiree Drug Subsidy Amounts

See the Part D Benefit Parameters table for a comparison of the cost threshold and cost limit between CY2023 and CY2024.

Attachment IV: Updates for Part C and D Star Ratings

Reminders for 2024 Star Ratings

The Tukey outlier deletion cut point methodology for non-CAHPS measures will be implemented in the 2024 Star Ratings. Table IV-1 in the Advance Notice shows the full list of 2024 Star Rating measures.

Extreme and Uncontrollable Circumstances for 2024 Star Ratings

For plans that qualify for disaster adjustments, the adjustment will result in the higher of their raw/unadjusted measure-level rating from 2023 (2021 performance) and 2024 (2022 performance) being used. Based on the criteria specified in the notice, this will impact the following regions:

- Several counties in New Mexico received EUC status (wildfires).
- Several counties in Kentucky received EUC status (severe storms, flooding, landslides, and mudslides).
- Puerto Rico received EUC Status (Hurricane Fiona).
- Several counties in Florida and South Carolina received EUC Status (Hurricane Ian).

New Measures for 2024 Star Ratings

- Plan All-Cause Readmissions returns with a weight of 1 in 2024 and a weight of 3 thereafter.
- Transitions of Care will be added as a new measure with a weight of 1.
- Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions will be added as a new measure with a weight of 1.

Removed Measures for 2024 Star Ratings

Diabetes Care – Kidney Disease Monitoring no longer a measure in 2024.

Existing Star Rating Measures with Changes for 2024

Controlling Blood Pressure – Weight increased from 1 to 3.

Changes to Existing Star Rating Measures for 2023 Measurement Year and Beyond

- CMS is considering including a "Universal Foundation" of quality measures across all Quality and Value-Based Care Strategy programs to support high quality care and serve as a standard for the health care system. The preliminary Adult Universal Foundation Measures include ten measures, six of which are currently included in Star Ratings.
- Optional Exclusions for HEDIS Measures (Part C) - For selected HEDIS measures, plans have the choice as to whether or not they applied optional exclusions. NCQA reviewed all applicable measures and is updating the following measures from optional exclusions to required exclusions:
    - Controlling Blood Pressure: The optional exclusions for pregnancy, end-stage renal disease/dialysis/nephrectomy/kidney transplant, and non-acute inpatient admissions are now required.
    - Colorectal Cancer Screening: The optional exclusions for colorectal cancer and total colectomy are now required.
    - Kidney Health Evaluation for Patients with Diabetes: The optional exclusions for polycystic ovary syndrome, gestational diabetes, and steroid-induced diabetes are now required.
- Care for Older Adults - Pain Assessment (Part C) – NCQA is considering retiring this measure.
- Care for Older Adults - Functional Status Assessment and Medication Review (Part C) – NCQA is considering developing new measures that may replace these measures and be reported for more than Special Needs Plans (SNPs).
- Medication Adherence for Diabetes Medication / Medication Adherence for Hypertension (RAS Antagonists) / Medication Adherence for Cholesterol (Statins) Measures (Part D) – CMS proposed implementing sociodemographic (SDS) risk adjustment for these measures in 2028 Star Ratings.
- Concurrent Use of Opioids and Benzodiazepines, Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults, and Polypharmacy Use of Multiple Central

Nervous System Active Medications in Older Adults (Part D) – CMS proposed adding these measures in 2026 Star Ratings.

- The following measures have non-substantive changes in 2025 star ratings and later:
    - Controlling Blood Pressure (Part C)
    - Colorectal Cancer Screening (Part C)
    - Kidney Health Evaluation for Patients with Diabetes (Part C)
    - Diabetes Care – Eye Exam (Part C)
    - Diabetes Care – Blood Sugar Controlled (Part C)
    - Breast Cancer Screening (Part C)
    - Statin Use in Persons with Diabetes (Part D)
    - Medication Adherence for Diabetes Medication / Medication Adherence for Hypertension (RAS Antagonists) / Medication Adherence for Cholesterol (Statins) Measures / Statin Use in Persons with Diabetes (Part D)
    - MTM Program Completion Rate for Comprehensive Medication Review (Part D)
- The following measures may be added to Star Ratings program through future rulemaking:
    - Depression Screening and Follow-Up (Part C)
    - Initiation and Engagement of Substance Use Disorder Treatment (Part C)
    - Timely Follow-up After Acute Exacerbations of Chronic Conditions (Part C)
    - Adult Immunization Status (Part C and D)

Display Measures

Display measures are published separately from the Star Ratings. CMS anticipates all 2023 display measures will continue to be shown on CMS.gov in 2024 unless noted. The following may be added to the 2026 Star Ratings Display page with data from the 2024 measurement year – CMS is requesting feedback

- Depression Screening and Follow-up (Part C) - measures the percentage of members who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care

- Adult Immunization Status (Part C and D) measure assesses the receipt of influenza, Td/Tdap, zoster, and pneumococcal vaccines.
    - CMS is considering as a part of the preliminary core set of measures across quality programs.
- Timely Follow-up After Acute Exacerbations of Chronic Conditions (Part C) assesses the percentage of acute events requiring an emergency department visit for one of six chronic conditions. Following are the conditions and the guideline-recommended timeframe follow-up
    - Hypertension: Within 7 days
    - Asthma: Within 14 days
    - Congestive Heart Failure (CHF): Within 14 days
    - Coronary Artery Disease (CAD): Within 14 days
    - Chronic Obstructive Pulmonary Disease (COPD): within 30 days
    - Diabetes: Within 30 days

Pending Rulemaking – the following may be added as a measure to the Star ratings in the future:

- Initiation and Engagement of Substance Use Disorder (SUD) Treatment (Part C) Previously called Initiation and Engagement for Alcohol and Other Drug abuse or Dependence Treatment. For measurement year 2022, there were several changes to the measure:
    - Changed from ‘member-based’ to ‘episode-based’
    - Removed the requirement that a psychosocial treatment encounter accompany pharmacotherapy
    - Split the adult age stratification between 18-64 and 65+
    - Emergency department and withdrawal services alone were removed from the measure’s negative SUD history

Pending Rulemaking – the following may be added as a measure to the 2026 Star Ratings (2024 measurement year):

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)

For the following, the display page will be updated for the 2023 measurement year based on PQA measure specification updates

- Antipsychotic Use in Persons with Dementia, Overall (PD)/Antipsychotic Use in Persons with Dementia, in Long-Term Nursing Home Residents (APD-LTNH) (Part D)
- Initial Opioid Prescribing – Long Duration (IOP-LD) (Part D)
- Other Part D related measures expect to be aligned with PQA measure specifications. Timing of those adjustments will be provided in the future.
    - Medication Adherence for HIV/AIDs (Antiretrovirals) (ADH-ARV)
    - Antipsychotic Use in Persons with Dementia, Overall (APD)/Antipsychotic Use in Persons with Dementia, in Long-Term Nursing Home Residents (APD-LTNH)
    - 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)

Potential New Measure Concepts and Methodological Enhancements for Future Years

CMS is considering the following new measure concepts and methodological enhancements and is requesting feedback.

- Health Equity (Part C and D).
    - Health Equity Index is outlined in the proposed rule (87 FR 79626-79632)
- Chronic Pain Assessment and Follow-up (Part C)
    - New measure to assess chronic pain and follow-up
    - Multidimensional pain assessment and confirmation of follow-up
- Sexual Orientation and Gender Identity for HEDIS Measures (Part C)
    - Evaluating approaches to ensure inclusivity
- Identifying Chronic Conditions in HEDIS Measures (Part C)
    - Updates would simplify identification of conditions and impact the following Star Ratings and display measures:

  - Diabetes Care – Eye exam
  - Diabetes Care – Blook Sugar Controlled
  - Follow-up after emergency department visit for patients with multiple chronic conditions
  - Kidney health evaluation for patients with diabetes.

- Blood Pressure Control (Part C)
  - New blood pressure control measures that utilize the capabilities of digital quality measure and leverage standardized electronic clinical data.
- Kidney Health (Part C).
  - Management related to person-centered outcomes, shared decision making, and preparedness for kidney failure.
- Social Connection Screening and Intervention (Part C)
  - Proposed measure may be posed for the HEDIS public comment period in February 2023
- Broadening the Mental Health Conditions Assessed by Health Outcomes Survey (HOS) (Part C)
  - Exploring adding the 2-item measure of Generalized Anxiety Disorder (GAD-2).
- Measuring Access to Mental Health Care on HOS (Part C)
- Addressing Unmet Health-Related Social Needs on HOS (Part C)
  - Developing a measure that will accompany the current Social Needs Screening and Intervention (SNS-E) measure to assess housing instability, food insecurity, and transportation availability.

CAHPS (Part C and D)

CMS tested a web-based survey in an effort to increase CAHPS response rates. They intend to continue the web-based mode in the 2024 CAHPS survey implementation used for the 2025 Star ratings.

Questions on unfair or insensitive treatment were tested as noted in the 2023 Advance Notice and Rate Announcement. The item may be considered as a potential display measure for the 2025 Star Ratings year.

Non-substantive changes to the questions are being considered to the Getting Appointments and Care Quickly measure.

Attachment V: Economic Information for the CY 2024 Advance Notice

Attachment V provides estimates of the net impact to the Medicare Trust Funds of changes to the Medicare Advantage and PACE plans for CY 2024.

Section A – Changes in Payment Methodology for Medicare Advantage and PACE for CY 2024.

- Medicare Advantage and PACE non-ESRD Ratebook.
    - Growth rate for 2024 FFS non-ESRD rates estimate: 2.15%.
    - Growth rate for 2024 MA non-ESRD rates estimate: 1.81%.
    - Effective growth rate for 2024 MA non-ESRD rates estimate: 2.09%.
        - Net impact $7.3 billion cost to Medicare Trust Funds.
    - MA growth percentage used to calculate the 2024 PACE non-ESRD is estimated to be 1.81%.
        - Net Impact $30 million cost to Medicare Trust Funds.
    - If CMS continues the adjustment to the calculation of county benchmarks in Puerto Rico for the number of beneficiaries with zero claims.
        - Net impact $280 million cost to Medicare Trust Funds.
- Indirect Medical Education (IME) Phase Out

Background: MIPPA (2008) requires CMS to phase out IME from pre-ACA MA capitation rates which are used to set the cap on MA benchmarks and are used as the basis for PACE non-ESRD capitation rates.

- The maximum incremental IME phase-out is 0.60% of the FFS rate per year. The maximum IME reduction in 2023: 8.4% and in 2024: 9.0%.
    - No counties in payment year 2024 have IME amounts greater than 8.4% of the FFS.
        - No impact in 2024 to the Medicare Trust Funds from the IME phase-out.
- Medicare Advantage and PACE ESRD Ratebooks.

  - FFS growth percentage for the 2024 MA ESRD rates is estimated to be 2.68%.
    - Net impact $550 million cost to Medicare Trust Funds.

- CMS-HCC Risk Adjustment Model
  - CMS is proposing an updated Part C CMS-HCC risk-adjustment model for organizations other than PACE.
    - Anticipated impact on MA risk scores: -3.12%
    - Represents $11.0 billion net savings to the Medicare Trust fund in 2024.
- ESRD Risk Adjustment.
  - CMS is proposing a continuing the use of the ESRD risk adjustment models implemented in CY 2023.
    - No economic impact.
- Frailty Adjustment for FIDE SNPs
  - CMS is proposing to calculate frailty scores for FIDE SNPs using updated frailty factors associated with the proposed 2024 CMS-HCC model.
    - Relative to CY 2023 frailty factors, the impact is: -15.68%
- MA Coding Pattern Difference Adjustment
  - Continue to apply statutory minimum coding patter difference adjustment: 5.9%.
  - No year-over-year impact.
- Normalization
- Purpose – to offset the trend in risk scores and maintain a 1.0 average FFS risk score. For CY 2024, the CMS-HCC risk adjustment models with a 2019 or 2020 denominator, CMS proposes to calculate the normalization factors using a five-year linear slope methodology and updated average FFS risk scores for 2018-2022 excluding 2021 (consistent with the development of the CY 2023 normalization factor). For the CMS-HCC risk adjustment models with a 2015 denominator and the RxHCC modes, CMS proposes to calculate the normalization factors using a five-year linear slope methodology and historical FFS risk scores (2016-2020).
  - The impact of normalization is $0.

Section B Changes in the Payment Methodology for Medicare Part D for CY 2024.

- Part D Risk Adjustment Model.
    - For CY 2024 –CMS continuing the use of the RxHCC risk adjustment model that was implemented in CY 2023.
        - No economic impact.
- Part D Parameters
    - Methodology for updating other Part D parameters remains unchanged from CY 2023.
        - No direct economic impact – impact is dependent on behavior and assumptions of Part D plan sponsors

Attachment VI: CMS-HCC Risk Adjustment Factors

This attachment in the notice includes multiple tables with details of the various risk model factors.