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Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Dr. Seshamani and Ms. Lazio:

AHIP[1] appreciates the opportunity to comment on the Advance Notice of Methodological Changes for CY 2024 for MA and Part D (Advance Notice).

As highlighted in our recently filed comment letter on the Contract Year 2024 Policy and Technical Changes proposed rule[2], Americans agree that the Medicare Advantage (MA) and Part D programs are enormously successful models of public/private partnerships that offer choice, competition, and innovation. These programs deliver high-quality, affordable coverage and care to tens of millions of America's seniors and people with disabilities.[3]

Compared to the original Medicare program, MA plans deliver coverage and care for a more diverse and vulnerable population, as more than half of individuals dually eligible for Medicare and Medicaid benefits are enrolled in MA.[4] MA plans also provide better and more coordinated care, more comprehensive benefits, and better outcomes; increased financial security; are more cost effective; lead the way in value-based care; and earn greater satisfaction rates.[5]

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[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.
[2] See https://www.ahip.org/resources/ahip-comment-letter-on-ma-part-d-proposed-rule-for-cy-2024.
[3] Currently, almost 31 million people choose MA— almost half of those eligible for Medicare. And more than 50 million enrollees are receiving robust access to prescription drugs through Part D plans, including more than 27 million receiving Part D coverage through MA plans.
[4] Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission. Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid. February 2023.
[5] AHIP. "Medicare Advantage By the Numbers" and "Medicare Advantage: Providing Better Services, Better Access to Care, and Better Value." Accessed at: https://www.ahip.org/issues/medicare-advantage. See also: "New

Advance Notice Would Cut Medicare and Reduce Benefits or Increase Premiums in 2024

AHIP has grave concerns that the Advance Notice would result in a cut in Medicare Advantage payment rates in 2024, thereby reducing the resources available to serve many of the 30 million enrollees who choose this successful, popular program for their Medicare benefits. We believe the Advance Notice is inconsistent with national and CMS policy goals of advancing health equity, improving the health care delivery system, expanding the use of quality- and value-based payments, and enhancing care coordination and disease management. If finalized, the proposals would ultimately increase premiums and/or reduce benefits for tens of millions of seniors and people with disabilities in 2024—and in an especially meaningful way for some of the most medically vulnerable and low-income seniors enrolled in MA.

Our most significant concern with the Advance Notice is the flawed revision to the proposed risk model for 2024. As outlined below, it included an inadequate process for considering such a complex change and a failure to account for the disproportionate and potentially devastating impacts it would have on certain areas and populations, including individuals dually eligible for Medicare and Medicaid. We therefore urge CMS to withdraw the proposed risk model changes for 2024. If CMS chooses to propose major risk model changes such as those in the Advanced Notice in the future, the agency should engage in a collaborative, deliberative, and transparent process with stakeholders to understand the full range of impacts across the population of MA enrollees.

We continue to respectfully disagree with characterizations by the Administration that CMS projections relating to "risk score trend" would result in an increase in funding from the Advance Notice. Moreover, CMS estimates of the risk model's impacts raise a number of important questions, including failing to recognize the wide differences in results across MA plans and geographic areas. For example, a study commissioned by AHIP from the Wakely Consulting Group (which is attached to this comment letter), based on data from a broad range of MA plans, shows an average payment cut of 3.7%. But the Wakely report finds that *cuts for all plans in Puerto Rico would average 11%*.[6] As another example, a report from Milliman estimates that *chronic condition special needs plans (C-SNPs) would see reductions of more than 24% in some states*, and *general enrollment MA plans would see cuts averaging 12% for plans in some states*.[7] Our concerns about disproportionate impacts on populations such as dual eligibles

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Survey: Senior Voters Overwhelmingly Want the Government to Protect Medicare Advantage Funding." Accessed at: https://medicarechoices.org/new-survey-senior-voters-overwhelmingly-want-the-government-to-protect-medicare-advantage-funding/.

[6] Wakely Consulting Group. "2024 Medicare Advantage Advance Notice." March 2023. Available at: https://www.ahip.org/resources/impact-of-2024-medicare-advantage-advance-rate-notice.

[7] Milliman. "High-level impacts of the proposed CMS-HCC risk model on Medicare Advantage payments for 2024." February 2023. Accessed at https://www.milliman.com/en/insight/analysis-of-2024-CMS-proposed-HCC-Model.

are further highlighted below. Moreover, while unclear, these estimates appear to be based on diagnoses from 2020, which is the first year of the COVID public health emergency (PHE) when health care utilization was significantly depressed. With more updated risk scores that are not affected by the pandemic, the average cuts could be even larger.

Additional Major Concerns with the 2024 Advance Notice

In addition to the overall and variable impacts of the Advance Notice, we have serious concerns with other specific elements, including:

- **There is a lack of transparency relating to various proposals in the Advance Notice.** For example, CMS does not provide any analysis regarding the accuracy of its proposed risk adjustment model in predicting costs, or the impacts with respect to different populations of enrollees or county-level payment benchmarks. CMS also provides an extremely limited explanation of its proposed technical adjustment for graduate medical expense payments that fails to adequately explain how the change will affect cost projections.

- **The short comment timeline and overall process for considering a major change to the MA payment structure are inadequate for stakeholders.** The proposed changes to the risk adjustment model are extremely complex, but CMS has provided only 30 days for comment. Unlike approaches the agency has routinely taken in the past in the MA program when proposing significant changes and approaches under the Affordable Care Act (ACA) risk adjustment program for the individual and small group markets, CMS did not provide an extended comment deadline or an opportunity for engagement in the process of developing the proposed risk model changes, such as through technical papers or other means. This has severely limited the opportunity for meaningful analysis and comment on major changes affecting more than 30 million Americans. Moreover, the limited timeline for issuing a final rate notice 30 days after the close of the comment period makes it effectively impossible for CMS to realistically consider changes if it did move forward with finalizing the model.

- **For many millions of Medicare enrollees, the negative impacts of the proposed risk adjustment model changes will be much worse than estimated by CMS.** More than half of dual eligibles are enrolled in MA, including more than 5 million[8] enrolled in dual-eligible special needs plans. Cuts to MA will impact payment for treatment and care for diagnoses such as major depressive disorder, diabetes with chronic conditions, or vascular disease, which disproportionately affect dual eligibles.

[8] See CMS SNP Comprehensive Report 2023.

- **Wakely's analysis shows there will be significantly larger cuts for enrollees in plans that treat a large proportion of dual eligible enrollees.**[9] *The proposed model would on average cut payments for dual eligibles by 6.4%.* This includes *average cuts of 6.7% for seniors who are "full" dual eligibles.* Cuts of this magnitude could severely limit available funding for critical supplemental benefits that may not be covered by the enrollee's Medicaid coverage.[10] *Moreover, for seniors who are "partial" dual eligibles, cuts would be even worse—on average, 8.9%—more than double the average cuts.* These low-income enrollees are particularly at risk when benefit cuts increase cost sharing or eliminate available benefits because they do not have Medicaid coverage for those services.

- **While the impacts on average are severe, they can be particularly devastating for enrollees in specific MA plans.** The Wakely report found that *the impact across all organizations varies by 140%, and the impact on dual segments varies by about 165%, from minimum to maximum.*[11]

- **The Advance Notice continues policies that fail to appropriately account for original Medicare costs in MA benchmarks.** CMS continues to include original Medicare enrollees who are ineligible for MA, and exclude certain original Medicare expenses, when setting benchmarks. This inappropriately reduces benchmarks and skews comparisons between MA and original Medicare.

Moreover, if CMS moves forward with the proposed changes to the risk model and other policies, efforts to advance and improve health equity would be negatively impacted. According to the American Diabetes Association, Black Americans are 64% more likely to have diabetes than whites, while Hispanic Americans are 60% more likely than non-Hispanic whites to have diabetes.[12] A 2022 report found that major depression goes undiagnosed and untreated at disproportionally greater rates in the majority of Black and Hispanic communities.[13] Thus, the MA cuts in 2024 will hurt CMS efforts to promote health equity, limiting critical funding needed to keep premiums low and/or support supplemental benefit offerings including benefits to help

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[9] Wakely Consulting Group. "2024 Medicare Advantage Advance Notice." March 2023. Available at: https://www.ahip.org/resources/impact-of-2024-medicare-advantage-advance-rate-notice.
[10] Even if the benefits are covered by an individual's state Medicaid program, the reduction in Medicare funding will shift a greater burden to that state.
[11] Wakely Consulting Group. "2024 Medicare Advantage Advance Notice." March 2023. Available at: https://www.ahip.org/resources/impact-of-2024-medicare-advantage-advance-rate-notice.
[12] See American Diabetes Association - Statistics About Diabetes
[13] Blue Cross Blue Shield Association. The Health of America Report. "Racial Disparities in Diagnosis and Treatment of Major Depression." May 31, 2022. Accessed at: https://www.bcbs.com/sites/default/files/file-attachments/health-of-america-report/Racial-Disparities-in-Diagnosis-and-Treatment-of-Major-Depression_2.pdf

overcome social barriers such as nutrition services, in-home supports, or transportation to medical appointments.

On balance, we believe the policies in the Advance Notice will threaten the stability of benefits for over 30 million seniors and individuals with disabilities, many of whom are low-income and have high healthcare needs. Given these concerns and for the reasons noted above, we urge CMS to withdraw the proposed risk model changes.

We know CMS agrees that Americans deserve a strong and stable MA program based on person-centered, high-quality coverage and care. We respectfully request that CMS consider our recommendations in the attached detailed comments to achieve those objectives. We look forward to continuing our work together to ensure plans can continue to provide innovative, high-quality care for current and future enrollees and improve their well-being, equity, and financial stability.

Sincerely,

Matthew Eyles

Matthew Eyles
President & Chief Executive Officer

AHIP Detailed Comments on Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies

Summary

AHIP has a number of significant concerns with proposals in the Advance Notice. For example:

- **There is a lack of transparency relating to various proposals in the Advance Notice.** For example, CMS does not provide any analyses regarding the accuracy of its proposed risk adjustment model in predicting costs, or the impacts with respect to different populations of enrollees. CMS also provides an extremely limited explanation of its proposed technical adjustment for graduate medical expense payments that fails to adequately explain how the change will affect cost projections.
- **The comment timeline and overall process for considering a major change to the MA payment structure is entirely inadequate.** The proposed changes to the risk adjustment model are extremely complex, but CMS has provided only 30 days for comment. Unlike approaches it has routinely taken in the past in the MA program and under the ACA risk adjustment program for the individual and small group markets, CMS did not provide an extended comment deadline or an opportunity for engagement in the process of developing the proposed risk model changes, such as through technical papers or other means. This has severely limited the opportunity for meaningful analysis and comment on major changes affecting more than 30 million Americans. Moreover, the limited timeline for issuing a final rate notice makes it effectively impossible for CMS to realistically consider changes if it does choose to move forward with finalizing the model.
- **For many millions of Medicare enrollees, the negative impacts of the proposed risk adjustment model changes will be much worse than CMS has estimated.** A study that AHIP commissioned from the Wakely Consulting Group shows there will be significantly larger cuts for enrollees in plans that treat a large proportion of dual eligible enrollees. Certain geographic areas will also see larger cuts.
- **The Advance Notice continues policies that fail to appropriately account for original Medicare costs in Medicare Advantage benchmarks.** CMS continues to include original Medicare enrollees who are ineligible for Medicare Advantage, and exclude certain original Medicare expenses, when setting benchmarks. These choices by CMS inappropriately reduce benchmarks and skews comparisons between Medicare Advantage and original Medicare.

These and other issues of concern, along with AHIP's recommendations, are discussed below.

Attachment I. Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for CY 2024

Section A. Data and Assumptions Supporting USPCCs

CMS proposes to make a technical correction to estimates for United States per capita cost (USPCC) baselines for both fee-for-service (FFS) and total costs. Specifically, CMS is proposing to remove graduate medical education (GME) payments, including indirect GME and direct GME costs paid to inpatient facilities on behalf of MA enrollees. In proposing the change CMS says that inpatient cost report experience supporting the baseline modeling did not separately identify GME payments made on behalf of MA enrollees from those paid on behalf of FFS enrollees, but modeling has been updated to separate out those payments. CMS is now proposing to remove MA-related GME costs from the historical and projected expenditures from the USPCCs beginning with the 2024 payment year. This change reduces the 2024 non- end stage renal disease (ESRD) FFS USPCC by 2.13% and the non-ESRD Total USPCC by 1.06%.

AHIP's members have a number of questions and concerns about the CMS proposal. First, CMS already removes direct and indirect GME payments from county-level benchmarks as part of the average geographic adjustment (AGA) process that adjusts USPCC amounts for each county. Removing GME payments from county benchmarks is appropriate, since GME payments, which are made to teaching hospitals, vary considerably across counties. It is our understanding that the these carve-outs reflect GME payments made on behalf of both FFS and MA patients. Given that CMS already removes GME payments from MA benchmarks, it is unclear why CMS would propose to remove such payments again at the USPCC level. Removing GME amounts from the USPCCs will affect MA benchmarks in all counties even though many counties are unlikely to have any GME payments.

Recommendation: Given these questions, we ask that CMS not move forward with the proposed correction to USPCCs for 2024. Instead, we recommend that CMS provide plans with more information about the underlying methodology for identifying GME payments and the process by which CMS has historically removed GME payments from MA benchmarks and the process CMS proposes to adopt. If CMS does move forward in making this correction for 2024, we recommend CMS phase-in the revised USPCC amount to provide more stability for plans and enrollees.

Section B. USPCC Estimates

CMS projects total United States per capita costs (USPCC) non-ESRD will grow by 1.81% and FFS USPCC (Non-ESRD) costs will grow by 2.15% for 2024. Both growth rate estimates are significantly lower than recent years, in large part due to the technical correction discussed earlier. As already discussed, we are concerned that the correction for GME payments results in

a lower growth rate than reflects actual experience, which could lead to incorrectly lower benchmarks.

Along with the growth rates, CMS published a comparison of its most current non-ESRD FFS cost projections with those in the April 4, 2022, final Rate Announcement (see Table 1 below). FFS cost projections are based in part on historical data, which CMS updates annually. A major reason for the restatement of prior years appears to be due to the removal of GME payments. CMS does not discuss other reasons for the revised cost projections.

Table 1. CMS Restatements of Non-ESRD FFS Cost Projections

Year	Current	Prior	Restatement
2021	$925.22	$935.10	-1.1%
2022	$968.38	$1,023.31	-3.0%
2023	$1,045.94	$1,078.63	-5.4%
2024	$1,101.81	$1,132.07	-2.7%

AHIP appreciates the information CMS has provided in the Advance Notice. Given the size of the changes to the restatements, particularly for 2022, we believe it would be helpful for CMS to provide additional information about the factors contributing to the modified projections. In particular, it would be helpful to know how the restatements are affected by changing experience with COVID-19 impacts. This information would assist MA plans in developing bids for 2024.

CMS also explains that USPCCs for 2023 (and future years) now reflect cost projections related to several provision of the Inflation Reduction Act (IRA), including Part B manufacturer rebates, changes in beneficiary coinsurance that may result from CMS determinations of excess price increases for Part B rebateable drugs, exclusion of the Part B deductible for insulin when it is furnished through durable medical equipment, and a $35 cap on beneficiary cost sharing for insulin. CMS notes that these provisions are expected to increase Part B FFS expenditures beginning with 2023 but does not provide any detail on the expected increase.

Recommendation: We request that CMS provide more information about the factors contributing to the changes in non-ESRD FFS cost projections. In addition to assisting plans in bid preparation, it is important that all stakeholders understand the factors that make up cost projections and have an opportunity to provide feedback to CMS on the accuracy and reliability of CMS' cost projections. Specifically, we ask that CMS explain how ongoing experience with COVID-19 affects CMS projections of prior and future FFS costs, as well as how changes required as part of the IRA will affect projected costs moving forward.

We also urge CMS to be more transparent in the agency's assumptions and methodologies. To promote accuracy and transparency, we request CMS provide the following information:

- Detailed information about the factors and assumptions used to calculate the growth percentages, including, for example, additional details on utilization changes and unit costs by type of service;
- More clarity about the extent to which CMS accounted for finalized payment rates for Medicare FFS inpatient and outpatient systems; and if not, reasoning as to why these payment rates were not taken into account; and
- More specificity about the extent to which coverage requirements related to the COVID-19 public health emergency are reflected in estimates of costs, utilization, and growth rates.

MA Coding Trend

While not addressed in the Advance Notice itself, in the Fact Sheet about the Advance Notice released on February 1, 2023, CMS includes an estimate of MA risk score trend for 2024, which CMS describes as the "average increase in risk scores, not accounting for normalization and MA coding adjustments." CMS includes this estimate – 3.3% for 2024 – in its chart showing the expected impact of proposed policy changes on MA plan payments for 2024.

This estimate of coding trend is not part of the benchmark calculation against which plans bid. The Advance Notice offers no additional information on the methodology or assumptions used in developing this trend estimate, the data used for such estimate, or how the estimate of MA coding trend relates to estimated coding in the FFS program. CMS has repeatedly cited this statistic as a core part of the change in MA payment rates for 2024, despite offering no analysis, evidence, or justification for its reliance on this number. If CMS believes coding trend is a component of the annual payment amounts for MA plans, it must address it in the Advance Notice to allow stakeholders an opportunity to evaluate and comment on the projection.

The estimate of 3.3% coding trend for 2024 is especially dubious given that the changes to the Part C risk adjustment model include removing and constraining codes CMS believes are subject to more complete coding in MA than FFS. The changes being proposed for the risk model would reduce the impact of coding for 2024. CMS cannot simultaneously make the changes described to the Part C risk model for 2024 and truly expect to see 3.3% coding trend.

Recommendation: We urge CMS to release detailed information on the data, methods, and assumptions used to estimate MA coding trend for 2024 so that stakeholders can better understand the estimate. If CMS includes a similar estimate in future announcements, the data, methods, and assumptions associated with such estimate should be included in the Advance Notice itself with an opportunity for stakeholders to review and comment on the data and methodology. Until such time as CMS provides such information, it should refrain from using projections of MA coding trend in its estimate of MA payment.

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

Section B. Calculation of Fee for Service Cost

B3. Adjustments for Medicare Shared Savings Program and Innovation Center Models and Demonstration Programs

Consistent with prior years, CMS proposes several changes to the calculation of the AGAs used to determine the county benchmarks. CMS indicates that these changes are primarily associated with adjusting the FFS claims data for shared savings and losses of alternative payment models, including accountable care organizations, bundled payment demonstrations, and other Center for Medicare and Medicaid Innovation (Innovation Center) payment models. CMS proposes to limit the adjustment for Innovation Center models to the models listed in Table B3-1 of the Advance Notice. CMS further proposes to continue excluding from FFS costs certain payments made through Innovation Center models when those payments are not funded from the Medicare Part A or B Trust Funds.

We are concerned that CMS is limiting its adjustment of the AGAs for Innovation Center demonstrations and payment models to those listed in Table B3-1, and that CMS continues to exclude from FFS cost calculations Innovation Center payments that do not come directly from the Medicare trust funds. We are not aware of any statutory basis for excluding these costs from the calculation of MA benchmarks. Similar to CMS' policy (discussed below) of including certain enrollees ineligible for MA in calculating benchmarks, the exclusion of these funds means CMS is not determining the cost of providing a benefit to MA enrollees that is comparable to what it would be if the benefit were provided to such enrollees under the FFS program. This should be the key test in setting MA benchmarks, not the source of FFS funding. We are also concerned that as the Innovation Center expands the scope and range of alternative payment models that diverge from traditional FFS payment methods, a growing share of FFS spending may be excluded from MA benchmarks.

In particular, we are concerned that CMS excludes advance payment of shared savings paid to providers under Innovation Center models. To the extent these advance payments are reconciled against actual provider experience after the end of the model performance period and additional payments from Part A or B Trust Funds are made, they are part of the overall payments made to providers through the Innovation Center and should be reflected in MA benchmarks. Further, excluding these payments makes assessments of FFS spending and subsequent comparisons of MA and FFS costs less accurate.

Recommendation: We recommend that CMS reconsider its policy of excluding models in its adjustment of the AGAs to the extent the models involve payments such as bonuses and care

management fees funded through the Innovation Center. In particular, CMS should include advance shared savings payments made as part of Innovation Center models in calculating historical FFS experience. We also ask that CMS provide stakeholders with information about the value of payments excluded from FFS costs.

B4. Additional Adjustment to FFS per Capita Costs in Puerto Rico

The MA program is critically important in Puerto Rico. More than three fourths of Medicare beneficiaries in Puerto Rico are enrolled in MA plans (83% as of January 2023). A substantial number of these beneficiaries have low incomes and enroll in plans to receive more care coordination and affordable Part D coverage, which otherwise may not be accessible due to the statutory prohibition on providing Part D low-income subsidies (LIS) to beneficiaries in the territories.

We continue to be concerned about the large disparity in payment rates between Puerto Rico and the mainland. The unusually low FFS expenditures for Puerto Rico, which serve as the basis for MA benchmarks, and the significant rate cuts for Puerto Rico put into place by the Affordable Care Act (ACA), jeopardize the continued availability of the comprehensive coverage provided by MA plans operating on the island to the low-income populations they serve. We also note that the disparity would be exacerbated if CMS finalizes the proposed changes to the risk adjustment model, given the prevalence of dual eligibles and other populations for whom payments will be significantly reduced.

The Secretary has previously directed the Office of the Actuary (OACT) to account for the fact that a higher proportion of beneficiaries in Puerto Rico did not have claims than beneficiaries outside of Puerto Rico. The agency has determined that from 2016 through 2020, an average of 15.3% of Puerto Rico beneficiaries enrolled in both Medicare Parts A and B had no claims reimbursements in a given year, compared to 6.4% of beneficiaries nationwide during the same period. To account for the large share of beneficiaries in Puerto Rico who have no claim reimbursements in a year, OACT applied an adjustment of 4.7% to the standardized per capita FFS costs in Puerto Rico for 2016 through 2020 and the resulting 2023 rates, and OACT is considering whether to make this adjustment for the 2024 rates. For an adjustment in 2024, CMS would perform a similar analysis to the one used to determine the 2023 adjustment, but with an updated five years of data: 2017 – 2021.

CMS also notes that it will continue to adjust the FFS calculation for Puerto Rico to include only those beneficiaries enrolled in both Parts A and B. In addition, in the CY 2018 Final Notice CMS expanded the criteria used to determine which counties qualify for a double quality bonus payment to include certain counties in Puerto Rico.

Recommendation: AHIP urges CMS to apply an adjustment to the calculation of benchmarks for Puerto Rico to reflect only claims data for beneficiaries enrolled in both Parts A and B. We also support continuation of the expanded criteria for double bonus counties.

In addition, we strongly urge CMS to apply an adjustment to account for the large number of Puerto Rico beneficiaries with no Part A or B claims. Such an adjustment remains necessary to ensure that plans in Puerto Rico can maintain benefits for the low-income populations they serve. We urge CMS to keep in mind that COVID-19 has affected utilization in many different and unexpected ways and ensure that any adjustment to MA benchmark rates for Puerto Rico is sufficient to ensure stability and access to MA benefits and high-quality care for its residents.

We also renew calls for CMS to explore additional options for increasing MA benchmark rates for Puerto Rico to achieve greater parity with FFS rates on the mainland. Even with the adjustments discussed above, payment disparities remain and can limit the availability of the comprehensive MA coverage that is absolutely critical to Puerto Rico residents.

Calculating FFS Costs Using Enrollees Enrolled in Medicare Part A and Part B

For several years we have raised concerns that CMS is not appropriately calculating all MA benchmarks from an actuarial perspective, as the current methodology includes beneficiaries who are not eligible to enroll in MA. A Medicare beneficiary must have both Part A and Part B to be eligible for MA plan enrollment, yet CMS calculates rates based on enrollees with either Part A or Part B. Actuarial principles require that an estimate of the benchmark must represent what that enrollee would cost in FFS. By using claims experience from FFS beneficiaries who are not eligible to enroll in MA, CMS is calculating benchmarks that include beneficiaries with only Part A and only Part B, and therefore does not appropriately estimate what would have been paid for the same beneficiary had they remained in FFS. CMS has made this adjustment to the benchmark rates for Puerto Rico since 2012.

CMS has recognized the need to count historical claims and enrollment of those beneficiaries with both Part A and Part B enrollment in calculating MA rates for Puerto Rico, as noted above. In addition, in a recently released public use file containing information on geographic variation in Medicare spending, CMS states that per-capita spending for beneficiaries enrolled in Part A only or Part B only "cannot be compared directly to spending for beneficiaries that are enrolled in both Part A and Part B."[14] We are disappointed that CMS continues to not make this adjustment to the calculation of MA rates nationwide. In 2021, CMS indicated the agency was considering revising MA rates based on data from beneficiaries with both Parts A and B, saying

[14] CMS. "Medicare Data for the Geographic Variation Public Use File: A Methodological Overview." February 2023. Accessed at: https://data.cms.gov/sites/default/files/2023-02/d30ee401-edd4-4d41-a631-69d95356dc2d/Geographic%20Variation%20Public%20Use%20File%20Methods%20Paper.pdf.

the agency intended to issue a request for information on the topic, though no such request has been made public.

AHIP believes the current methodology is inappropriate from an actuarial perspective because it includes beneficiaries who are not eligible to enroll in MA. We also continue to believe the Social Security Act requires that the Agency exclude Part A-only enrollees from the calculation of county benchmarks, to ensure the estimate best represents what that enrollee would cost in FFS.

Recommendation: We urge CMS to revise the way all MA benchmarks are determined to include only individuals enrolled in Parts A and B in calculating FFS costs. We also encourage CMS to issue a request for information on this issue so that stakeholders can provide input.

Section C1. Direct Graduate Medical Education

CMS describes the method it will use to carve out direct GME (DGME) payments from FFS per capita costs used to develop MA benchmarks. CMS has made this adjustment, as required by the Social Security Act, in past years. As noted in our comments earlier on Section A, we have significant questions about how this carve out is related to and interacts with the technical correction to reduce FFS costs CMS is proposing to make to the USPCCs. If there is overlap between the amounts being removed at the county level and USPCC level, will CMS revise the calculation of amounts to be removed through the AGAs?

Recommendation: We ask CMS to provide more information about how the DGME costs being removed by the adjustments in this section differ from and are impacted by the GME amounts being removed from USPCCs, including whether and how the methodology for removing DGME amounts through the AGA process is changing.

Section C2. Organ Acquisition Costs for Kidney Transplants

As required by the 21st Century Cures Act, CMS describes a methodology for excluding costs related to kidney acquisitions from MA benchmarks. In 2021 CMS began removing kidney acquisition costs from MA benchmarks, and in 2023 CMS adopted a new approach for the development of the exclusion amounts to incorporate variations in the way provider payments are calculated by Medicare Administrative Contractors (MACs). The revised carve-out method resulted in a slight increase in average MA non-ESRD and ESRD county rates of about $1 per member per month (PMPM), but the impact varied dramatically by jurisdiction, from a negative impact of -$11 PMPM to a positive impact of $33 PMPM.

Recommendation: We urge CMS to closely monitor the net impact of payment changes and take steps to limit large drops in county benchmarks that may result from these changes.

Section C3. IME Phase Out

CMS proposes to make an adjustment to county benchmarks to phase out indirect medical education (IME) amounts from MA benchmarks, as required by the Medicare Improvements for Patients and Providers Act of 2008. As with the removal of DGME amounts discussed in C1, it is unclear how this carve out is related to the reduction of FFS costs CMS is proposing to make to the USPCCs as discussed earlier. If there is overlap between the amounts being removed at the county level and USPCC level, will CMS revise the calculation of amounts to be removed through the AGAs?

Recommendation: We ask CMS to provide more information about how the IME costs being removed by the adjustments in this section differ from and are impacted by the GME amounts being removed from USPCCs, including whether and how the methodology for removing IME amounts through the AGA process is changing.

Section D. MA ESRD Rates

CMS sets payment benchmarks for ESRD enrollees at the state level rather than the county level (the geographic level at which non-ESRD MA payment benchmarks are calculated). AHIP's members have long expressed concerns about state-based ESRD rates because they mask large variations in costs within some states, and lead to significant underpayment for ESRD enrollees in many areas.

In 2023 CMS evaluated the possibility of moving to Core-Based Statistical Areas (CBSAs) as the geographic basis for ESRD benchmarks but did not propose to adopt CBSA benchmarks. In the current Advance Notice, CMS describes additional analysis looking at the health equity impact of moving to CBSA-based rates, as measured by the Area Deprivation Index (ADI). CMS says that moving from state-based to CBSA-based ESRD benchmarks would lead to payment reductions in areas with high socioeconomic deprivation and payment increases in areas with low deprivation. Therefore, CMS does not plan to adopt CBSA-based ESRD benchmarks and will continue setting payment rates at the state level.

AHIP continues to believe that state-based ESRD costs are not an appropriate level at which to set payment benchmarks. Further, we have serious concerns that ESRD benchmarks do not reflect the costs of providing care and benefits for enrollees with ESRD, in large part because the highly concentrated dialysis provider market[15] leads to significantly higher costs for dialysis in MA than original Medicare's regulated payment structure. Higher costs for dialysis are especially impactful because dialysis accounts for a substantial share (almost one-third) of all

[15] Two companies own about 74% of all dialysis centers. See Medicare Payment Advisory Commission. Report to the Congress. March 2021.

Medicare spending for individuals with ESRD.[16] The Medicare Payment Advisory Commission (MedPAC) found that the prices MA plans paid for dialysis services were about 14 percent higher, on average, than the FFS payment rate for dialysis.[17]

In addition, maximum out-of-pocket (MOOP) limits apply to ESRD costs for Medicare Advantage organizations (MAOs) but not to such costs in the FFS program. This has resulted in many MA plans incurring costs for dialysis services well above original Medicare rates and medical loss ratios (MLRs) in excess of 1 for these enrollees (well above average MLRs for other enrollees).[18]

Recommendation: Given the large within-state variations in ESRD costs, AHIP urges CMS to continue considering the use of smaller geographic areas as the basis for calculating MA ESRD benchmarks. In moving to smaller areas, CMS should consider adjustments to rural and medically underserved areas to ensure beneficiary access to high-quality MA plan options. We also renew our request that CMS take additional steps to address the inadequacy of payments for ESRD enrollees overall.

Section F. MA Employer Group Waiver Plans (EGWPs)

CMS proposes to maintain the current payment methodology for EGWPs in 2024. Under that approach, CMS waives the bidding requirements that apply to non-EGWP plans and instead determines EGWP rates based on average bid-to-benchmark ratios using 2023 bids. In response to requests from stakeholders, CMS provides preliminary bid-to-benchmark ratios for EGWPs in the Advance Notice, noting that the ratios are not final and could differ from final ratios used to determine EGWP rates for 2023.

Recommendation: AHIP appreciates CMS publishing preliminary bid-to-benchmark ratios for 2023, which facilitates MAO engagement with employers as they develop EGWP offerings and bids. We are concerned that the published preliminary bid-to-benchmark ratios are lower than expected, and request that CMS provide additional detail about how the ratios were calculated. We recommend that CMS consider updating its methodology to exclude negative margin plans from the calculation of estimated bid-to-benchmark ratios for EGWPs. Finally, we note that some EGWPs may be negatively impacted by proposed risk model changes without the ability to adjust bids in response to lower risk scores, which may harm EGWP enrollees.

[16] Medicare Payment Advisory Commission. Report to the Congress. March 2021.
[17] Medicare Payment Advisory Commission. Report to the Congress. March 2021.
[18] See: https://www.ahip.org/documents/AHIP-2021-Advance-Notice-Comment-Letter_WakelyReport.pdf

Section G. CMS-HCC Risk Adjustment Model for CY 2023

As part of the 2024 Medicare Advantage and Part D Advance Notice, CMS is proposing a new risk adjustment model for 2024 with three major revisions:

1) Model Data Years: CMS would update the data years used to calculate the model's risk factors,
2) Model Use of ICD Diagnoses Codes: CMS would move from using ICD-9 diagnosis codes to using ICD-10 diagnosis codes in creating the model, and
3) Changes to Diagnoses & Condition Categories: CMS would make numerous changes to the diagnoses and condition categories (HCCs) included in the model.

Process Concerns

While AHIP has supported the use of more recent data years and the move to ICD-10 diagnosis codes in the risk model, we have also urged CMS to be transparent and timely in sharing information about these changes with stakeholders. Given the scope and complexity of the risk model changes being proposed, it is critical for stakeholders to have significantly more time for expert review, analyses, and input on the proposed changes than allowed for by the Advance Notice.

CMS in the past has recognized the need for engaging stakeholders in the development of significant changes to the risk model and for providing sufficient time for meaningful analysis and feedback. When implementing changes to the risk model beginning with the 2017 payment year, for example, CMS first shared its planned changes with stakeholders in October of 2015 via a Health Plan Management System (HPMS) memorandum and request for comment on the proposed changes. In that memorandum, CMS explained in detail the proposed changes to the model and the impact of the revised model. Specifically, CMS shared initial results of analysis comparing the predictive accuracy of the revised model relative to the prior model. In implementing changes to the risk adjustment model beginning with 2019, as required by the 21st Century Cures Act, CMS provided plans with 60 days to review and provide feedback on the proposed changes.[19] The information included detailed information about the performance of the revised model relative to the existing model and discussion of alternative model specifications the agency had considered so that stakeholders could evaluate the alternative specifications and provide input to CMS on the most accurate and appropriate model. Further, in the risk adjustment program established under the ACA that HHS operates for plans in the individual and

[19] CMS. "Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for the Medicare Advantage (MA) CMS-HCC Risk Adjustment Model." December 2017. Accessed at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2019Part1.pdf.

small group markets, HHS has shared detailed analysis in prior technical papers before formally proposing and finalizing risk adjustment changes.[20]

In contrast to these prior approaches, the agency has not provided adequate time or information to permit adequate analyses of the complex changes proposed for 2024 in the Advance Notice.

- CMS provided only a 30-day comment period, the statutory minimum for Advance Notice proposals. There was no technical paper, no detailed request for information, or any similar opportunity for meaningful input in advance of the model's development. And the complexity of the proposal limits the potential for meaningful modeling and analysis prior to the end of the comment period.
- The Advance Notice fails to provide key information. For example, unlike prior proposed changes to the risk adjustment model, CMS has not shared any information about the 2024 proposed model's performance in predicting costs overall or for particular subgroups such as those with very high costs, those with specific diseases, or those with very low costs.[21] CMS does not summarize for stakeholders the impact of the model with respect to different segments in the risk adjustment model, including full and partial dual eligibles. The Advance Notice also does not include analyses provided for prior proposed model changes about the overall performance of the model in accounting for variation in costs, a measure known as the model R^2.
- It was not until more than two weeks after release of the Advance Notice (February 1) that CMS shared the risk adjustment model software used to produce plan-level risk scores for the new model. This software allows plans to replicate risk scores provided by CMS, an essential part of evaluating the proposed changes. Waiting two weeks before releasing the software, with two weeks left in the comment period, leaves little time for plans to validate and evaluate CMS risk score estimates.
- Despite prior recommendations from AHIP, CMS has not established a Technical Expert Panel (TEP) to address issues such as FFS normalization and any model recalibration activities. This TEP would be an excellent approach for considering alternative methodologies to developing the FFS normalization factor or how recalibration of the risk adjustment model using ICD-10 data should be undertaken. Such a collaboration would also allow for substantive analysis and discussion of changes to the risk adjustment model outside of the limited Advance Notice schedule. There are many examples of TEPs and other Federal Advisory Committees across the FFS Medicare payment systems, including for the Medicare Physician Fee Schedule as well as for

[20] CMS. "HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes." October 2021. Accessed at: https://www.cms.gov/files/document/2021-ra-technical-paper.pdf.
[21] See, for example, CMS Report to Congress Accessed at: https://www.cms.gov/files/document/report-congress-risk-adjustment-medicare-advantage-december-2021.pdf.

hospital outpatient payment, clinical diagnostic laboratory tests, and the ESRD prospective payment system.[22]

We are also concerned that in proposing changes to the risk model for 2024 CMS has not addressed the implications of such changes on AGA factors and resulting county-level benchmarks. One component of the AGA adjustment depends on the five-year weighted average risk score. The weighted average is developed using the current risk model. Given the large variation in impact from the proposed model based on geographic area and enrollee mix, the AGA factors may see large, unexpected changes. CMS should provide more information about the impact of the proposed risk model on AGA factors. In addition to our concerns about the process by which CMS has proposed the risk model changes, we are also concerned that CMS is proposing to make such a large change in a single year. In the past when making such major changes to the risk model, CMS has phased in the changes over time to mitigate the impact while plans educate providers, adjust internal systems, and gain additional understanding of the revised models. For example, the revisions to the Part C risk model that resulted from the 21st Century Cures Act were phased in over three years; similarly, Version 22 of the model, which incorporated a number of clinical updates, was phased in over three years (2014 – 2016).

Impact on Dual-Eligible and Disadvantaged Populations

While CMS fails to provide critical analyses about various impacts of the proposed model in the Advance Notice, stakeholders have been able to perform certain analyses despite limited time and information. Those analyses raise serious concerns about the impact of model changes on enrollees with serious chronic conditions and with respect to dual eligibles and other populations served by MA plans. The analyses suggest the proposal will reduce funding needed to help diagnose and manage these diseases and coordinate care for patients, and thereby hurt efforts to reduce health disparities and improve health equity.

Minorities and people with low incomes make up a larger share of MA enrollees than FFS,[23] and more than half of individuals dually-eligible for Medicare and Medicaid benefits are enrolled in MA.[24] Many of the diagnoses targeted for removal from the payment model or to have their payment levels constrained are associated with significantly higher costs of care and include diagnoses - such as major depressive disorder, diabetes with chronic conditions, or vascular disease - that are very prevalent among disadvantaged populations. For example, according to

[22] For the Medicare Physician Fee Schedule, see: https://www.ama-assn.org/about/rvs-update-committee-ruc/rvs-update-committee-ruc. For other Federal Advisory Committees serving CMS, see: https://www.cms.gov/Regulations-and-Guidance/Guidance/FACA.
[23] AHIP. Medicare Advantage Demographics. February 2023. Accessed at: https://www.ahip.org/resources/medicare-advantage-demographics.
[24] Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission. Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid. February 2023.

the American Diabetes Association, black Americans are 64% more likely to have diabetes than whites, while Hispanic Americans are 60% more likely than non-Hispanic whites to have diabetes.[25] Individuals with low income are also more likely to have diabetes; a 2021 study found that compared with individuals with high income, individuals living below poverty were more than twice as likely to have diabetes, while near-poor were 74% more likely to have diabetes than those with high income.[26] Moreover, almost 1 in 4 individuals with diabetes in America had not been diagnosed with the disease according to the CDC, and minorities are significantly more likely to have undiagnosed diabetes than non-Hispanic whites.[27] Similarly, a 2022 report found that major depression goes undiagnosed and untreated at disproportionally greater rates in majority Black and Hispanic communities.[28]

In addition, analysis of the impact of the proposed risk model conducted by Wakely Consulting Group shows that CMS' overall estimated average impact of the model masks much larger impacts on payments for dual-eligible enrollees than non-duals. Wakely finds that overall, the proposed risk model would reduce risk adjusted payments by 3.7% in 2024. However, as Table 2 shows, the impact varies across risk model segments, and is significantly larger for dual-eligible segments than overall.[29]

[25] See https://diabetes.org/about-us/statistics/about-diabetes#:~:text=12.1%25%20of%20non%2DHispanic%20blacks,7.4%25%20of%20non%2DHispanic%20whites.
[26] Chen, Yu. "Income-Related Inequalities in Diagnosed Diabetes Prevalence among U.S. Adults, 2001−2018." American Diabetes Association 81st Scientific Sessions. June 2021.
[27] See https://www.cdc.gov/diabetes/data/statistics-report/diagnosed-undiagnosed-diabetes.html.
[28] Blue Cross Blue Shield Association. Racial Disparities in Diagnosis and Treatment of Major Depression. May 2021. Accessed at: https://www.bcbs.com/the-health-of-america/reports/racial-disparities-diagnosis-and-treatment-of-major-depression.
[29] Wakely Consulting Group. "2024 Medicare Advantage Rate Notice." March 2023. Available at: https://www.ahip.org/resources/impact-of-2024-medicare-advantage-advance-rate-notice.

Table 2. Risk-Adjusted Payment Impact, Proposed vs. Current Part C HCC Model

Model Segment	Estimated Impact
Full Dual Benefit Aged	-6.7%
Full Dual Benefit Disabled	-3.6%
Institutional	3.2%
C-SNP New Enrollee	4.3%
New Enrollee	16.0%
Non-Dual Benefit Aged	-4.0%
Non-Dual Benefit Disabled	-4.4%
Partial Dual Benefit Aged	-8.9%
Partial Dual Benefit Disabled	-5.8%
Overall	-3.7%

Across all dual-eligible segments, Wakely finds an average reduction in risk scores of 6.4% under the proposed model, though the impact varies widely by plan – by about 165% between the minimum and maximum change in risk scores. A report from Milliman examining the impact of the risk model changes also finds that plans serving dual-eligibles would see significantly larger payment cuts than general MA plans, with 20% of D-SNPs seeing reductions of more than 11% on average.[30]

[30] Milliman. "High-level impacts of the proposed CMS-HCC risk score model on Medicare Advantage payments for 2024." February 2023. Accessed at: https://www.milliman.com/en/insight/analysis-of-2024-CMS-proposed-HCC-Model.

The disparate impacts on both full and partial duals are extremely troubling.

- In 2017, CMS instituted major changes to the Part C risk model with the specific goal of increasing payment for full-benefit dual eligible enrollees.[31] CMS' justification for those changes was that the existing model underpaid plans that enrolled full-benefit dual-eligibles. It is deeply concerning that CMS is now proposing to undo the impact of those changes, putting the benefits and services aimed at helping dual-eligible enrollees achieve better health and outcomes at risk.
- Partial-benefit dual eligibles are most dependent on the low (often $0) premiums and supplemental benefits MA plans provide. Reducing payment for these enrollees will likely lead to reduced benefits, higher premiums, or both.

The proposed risk model changes would also impact some geographic regions more than others. Wakely's analysis shows disparate impacts across geographic regions. Plans serving enrollees in the South would see much higher cuts, 5% on average, than plans serving other geographic regions.[32] Milliman's analysis finds C-SNPs in some states would see cuts of more than 24% and general enrollment plans would see cuts of more than 12% in certain states.[33] The impact of the risk model changes would be especially acute for Puerto Rico, where the cuts resulting from the proposed risk model would exacerbate existing inadequate payment benchmarks. Wakely's analysis shows the proposed risk model would lead to average reductions of 11% for plans serving Puerto Rico.

We also note that clinicians have raised concerns about the impact of removing conditions known to be associated with higher costs of care. For example, physician groups that serve millions of Medicare patients have estimated revenue cuts ranging from more than 10 percent to 20 percent and worry they may be forced to close inner-city and rural clinics, many of which provide care for vulnerable MA populations with high levels of chronic diseases mentioned earlier.[34] Milliman's analysis shows that SNPs focused on caring for enrollees with serious

[31] See CMS. "Advance Notice of Methodological Changes for Calendar Year (CY) 2017 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2017 Call Letter." February 19, 2016. Accessed at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents-Items/2017Advance
[32] Wakely Consulting Group. "2024 Medicare Advantage Rate Notice." March 2023. Available at: https://www.ahip.org/resources/impact-of-2024-medicare-advantage-advance-rate-notice.
[33] Milliman. "High-level impacts of the proposed CMS-HCC risk score model on Medicare Advantage payments for 2024." February 2023. Accessed at: https://www.milliman.com/en/insight/analysis-of-2024-CMS-proposed-HCC-Model.
[34] See "APG Statement on 2024 Medicare Advantage and Part D Advance Notice" February 8, 2023. Accessed at: https://www.apg.org/news/apg-statement-on-2024-medicare-advantage-and-part-d-advance-notice/.

chronic illnesses (C-SNPs) would see average cuts of more than 11% as a result of the risk model changes.[35]

The absence of any attempt by CMS in the Advance Notice to model these impacts or address the policy implications suggests that the proposal has not been sufficiently considered by CMS to allow it to be finalized for 2024. Before moving forward with the model, CMS should identify for public input the potential disparate impacts of the model changes with respect to specific diseases and populations such as those dually eligible for Medicare and Medicaid. CMS should also identify potential alternatives that could minimize such disparate impacts.

Impact on Value-Based Payment

Another significant concern with CMS' proposed introduction of the model for 2024 is the impact on providers engaged in value-based payment models with MA plans. CMS has made the move to value-based payment a priority for the Medicare program and across the health care system. MA plans are at the forefront of the movement toward advanced payment models, which often involve shared risk between plans and providers for the patient's care, outcomes, and costs.[36] Many contracts between plans and their provider partners are based on the existing risk model. These contracts will need to be revised to ensure shared risk reflects the new model, a process that will take some time as plans and providers assess the new model fully and determine appropriate payment and risk arrangements.

Moreover, coding education and systems for 2023 are already in place. By the time of the final Rate Notice (April 3), one quarter of the year will be past, leaving limited time for providers to adopt new protocols or new shared risk arrangements.

Recommendation: For these reasons, AHIP strongly recommends CMS retain the existing risk adjustment model and not move forward with the proposed new model. If the agency desires to move forward with the proposal or other significant risk model change for future years, CMS should provide more information about the impact of the changes on model performance and on beneficiaries with disease and conditions associated with higher costs; identify potential alternative approaches; and afford stakeholders sufficient time (at least 60 days) to evaluate the proposed changes, provide meaningful feedback, and incorporate model changes into value-based payment and shared risk agreements. Further, when the Agency does move forward with a change to the risk model consistent with the transparent, collaborative process and timeline we

[35] Milliman. "High-level impacts of the proposed CMS-HCC risk score model on Medicare Advantage payments for 2024." February 2023. Accessed at: https://www.milliman.com/en/insight/analysis-of-2024-CMS-proposed-HCC-Model.
[36] Health Care Payment Learning and Action Network. APM Measurement: Progress of alternative payment models. November 2022. Accessed at: http://hcp-lan.org/workproducts/apm-methodology-2022.pdf.

have described, the changes should be phased in to ensure stability for plans, providers, and the enrollees who depend on them for care.

Section H. ESRD Risk Adjustment Models for CY 2024

CMS proposes to use the same ESRD risk adjustment model for 2024 that was used for 2023, when CMS introduced several changes to the model, including implementing an updated clinical version of the ESRD model, updating the data years used for model calibration, and accounting for differences in cost patterns for dual-eligible enrollees by creating separate model segments for the single functioning graft community model based on an enrollee's disabled status and eligibility for full or partial Medicaid benefits.

Recommendation: AHIP supports the continued use of the current ESRD risk model for 2024. At the same time, we continue to believe the ESRD risk model does not appropriately reflect the higher costs MA plans face in providing care and coverage for ESRD enrollees. The changes to the ESRD risk model adopted for 2023 further reduced payments for these enrollees, exacerbated the payment shortfall discussed earlier in this letter. For future years we urge CMS to consider changes to ESRD payment through the ESRD risk model to ensure MA payments are adequate to ensure access to care. For example, the ESRD risk model should take the impact of MA's MOOP limits into account. In implementing any future changes to the ESRD risk model we strongly urge CMS to engage stakeholders in the process and provide at least 60 days for comment on any proposed changes.

Section I. Frailty Adjustment for PACE Organizations and FIDE SNPs

CMS proposes to update the frailty factors that are applied to Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) to reflect higher expenditures of beneficiary with functional impairments that are unexplained by the risk model. CMS states that the update is necessary whenever the risk adjustment model changes. CMS notes in the Economic Impact section of the Notice that updating the frailty factors will result in an average reduction in frailty scores of 15.68%, reflecting a cut of $50 million in payments to FIDE SNPs.

Recommendation: AHIP is concerned that the sharp reduction in frailty scores for plans serving disadvantaged and vulnerable populations will lead to fewer resources available for the additional care coordination, support programs, and supplemental benefits designed to keep these enrollees able to live and function in the community. This impact on frailty scores reinforces our concerns about the proposed changes to the risk adjustment model noted above. Accordingly, we renew our recommendation that CMS not move forward with the proposed risk adjustment model with its associated frailty factor score changes. When CMS does choose to move forward with proposing risk model changes that impact frailty factors, we ask CMS to provide detailed information about how and why the changes in the proposed model impact the frailty factors and

to phase in new frailty scores that would reduce payments to ensure enrollees in these FIDE SNPs plans are not affected by large changes in benefits.

Section J. Medicare Advantage Coding Pattern Adjustment

The Advance Notice announces that for CY 2024 CMS is proposing to apply the statutory minimum MA coding adjustment factor of 5.90%. The coding adjustment factor is applied to all the risk score for all MA enrollees to reflect differences in the likelihood that any individual diagnosis is reported in MA relative to original Medicare.

Recommendation: AHIP supports the agency's decision to maintain and not exceed the statutory minimum adjustment.

Section K. Normalization Factors

K1. Normalization for the Part C CMS-HCC Models

The CMS risk model is designed to generate an average risk score of 1.0 for FFS beneficiaries for a given data year. However, each year, the average risk score changes due to trends in the health of the Medicare population and differences in how diseases are coded. Accordingly, CMS applies a "normalization" factor to risk scores so that the average expected risk score in the payment year will also be 1.0. CMS divides each MA plan's average risk score by this normalization factor to calculate the final risk score, which determines plan payments. Thus, the higher the normalization factor, the lower the risk score – and the lower the payments to the MA plan.

The normalization factor CMS will use in determining 2024 risk scores will depend on which risk model is used. In the Advance Notice, CMS discusses various scenarios for different risk models. All scenarios must address the ongoing impact of COVID-19 on risk score trends.

If CMS were to use the proposed Part C CMS-HCC model for 2024, the agency proposes to also apply a normalization factor of 1.015. This factor is based on a denominator year of 2020, and use of three additional years (2018 – 2020 and 2022) to calculate the trend in FFS risk scores. CMS proposes to exclude 2021 from the calculation because it believes 2021 risk scores (based on 2020 diagnoses) were lower than expected and would result in a projection of 2024 FFS risk scores that underestimates what the 2024 FFS risk scores are likely to be. CMS also notes that if it were to continue using the current Part C risk model, which has a 2015 denominator year, it would propose to exclude both 2021 and 2022 risk scores in calculating the trend, relying instead on 2016 – 2020 risk scores, because use of 2021 and 2022 risk scores predict a 2024 risk score that is below the actual 2022 risk score.

Analyses of risk score trends and normalization factors show that CMS' proposal to exclude 2021 risk scores from the 2024 calculation results in a significantly higher normalization factor than would result if 2021 were included, and therefore significantly lower risk adjustment payments to MA plans. Using information provided in the Advance Notice, Wakely estimates that calculating a normalization factor for 2024 for the proposed Part C risk model including 2021 risk scores would result in a factor of 1.004 as opposed to the 1.015 normalization factor CMS is proposing.[37] CMS' proposal would result in further reductions to Part C risk scores and resulting payments, despite CMS' own data showing continued lower risk scores in FFS.

AHIP has several concerns with CMS' proposal to exclude 2021 risk scores (based on 2020 diagnoses) entirely for purposes of calculating the 2024 normalization factor:

- CMS uses 2020 experience in the calculation of the AGA factors and MA benchmark rates. Given the varying impact of COVID-19 across states and regions, it seems inconsistent to ignore 2020 experience in normalization while using for benchmark calculations.
- As mentioned earlier, the new risk model uses 2020 as a denominator year. While this is based on 2019 diagnoses, it used expenditures in a year that was significantly impacted by COVID-19. If CMS believes 2020 experience is valid as a denominator year for the proposed model, it is unclear how or why CMS would not use 2021 risk scores, which are based on that 2020 experience.
- The normalization factors CMS is now proposing reflect a period of higher trend prior to 2020 and lower trend for 2020-2022, even when 2021 is ignored. By continuing to ignore more recent years, CMS is deviating from its longstanding methodology for calculating normalization factors based on actual FFS experience.

Recommendation: AHIP understands that COVID-19 presents unique challenges for purposes of making valid estimates and projections of costs, utilization, and risk scores. At the same time, we are concerned that CMS is being inconsistent in how it chooses to modify its methods and calculations to reflect data impacted by COVID-19. If CMS determines that 2020 cost and utilization experience is appropriate for purposes of calculating USPCCs and establishing the baseline FFS spending, then 2020 experience and resulting 2021 risk scores should be used in calculating normalization factors. If CMS moves forward with excluding the 2021 risk scores, we recommend CMS weight 2022 risk scores more heavily in the trend calculation to reflect the reality that risk score experience prior to COVID-19 may no longer be applicable.

[37] Wakely Consulting Group. "2024 Medicare Advantage Advance Notice: Summary and Analysis." March 2023. Available at: https://www.ahip.org/resources/impact-of-2024-medicare-advantage-advance-rate-notice.

K3. Normalization for the CMS-HCC ESRD Models

As with the CMS-HCC risk adjustment model, CMS is proposing to also use 2018 – 2022 risk scores, excluding 2021, in the calculation of normalization factors for the CMS-HCC ESRD dialysis model and the CMS-HCC ESRD functioning graft model for 2023.

Recommendation: AHIP has the same questions and concerns with CMS' proposal to disregard 2021 risk scores in calculating normalization factors for the ESRD models as we have with the Part C model. We urge CMS to be consistent in how experience from years affected by COVID-19 is used in setting MA payment rates, and to recognize that trends from years before the onset of COVID-19 may no longer reflect expected experience going forward.

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

For 2024 CMS proposes no changes to the Part D risk adjustment (RxHCC) model. CMS states an intent to revise the RxHCC model for 2025 to reflect changes to the Part D benefit implemented as part of the Inflation Reduction Act.

AHIP is pleased that CMS intends to revise the RxHCC model for 2025, a step we consider essential to appropriately reflecting relative risks of Part D enrollees. We note that a number of benefit changes impacting plans' risk-based costs will be in effect in 2024; the fact that CMS has not updated the RxHCC for 2024 will mean plans serving higher cost Part D enrollees will not receive risk adjusted payments that do not accurately or fully capture higher expected costs.

Recommendation: We are disappointed that CMS has not made any changes to the RxHCC model for 2024 in recognition of the multiple significant changes to beneficiary cost sharing that will impact plans costs. To promote greater stability for enrollees, especially those eligible for the low-income subsidy and may be auto enrolled in qualifying plans, we recommend CMS provide plans with additional flexibility to adjust margins during the rebate reallocation process.

For 2025, we urge CMS to provide plans and other stakeholders with information about changes to the RxHCC model well in advance of the 2025 bid cycle. The Part D benefit is undergoing multiple significant changes that impact plan costs. In addition, new requirements for direct and indirect remuneration, enrollee out-of-pocket cost smoothing, and cost sharing limits for drugs effected by inflation rebates will require plans to rethink existing expectations around utilization and costs across the Part D population. It is essential that plans have as much information as possible about the risk adjustment model to inform cost estimates and bids for 2025 and beyond.

Attachment IV. Updates for Part C and D Star Ratings

Reminders for 2024 Star Ratings

In the Advance Notice, CMS reminds plans that beginning with 2024 Star Ratings, CMS will use the "Tukey" method to remove outliers from non-Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure scores for purposes of determining cut points, as initially specified in the CY 2021 MA and Part D rule.[38]

As we have indicated in previous comment letters, we do not support the Tukey outlier deletion policy and do not agree with CMS' position that the addition of this methodology to Star Ratings would increase cut point predictability and stability in a meaningful way. Moreover, a recent analysis from Wakely has found that the addition of the Tukey outlier deletion methodology along with another Star Ratings proposed change would "have a significant negative impact on Overall Star Ratings and corresponding Quality Bonus Payments."[39] We also encourage CMS to consider comments that AHIP members have submitted in response to the CY 2024 MA and Part D proposed rule on other reasons for delaying the Tukey outlier deletion policy.

We continue to believe that the use of pre-determined cut points is the most effective way to improve predictability, stability and methodological transparency in the Star Ratings program and that CMS should reinstate this policy.[40] Such predictability and stability allow plans and their network providers to better understand the goals for each Star Ratings measure. Pre-determined cut points also promote several critical CMS policy objectives:

- Setting cut points for Star Ratings measures well in advance of the measurement period would enable MA plans and their network providers to better manage their quality improvement efforts. Under the Institute for Healthcare Improvement's (IHI) Model for Improvement, a widely accepted framework for quality improvement programs,[41,42] the setting of quality aims and identifying measurement targets is the model's fundamental

[38] 85 FR 33796, June 2, 2020.
[39] Wakely Consulting Group. Proposed Changes to the Medicare Star Rating Program in the 2024 Contract Year Policy and Technical Rule. December 2022. Accessed at: https://www.wakely.com/sites/default/files/files/content/summary-2024-medicare-proposed-rule-star-rating-changesformatted0.pdf
[40] Since 2011 and up through 2016 Star Ratings, CMS used pre-determined cut points for qualifying measures. CMS eliminated its pre-determined cut point policy starting with 2016 Star Ratings as indicated in the 2015 MA Rate Notice.
[41] Institute for Healthcare Improvement, "Science of Improvement: How to Improve." Accessed at: https://www.ihi.org/resources/Pages/HowtoImprove/default.aspx.
[42] Langley, G., Moen, et. al. "The Improvement Guide: A Practical Approach to Enhancing Organizational Performance." 2nd Edition. April 2009.

starting point. CMS should be aligning the MA program's quality improvement strategy with these well-established quality frameworks, consistent with its broader goal of aligning quality measurement across federal programs and private payers.

- Pre-determined cut points could identify "stretch goals" that align with IHI's quality aims best practices to incentivize plans to identify and direct care toward populations experiencing health disparities that require individualized quality improvement solutions. Establishing pre-determined cut points for measures linked to clinical disparities can help plans set goals to aim quality improvement efforts toward populations with unique needs.
- Use of pre-determined cut points also empowers consumer choice as consumers are increasingly relying on categorical ratings and scores to inform their decisions. Consumers expect consistency in categorical evaluation and fluctuations in cut points create inconsistency in what Star Rating assignments mean over time. As measure thresholds change, plan performance may not accurately reflect whether the plan's performance has increased or decreased year over year. Pre-determined cut points could help clearly and meaningfully communicate the value of each available MA plan to the beneficiary. For example, a beneficiary with diabetes may be most interested in choosing a plan with high Star Ratings on diabetes care measures.

We therefore believe establishment of pre-determined thresholds is the best means to ensure transparency, predictability, stability, and quality improvement.

Recommendation: We continue to urge CMS to withdraw its Tukey outlier deletion policy and return to the use of predetermined cut points in advance of the measurement period.

Measure Updates for 2024 Star Ratings

We appreciate the Advance Notice providing the complete set of measures and updates for 2024 Star Ratings. However, it would be helpful if future Advance Notices also provide the measure sets for the following year. This would greatly assist plans with their efforts to review and provide meaningful comments in response to potential future Star Ratings changes discussed in the Advance Notice. Plans need to evaluate the complete measure sets against the addition of potential new measures collectively to comprehensively assess impacts on quality improvement, reporting and burdens on providers, plans, and other stakeholders.

In addition, we request that CMS consider reinstating annual user group calls that CMS held previously on Star Ratings.[43] MA plans found these calls to be extremely informative. During annual user group calls, CMS can share critical information about key program requirements and changes, including explaining and clarifying key changes. The calls also allow plans to ask questions about the impact of the changes on specific methodologies and policies. Such

[43] For example, CMS held a plan user group call in August 2017 to discuss changes for 2018 Star Ratings.

opportunities can also minimize the number of questions that CMS may receive at later points such as during the Star Ratings preview periods.

Recommendation: We appreciate the inclusion of the complete measure set for 2024 Star Ratings in the Advance Notice as we had recommended. For future Advance Notices, we further recommend CMS include the measures sets for both the upcoming Star Ratings year and the following year. Additionally, we ask CMS to hold annual user group calls with plans to discuss key changes for the upcoming Star Ratings year.

Changes to Existing Star Ratings Measures for the 2023 Measurement Year and Beyond

Universal Foundation – Alignment Concept

In the Advance Notice, CMS indicates its plans to incorporate a "Universal Foundation" of quality measures (a core set of measures) in CMS' quality rating and value-based care programs, including MA Star Ratings. CMS explains that this alignment of measures across programs would enable measurement of quality "across the entire care continuum in a way that promotes the best, safest, and most equitable care for all individuals."[44]

CMS also provides information on the preliminary set of core measures that would include existing Star Ratings measures (certain HEDIS and CAHPS measures) as well as potential new HEDIS measures such as screenings for depression and social drivers of health (SDOH) along with required plan interventions.

AHIP strongly supports CMS' goal to align certain measures across CMS' quality rating and value-based programs. AHIP and the industry have partnered with CMS, as well as primary and specialty societies, consumer and employer groups, and quality collaboratives, through the Core Quality Measures Collaborative (CQMC) to align performance measures used to assess clinician quality across public and private payers to improve care and reduce burden.[45] As a first step to alignment, the CQMC created parsimonious core sets of measures for 10 clinical areas known to have high costs, variations in quality, and misaligned measures. The CQMC also recognizes the value in aligning health plan and clinician measurement to improve quality across the healthcare system. The CQMC has looked to programs like the MA Star Ratings, the Qualified Health Plan (QHP) Quality Rating System (QRS), and the Adult and Child Medicaid Core Sets to inform its core sets of clinician measures. In its second phase, the CQMC is compiling best practices on how to align beyond the measures to the full measurement model including collecting, reporting, calculating, exchanging, and displaying data. This broad-based, multi-stakeholder, public-private collaborative will continue to drive progress toward consensus-based voluntary standards that will advance quality outcomes nationwide. Thus, we appreciate that CMS largely aligned the

[44] Advance Rate Notice for CY 2024, page 103.
[45] See https://www.qualityforum.org/cqmc/.

Universal Foundation with the work already done by the CQMC, and further hope that CMS will continue to look to this group for maintenance guidance.

Universal Foundation – Specific Measures for the Core Set

Social Connection Screening and Intervention (Part C)

In the Advance Notice, CMS indicates it plans to consider including a new SDOH measure being developed by the National Committee for Quality Assurance (NCQA) in the core set of measures. CMS explains that the potential new SDOH measure would assess the percentage of members aged 65 or older who were screened using pre-specified instruments at least once during the measurement period for social isolation, loneliness, or inadequate social support and received a corresponding intervention if they screened positive. This measure would be reported using electronic clinical data and administrative claims. CMS further notes that NCQA is considering stratifying the measure by age and race/ethnicity.

In the Advance Notice CMS solicits feedback on the new NCQA measure and a CMS-developed measure focused on SDOH for potential use in Star Ratings. We appreciate that CMS recognized that an aligned but not uniform approach is warranted in this case. While CMS has been adopting its measure as part of its various FFS programs, applying the CMS measure to plans would duplicate the same measure concept as NCQA's existing measure, but create different reporting requirements and result in potentially incongruent results. Thus, AHIP supports CMS considering a somewhat different, yet aligned approach for MA plans.

There are important challenges that we also believe would need to be fully addressed prior to adoption of the new NCQA SDOH measure for the Star Ratings program. For example, health insurance providers have had difficulty collecting the data from providers on screenings that are required to meet the first indicator under this new SDOH measure. Specifically, the measure relies on the inclusion of LOINC codes to demonstrate that an approved screening tool was used, but this information is generally included, if at all, in the electronic health record (EHR) and not in claims data. Thus, plans do not have an automated way in which to collect this information from providers to satisfy the measure. We have requested that NCQA alter the measure specifications to accept ICD-10 Z codes that can be transmitted on the claim to reflect the current state of provider and plan systems until greater interoperability is achieved.

However, even if Z codes are accepted, there remain gaps in these existing interoperable codes to appropriately document the different needs associated with social isolation, loneliness, and inadequate social support. NCQA acknowledges that there are important and distinct nuances in the definitions across these social needs and thus each deserves its own appropriate code to ensure accurate documentation. For example, there are currently only ICD-10 Z codes for "problems related to living alone," "social exclusion and rejection," "other problems related to

social environment," and "other specified problems related to primary support group." There are no Z codes to appropriately document "loneliness." AHIP submitted a letter in May 2022 to the ICD Committee to support the Gravity Project's recommendations to include additional codes to fill in these gaps by adding an inclusion term for "loneliness" under R45.89 (Other symptoms and signs involving emotional state) and "lack of emotional support" under Z60.8 (Other problems related to social environment) to fill in gaps in missing concepts that are different from "social isolation." These recommendations have not been approved yet by the ICD Committee.

Given all of the difficulties with properly documenting and sharing social needs data, we believe CMS should delay adoption of such a measure until not only appropriate codes exist to accurately and sufficiently document the different social needs but also can be shared in an interoperable way between providers and plans.

Other Measures for the Core Set

In a recent article[46], CMS officials noted their intention that the Universal Foundation of quality measures "will eventually include selected measures for assessing quality along a person's care journey — from infancy to adulthood — and for important care events, such as pregnancy and end-of-life care."[47] CMS officials also noted that their efforts for identifying preliminary measures for the Universal Foundation of quality measures includes adult and pediatric measures.[48] CMS should ensure that measures for the adult core set take into account the Medicare population. We also recommend that CMS review our comments below on other measures that CMS is contemplating for the core set of measures (e.g., adult immunization status and initiation and engagement of substance use disorder treatment).

<u>Data Collection and Other Challenges That Impact Plan Performance on SDOH and Other Measures</u>

As noted in our comments in response to the MA and Part D proposed rule for 2024,[49] improvements are needed in enrollee data collection and alignment of data collection standards across programs so that MA plans can identify individuals and populations facing health disparities and subsequently initiate activities and strategies, including through quality measurement, to reduce such disparities. To address these issues, we reiterate the following recommendations:

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[46] Jacobs, D., M.D., M.P.H., Schreiber, M., M.D., Seshamani, M., M.D., Ph. D., et. al., "Aligning Quality Measures across CMS — The Universal Foundation." *New England Journal of Medicine*. DOI: 10.1056/NEJMp2215539. February 1, 2023.
[47] Id.
[48] Id.
[49] See https://www.ahip.org/documents/AHIP_Comments_CY2024-MA-Proposed-Rule-2.13.23.pdf.

- Improve data collection. Data collection through enrollment forms continues to be a critical part of efforts to address health equity and SDOH. CMS should propose further changes to the Medicare FFS and MA enrollment forms to enable collection of more sociodemographic information directly from enrollees. AHIP and our members also welcome the opportunity to work with CMS to educate Medicare enrollees about the value of self-reported sociodemographic data for improving quality of care.
- Support broader data collection through a phased approach. Sociodemographic data collected and reported by health plans, hospitals, clinicians, and other providers are critical in informing care, improving the quality of care, and in identifying and reducing health disparities. CMS should support incremental steps to facilitate broader data collection and reporting by stakeholders on a wider set of sociodemographic data. Plans, hospitals, clinicians, and other organizations will need to design, align, implement, test, evaluate, and revise data collection and application workflows. Accordingly, CMS should focus initially on a small number of social needs and/or demographic data elements with interoperable codes, and then add additional data elements in subsequent years in a phased approach.
- Support alignment of data standards. A major challenge to equity efforts and related quality measurement are that health insurance providers, hospitals, and clinicians are following various federal and state data collection requirements on demographics and social needs. Varying data collection standards hinder efforts to aggregate, analyze, and enable apples-to-apples comparisons across markets and across health care entities and the ability to measure improvement. Having interoperable patient demographic data would allow the health care ecosystem to collect this data when most appropriate and convenient for patients and share the information with other partners with patients' consent to inform their care and population health management efforts, as well as to more effectively address disparities in access to care and outcomes. To promote interoperability across different standards and codes, AHIP's Health Equity Workgroup (composed of varied stakeholders and perspectives) mapped demographic data standards to standardized codes (e.g., LOINC, SNOMED, ICD-10) and developed a data documentation framework that provides guidance on how frequently each question should be asked and how various responses should be coded.[50] We believe CMS should support alignment of demographic data standards at the ecosystem level through federal policy changes to advance health equity and support quality measurement efforts.

In addition, as noted in our comments in response to the 2024 MA and Part D proposed rule[51], we are concerned about the impact on plan performance in Star Ratings if D-SNP only contracts

[50] AHIP letter, "Improving Demographic Data Standards to Advance Health Equity," October 2022. Available online at: https://www.ahip.org/documents/AHIP-Letter-on-Demographic-Data-Standards-with-Appendix.pdf.
[51] See https://www.ahip.org/documents/AHIP_Comments_CY2024-MA-Proposed-Rule-2.13.23.pdf.

are compared to non-D-SNP contracts and welcome the opportunity to engage with CMS on these concerns.

Recommendation: AHIP strongly supports CMS' goal to align certain measures across CMS' quality rating and value-based programs. Our efforts through the CQMC have demonstrated that alignment of measures across federal quality programs is an effective way to reduce burdens on providers, improve efficiencies, and help plans and providers focus on high-priority areas to improve care and health outcomes. We encourage CMS to look to the CQMC to guide its work to define and track progress on core clinical measures that target high-priority health conditions and services. We also recommend CMS establish a forum and bring AHIP and other stakeholders together to address questions about how the Universal Foundation will work within the current Star Ratings regulatory framework, including comment opportunities and timelines for adoption of new measures. We also recommend that CMS discuss and develop with plan input guiding principles for the "Universal Foundation" initiative. Additionally, we recommend that CMS ensure that measures for the adult core set consider the Medicare population.

We also recommend CMS delay adoption of the new SDOH measure for the Star Ratings system until the documenting, coding, and other issues raised by AHIP and our member plans are addressed. We appreciate CMS' reminder in the Advance Notice that potential new measures for Star Ratings, including the SDOH measure, would have to be proposed through rulemaking.

Finally, we urge CMS to consider and assess the challenges raised by AHIP and our member plans on data collection and the need for alignment of data standards. Improvements to data collection and alignment of data collection standards across programs must occur for plans to identify individuals and populations facing health disparities and subsequently initiate activities and strategies including through quality measurement to reduce such disparities.

Diabetes Care – Eye Exam and Diabetes Care – Blood Sugar Controlled (Part C)

In the Advance Notice, CMS indicates that NCQA is evaluating potential specification updates and whether to remove the hybrid reporting method for these diabetes measures for measurement year 2024 and beyond. While we recognize that NCQA will make this determination, we continue to raise concerns about limiting data collection to electronic clinical data systems (ECDS) reporting for these and other Star Ratings measures. We have concerns with the pace at which NCQA proposes to implement ECDS measures as plans are experiencing significant implementation challenges outside of their control. The rapid transition to ECDS measures puts a disproportionate burden on providers practicing in rural areas or in smaller groups. While large systems may have the infrastructure in place to transition to ECDS measures, smaller providers may not have the resources to implement such a large change at such a rapid pace. Given that interoperability between plan and provider systems is still progressing, moving to exclusive ECDS reporting would risk missing key data, especially from individual providers and small

group practices with minimal or no EHR use. Additionally, we do not agree with CMS that this change would be non-substantive because it could have a significant impact on the numerator or the denominator and subsequently a plan's performance results.

Recommendation: AHIP does not support removing the hybrid reporting method for the diabetes and other measures in Star Ratings. We also believe that this change should be considered substantive under the Star Ratings rules. We further recommend CMS work with NCQA to ensure public release of ECDS data, benchmarks, and national performance of ECDS-reported measures for a minimum of two years in advance of changing the reporting methods for the Star Ratings.

Medication Adherence for Diabetes Medication/Medication Adherence for Hypertension (RAS Antagonists)/ Medication Adherence for Cholesterol (Statins) (Part D)

In the Advance Notice, CMS describes its plans to implement risk adjustment for the three Part D medication adherence measures based on sociodemographic status (SDS) characteristics for 2028 Star Ratings. CMS also proposes to implement other changes to these measures, including removing the adjustment for stays in inpatient (IP)/skilled nursing facilities (SNF), starting with the 2026 measurement year (2028 Star Ratings).

Recommendation: We ask CMS to consider feedback and recommendations that we included in our comment letter in response to the MA and Part D proposed rule for 2024 on the proposed changes to the medication adherence measures.[52] To prepare for the application of SDS risk adjustment for the medication adherence measures, AHIP and our members have recommended CMS provide more details on the risk adjustment methodology for these measures to allow for additional assessment and input. We also recommended that CMS provide plans with more details on its analysis related to the removal of the IP/SNF stay adjustment prior to finalizing this proposed change.

MTM Program Completion Rate for Comprehensive Medication Review (CMR) (Part D)

In the Advance Notice, CMS describes its process to identify and exclude enrollees in hospice from the denominator for the measure.

Recommendation: We ask CMS to consider our concerns and related recommendations about the impact of the proposed changes to the Part D MTM program requirements on this related Star Ratings measure, as explained in our comment letter in response to the MA and Part D proposed rule for 2024.[53] CMS' proposed changes to the MTM program requirements involve multiple changes to the enrollee targeting/eligibility criteria. Accordingly, any of the changes that CMS

[52] See https://www.ahip.org/documents/AHIP_Comments_CY2024-MA-Proposed-Rule-2.13.23.pdf.
[53] See https://www.ahip.org/documents/AHIP_Comments_CY2024-MA-Proposed-Rule-2.13.23.pdf.

finalizes related to the MTM program requirements should be considered as substantive changes under the Star Ratings program rules at §423.184. We have recommended that CMS address the impact of these substantive changes to the Part D MTM measure in a future rule for additional stakeholder input prior to finalizing the proposed changes to the MTM program requirements.

Display Measures

Initiation and Engagement of Substance Use Disorder (SUD) Treatment (Part C)

CMS is considering adding this measure to Star Ratings and the Universal Foundation of quality measures through future rulemaking. We have heard concerns about this measure from member plans including potential data collection and other issues. For example, plans have raised concerns regarding federal and state privacy laws that may impact the exchange of information about SUD screening and the ability to encourage follow-up care.

Recommendation: CMS should delay adding this measure to the Star Ratings system until concerns raised by AHIP and our members are addressed.

Timely Follow-up After Acute Exacerbations of Chronic Conditions (Part C)

While we appreciate the value of prompt follow-up care, we do not support adding this new measure to the Star Ratings system at this time. Although claims data may assist MA plans in assessing whether a physician provided timely follow-up care, lags in the submission of claims data can prevent MA plans from proactively taking steps to ensure such care is provided. Further, the current information sharing policies established by CMS and the Office of the National Coordination for Health Information Technology (ONC) do not require providers to share clinical data with health plans. CMS and ONC should implement bidirectional data sharing through the Interoperability and Information Blocking rules prior to the implementation of this measure in Star Ratings so plans have the data they need to support care coordination and improve performance on this measure. Without real-time clinical data, plans will be limited in their ability to intervene and help patients receive timely follow-up care. We are also concerned about the extent to which this measure overlaps with the 2024 Star Ratings measure focused on follow-up after emergency department visit for patients with multiple chronic conditions. CMS should assess this concern with further stakeholder input.

Recommendation: CMS should delay adding this measure to the display page based on the concerns we raised above.

Adult Immunization Status (Part C and D)

CMS plans to add NCQA's Adult Immunization Status measure to the 2026 display page starting with data from the 2024 measurement year. This measure would assess the receipt of influenza, Td/Tdap, zoster, and pneumococcal vaccines. This measure is specified for the HEDIS ECDS reporting standard and would capture receipt of vaccinations using data from a variety of electronic sources including administrative claims, immunization registries, and EHRs.

Recommendation: We continue to hear concerns that health plans face challenges having complete and accurate immunization information for their enrollees given the variety of options enrollees have for receiving immunizations, including options that do not involve the submission of a claim to the health plan or easy access to immunization information. Plans also may have challenges with determining the pneumococcal vaccine history if a patient was vaccinated before they joined the plan. We recommend CMS ensure the data collection challenges are fully addressed and resolved prior to consideration of a comprehensive immunization measure for Star Ratings, including for inclusion in the Universal Foundation of quality measures.

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)

In the Advance Notice, CMS indicates that it has proposed to add these three Part D display measures to the 2026 Star Ratings through the MA and Part D proposed rule for 2024.[54] AHIP has concerns with CMS' proposal to move these three measures from the display page to Star Ratings for 2026.

Recommendation: While we recognize the potential harmful impacts associated with the use of these medication regimens in the Medicare population, we do not support adding these measures to Star Ratings as they may hamper a plan's ability to support appropriate medication use and ensure access to care, as discussed in detail in our comment letter in response to the 2024 MA and Part D proposed rule.[55] We are urging CMS to delay adding these Part D measures to the Star Ratings until the concerns we and our members have raised in response to the proposed rule are fully considered and addressed.

[54] 87 FR 79452, December 27, 2022.
[55] See https://www.ahip.org/documents/AHIP_Comments_CY2024-MA-Proposed-Rule-2.13.23.pdf.

Potential New Measure Concepts and Methodological Enhancements for Future Years

Health Equity (Part C and D)

In the Advance Notice, CMS encourages comments on its health equity index (HEI) proposal that it discussed in the MA and Part D proposed rule for CY 2024.[56]

CMS proposes to use a HEI in the Part C and Part D Star Ratings starting with the 2027 Star Ratings (which would include data from the 2024 and 2025 measurement periods). The HEI adjustment would reward contracts for obtaining high measure-level scores for the subset of their enrollees with specified social risk factors (SRFs). The SRFs included in the HEI would be low-income subsidy or dual eligibility (LIS/DE), or disability. CMS also proposes to eliminate the reward factor after 2026 Star Ratings, contingent on finalizing the addition of the proposed HEI reward.

Recommendation: We ask CMS to review our detailed feedback on the HEI proposal contained in our response to the MA and Part D proposed rule for 2024.[57] As we indicated in our comment letter, we support the goal of the HEI to further incentivize MA plans to focus on improving care for enrollees with SRFs. However, we urge CMS to address questions raised about the HEI, perform additional modeling, and make certain changes prior to finalizing and adding the HEI to Star Ratings.

We also oppose CMS' proposal to pair the HEI with the elimination of the reward factor, which we explained could penalize high-performing plans including those with a disproportionate share of enrollees with SRFs, and adversely impact Medicare enrollees by reducing additional benefits offered by plans or increasing cost sharing. We reiterate our strong recommendation that CMS not adopt its proposal to eliminate the reward factor and have recommended the agency further analyze the potential adverse impacts of its proposal.

Social Connection Screening and Intervention (Part C) (See AHIP comments above under the Universal Foundation - Specific Measures for the Core Set)

Broadening the Mental Health Conditions Assessed by Health Outcomes Survey (HOS), Measuring Access to Mental Health Care on HOS and Addressing Unmet Health-Related Social Needs on HOS (Part C)

In the Advance Rate Notice, CMS requests feedback on possible changes to the HOS, including addition of questions that would cover a broader array of mental health conditions, measure

[56] 87 FR 79452, December 27, 2022.
[57] See https://www.ahip.org/documents/AHIP_Comments_CY2024-MA-Proposed-Rule-2.13.23.pdf.

access to mental health services, and questions focused on enrollees' perceptions of unmet health-related social needs and plans' assessments and interventions.

We have serious concerns with these potential changes. There is significant variability in plan performance year to year on HOS measures and research has identified reliability issues with patient reported outcome measures.[58] Furthermore, performance on the HOS measures is heavily influenced by factors beyond the care received by the patient, and there is limited evidence of the measures' responsiveness to health care interventions.

We are also concerned that with the addition of mental health and social needs related questions, workforce shortages and other factors outside plan control could exacerbate reliability issues that would adversely impact plan performance on HOS measures.

The inclusion of a broad array of mental health related questions in the HOS should also be examined against federal and state behavioral health and information privacy laws. Based on the sensitive information that can be provided as part of the process, it is vital that the privacy and security of individuals' health data be protected. Safeguards required by the Health Information Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act should be in place. Data will be provided by individual plans, the beneficiaries themselves, and then shared with the agency and its contractors. Non-identifiable data released for subsequent uses and disclosures should likewise follow the HIPAA de-identification requirements and processes should be in place (i.e., legal, contractual) to ensure that data are not reidentified. Additionally, there are other factors that could impact the statistical reliability of the HOS including sample size issues that should be examined.

Recommendation: We recommend CMS engage with AHIP and our member plans to examine reliability and other concerns raised above prior to considering the proposed changes to the HOS.

CAHPS (Part C and D)

In the Advance Rate Notice, CMS highlights changes to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey intended to increase response rates, including the addition of a web-based mode for the survey and changes to the survey to explicitly reference telehealth services. CMS indicates these changes would impact the 2024 CAHPS survey used for the 2025 Star Ratings.

While we support the addition of a web-based mode (as an addition to the current mixed mode protocol) for the MA and prescription drug plan (PDP) CAHPS survey, we believe that this

[58] See https://www.rand.org/pubs/research_reports/RR1844.html.

change should be considered substantive under the Star Ratings rules. Differing survey modalities have been shown to produce varying results, even when the same survey questions are asked.[59,60] Additionally, survey modality preferences differ by age groups,[61,62] which may also affect the population responding and, therefore, the survey results. We believe adding a web-based data source for the surveys, especially CAHPS, would likely increase the number of respondents which could have a significant impact on the numerator or the denominator and subsequently a plan's performance results.

We appreciate that CMS continues to work with the Agency for Health Research and Quality (AHRQ) and NCQA to research longer-term solutions to improve the CAHPS survey and response rates. Reducing the length of the survey, increasing sample size, and revising the questions to better reflect the current health care delivery system, including use of telehealth and non-physician clinicians, are potential approaches that could be considered. Additionally, removing questions from surveys addressing circumstances falling outside of a health insurance provider's control or with low reliability and/or validity would make room on the survey for questions that could be used to measure emerging quality issues and address health equity concerns without increasing the burden on respondents. We note and appreciate that CMS is providing a comment opportunity under the Paperwork Reduction Act on the CAHPS survey.[63]

Recommendation: We recommend CMS treat the addition of a web-based mode for the MA and PDP CAHPS survey as a substantive change in accordance with existing Star Ratings rules that cover substantive updates. We also welcome the opportunity to engage with CMS on comprehensive evaluation and field testing of additional improvements to the CAHPS survey.

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[59] Keeter, S. "*Methods Can Matter: Where Web Surveys Produce Different Results than Phone Interviews.*" PewResearch.org. Available online at: https://www.pewresearch.org/fact-tank/2015/05/14/where-web-surveys-produce-different-results-than-phone-interviews/.

[60] Christensen A, Ekholm O, et. al. "Effect of Survey Mode on Response Patterns: Comparison of Face-to-Face and Self-administered Modes in Health Surveys." Eur J Public Health. 2014.

[61] Palonen M, Kaunonen M, Åstedt-Kurki P. "Exploring How to Increase Response Rates to Surveys of Older People." Nurse Res. 2016.

[62] Gigliotti, L. and Dietsch, A. "Does Age Matter? The Influence of Age on Response Rates in a Mixed-Mode Survey." Human Dimensions of Wildlife. 2014.

[63] 88 FR 7976 at pages 7977-7978. February 7, 2023.

March 6, 2023

Lynn Nonnemaker
Vice President, Medicare Policy
America's Health Insurance Plans

RE: CY 2024 ADVANCE NOTICE, ESRD ANALYSIS, AND FFS NORMALIZATION

Dear Lynn:

America's Health Insurance Plans (AHIP) has retained Wakely Consulting Group LLC. (Wakely) to provide a financial impact summary report of the information presented in the February 1, 2023 CY2024 Advance Notice published by the Centers for Medicare and Medicaid Services (CMS). Specifically, we were asked to analyze changes to Medicare Advantage (MA) revenue, risk adjustment models, and FFS normalization.

The attached report contains the results, assumptions, and methods used in our analysis, and satisfies reporting requirements in Actuarial Standards of Practice (ASOP) 41. Reliance on this report is at AHIP's discretion. This information has been prepared for the sole use of the management of AHIP and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. This information is confidential and proprietary.

Sincerely,

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Wakely
An HMA Company

2024 Medicare Advantage Advance Notice

Summary and Analysis

March 6, 2023

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Wakely Consulting Group

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Consulting Actuary

Table of Contents

Executive Summary

On February 1, 2023 the Centers for Medicare & Medicaid Services (CMS) released the contract year (CY) 2024 Advance Notice with an accompanying Fact Sheet.

AHIP has retained Wakely Consulting Group LLC. (Wakely) to provide a financial impact summary report of the information presented in the Notice.

Key highlights of our analysis are:

- The CY2024 fee-for-service (FFS) growth rate is lower than projections from the 2023 Final Announcement. A portion of the downward restatement is driven by a technical change. CMS has not commented on the additional drivers.
- The proposed Part C risk adjustment model is expected to decrease plan risk adjusted payment by 3.7% overall. The impacts vary significantly by model segment and geographic region, and for individual plans.
- The proposed FFS normalization factor excludes PY2021 risk scores in the calculation of the underlying trend. The exclusion of PY2021 increases the FFS normalization factor which decreases PY2024 risk scores.

The sections below provide additional detail and discussion of these issues.

Growth Rate and Expected Average MA Payment Change for 2024

Estimated MA Payment Change for 2023

The CY 2023 FFS growth rate, which is the major driver of Part C benchmark rates, 2.15%. The total (FFS and MA) growth rate is 1.81%. The FFS growth rate is 274 basis points (bps) lower than the final 2023 growth rate.

Table 1 compares these growth rate estimates.

Table 1 – CMS Projected 2024 Growth Rate

Component	2023 Advance Notice	2022 Final Notice
Non-ESRD FFS	2.15%	4.89%
Non-ESRD Total	1.81%	4.75%

CMS published a comparison of its most current non-ESRD FFS cost projections with those in the 2022 Final Announcement. Table 2 below shows the restatement in CMS estimates for selected years.

Table 2 - Restatements in CMS Non-ESRD FFS Cost Projection

Year	Current	Prior	Restatement
2024	$1,101.81	$1,132.07	-2.7%
2023	$1,045.94	$1,078.63	-3.0%
2022	$968.38	$1,023.31	-5.4%
2021	$925.22	$935.10	-1.1%

A significant portion of the 2024 restatement is driven by a proposed technical change which removes costs of indirect medical education (IME) and direct graduate medical education costs (DGME) attributable to MA beneficiaries. CMS states the impact to the 2024 non-ESRD FFS rate is -2.13%. CMS has not provided specifics for the other drivers of the restatements. Given the size of the restatements, specifically for 2022, we believe it will be important for CMS to provide additional explanation. For example, it is likely that the downward restatement to 2022 costs is related to an overestimation of the pent-up demand caused by COVID-19.

Background of the IME and DGME Adjustment

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

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. Details on these carve out factors are explained in Attachment II of the Notice. In the 2023 rates the member weighted average IME cost removal across all counties was 1.7% and the member weighted average DGME cost removal across all counties was 0.5%.

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. On a February 23, 2023 OACT call, CMS explained the data used to calculate the USPCC rates is different than the data used to calculate the FFS county level rates and that the historical county level adjustments have only reflected costs attributable to FFS beneficiaries.

We believe CMS should consider the following points and provide further clarity on this proposed change:

CMS should provide better documentation explaining the differences between the proposed technical adjustment to the USPCCs and the adjustments that have been made historically at the county level. CMS should also provide numerical support to show the IME costs removed from the USPCC amounts published in the Notice.

The FFS growth rate is calculated by taking the current estimate of the 2024 FFS USPCC (2023 Advance Notice) divided by the prior estimate of the 2023 FFS USPCC (2022 Final Rate Announcement). In other words, the 2023 USPCC used in the denominator of the growth rate calculation does not include the technical change correction. If it is a technical adjustment, and not a factor contributing to the trends of the FFS costs, should the adjustment also be made to the prior USPCCs and therefore not impact the growth rate. Is CMS statutorily able to restate "prior" USPCCs? Table 3 displays the growth rates if CMS were to also adjust the prior 2023 USPCC amounts for the IME/GME technical change.

Table 3 – Revised Growth Rate after Applying Proposed IME/GME Technical Change to 2023 USPCC from 2022 Final Rate Announcement

Year	Current w/ Tech Change	Prior w/out Tech Change	Prior w/ Tech Change	Published Growth Rate	Revised Growth Rate
FFS	$1,101.81	$1,078.63	$1,055.66	2.15%	4.37%
Total	$1,158.53	$1,137.92	$1,125.86	1.81%	2.90%

Other Notable Changes to the FFS Rates

Inflation Reduction Act: CMS 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. It is unclear what the magnitude of the increase will be and therefore the impact on USPCCs and growth rate.

Consolidated Appropriations Act: CMS notes that the CY2024 Final 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.

Advanced Alternative Payment Models: The Medicare Access and CHIP Reauthorization Act of 2015 requires payment of an incentive for physicians and other eligible clinicians who become qualifying APM participants (QPs) through sufficient participation in an Advanced Alternative Payment Model (A-APM) for payment years from 2019 through 2024. CMS is proposing to include with the ratebook historical experience of the APM incentive payments disbursed in 2019 through 2021. The APM incentive payments will be added to ratebook FFS experience for the payment year. It is unclear how this adjustment will be incorporated into the rates.

CMS estimates that the nationwide average change in blended standardized (non-risk adjusted) MA Benchmarks from 2023 to 2024 will be 0.85% and the nationwide average change in the blended risk adjusted benchmark will be -2.27%.

Table 4 presents the components of these changes.

Table 4 – Estimated Change in MA Payment – 2023 to 2024

Component	CMS Estimated Annual Change
Effective Growth Rate	2.09%
Rebasing/Re-pricing (AGA)	0.00%
Change in Star Ratings	-1.24%
Total Benchmark Change	**0.85%**
MA Coding Pattern	0.00%
Risk Model Transition (FFS Normalization & Risk Model Change)	-3.12%
Total Risk Score Change	**-3.12%**
Total	**-2.27%**

Below is a brief definition of each of the elements in Table 4.

Effective Growth Rate. This is the combined impact of the FFS growth rate (2.15%), changes to the applicable percentage, and the benchmark cap.

Applicable Percentage

The applicable percentage varies according to a county's quartile ranking. The 2024 county quartiles are determined by the 2023 FFS rates.

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 change year-to-year as plans Star Ratings change, and as the Total growth rate – formally referred to as the National Per Capita Medicare Growth Percentage (NPCMGP) – varies from the FFS trend. The 2024 Total growth rate of 1.81% is lower than the FFS growth rate of 2.15%, which can contribute to a negative year over year impact. (i.e. the cap applies for more contracts than before). The impact of benchmark caps by county vary depending on a contract's Star Rating.

Star Rating/Quality Bonus. This is the difference in quality bonus impact on benchmarks due to star rating changes between 2023 and 2024. We assume that the CMS estimated impact of Star Rating changes includes both changes in the ratings as well as change in enrollment by plan, although CMS does not provide a description of its method in the Fact Sheet. For PY2023 Star ratings, CMS implemented an adjustment for extreme and

uncontrollable circumstances, which took the higher of each plan's raw/unadjusted measure-level rating from 2022 and 2023. That is, there were a number of plans whose Star ratings would have decreased for PY2023, but because of the COVID-19 adjustment they received the same Star rating as PY2022. This adjustment will not apply for PY2024, therefore, Star rating decreases are expected.

Change in Coding Pattern Adjustment. The PY2023 coding pattern adjustment is -5.90%, which is the minimum adjustment required by the Affordable Care Act. This is the same adjustment used in PY2023.

Risk Model Transition. CMS has proposed a new risk score model for Part C. 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%.

The 2023 Part C FFS normalization was 1.127. For 2024, the FFS normalization factor is proposed to be 1.015. The two factors are not comparable since they are based on different denominator years. More on the changes in the FFS normalization and risk model changes are explained below.

In addition to the amounts included in Table 3, CMS also published an expected MA risk score trend of 3.3% in the Fact Sheet[1], making the total expected average change in revenue 1.03%. Table 5 displays the coding trend amounts CMS has included in past year's Fact Sheets. It is unclear how the new risk score model will impact coding trend, particularly because the new model reflects a significant reclassification of HCCs based on diagnoses that plans may not have necessarily submitted in the past.

Table 5 – Historical Coding Trend Presented in CMS Fact Sheet

Advance Notice Year	Expected Annual Coding Trend	Reflected in Total Expected Avg Change in Revenue
2024	3.30%	Included in total
2023	3.50%	included in total
2022	N/A	N/A
2021	3.56%	not included in total
2020	3.30%	not included in total
2019	3.31%	not included in total

[1] https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-advance-notice-fact-sheet

As has been the case in past years, the change in benchmarks can vary significantly depending on geographic area and plan Star Rating.

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, and benchmark cap) as estimated by Wakely.

Table 6 – States with Highest and Lowest Expected Benchmark Change

Rank	State	Benchmark Change	Risk Adjusted Change [1]
1	MI	3.5%	-0.1%
2	UT	3.2%	-0.1%
3	WA	3.2%	-0.1%
4	LA	3.1%	-0.2%
5	NJ	2.7%	-1.0%
46	NE	1.4%	-3.0%
47	CT	1.4%	-3.1%
48	NY	1.2%	-3.2%
49	GA	1.1%	-3.7%
50	NH	1.0%	-3.8%
[1] We assumed a -3.12% total risk score change to every state. Actual impacts due to the proposed risk score changes will vary by plan.			

Table 6 is based on the January 2023 County level enrollment file, fall 2022 Star Rating information and 2024 growth rates published by CMS. Please note the estimated benchmark changes do not include any changes due to repricing or rebasing to the average geographic adjustment factors (AGA). There could be a significant shift in the AGA factors due to the proposed risk adjustment model. More details are provided below.

Part C Risk Adjustment Model for CY 2024 and Analysis of the FFS Normalization Factor

For CY2024 Part C risk adjustment, CMS is proposing a new model for payment year (PY) 2024. The new model follows the same structure as the current 2020 CMS-HCC model, but with the following key changes:

Updated diagnosis data year used to calibrate the model

Updated expenditure year (aka denominator year) to determine predicted expenses and HCC coefficients

Clinical reclassification of the hierarchical condition categories using ICD-10 codes

The regression coefficients are calculated by using 2018 ICD-10 diagnosis codes to predict 2019 expenditures. The denominator year for the proposed model will be updated to 2020 (2019 diagnoses for a 2020 cohort of beneficiaries).

The HCC definitions have been significantly changed, including elimination of categories, introduction of new categories, and the consolidation of multiple categories from the previous model into fewer categories.

An important component of the CMS reclassification is the consideration for conditions that are coded more frequently in MA relative to FFS. In support of this consideration, CMS cites Principle 10 from a December 2000 report[2] articulating core goals a Medicare risk adjustment model should strive to achieve. Principle 10 states that diagnostic categories developed in a risk adjustment model should not be used if susceptible to intentional or unintentional discretionary coding.

It is unclear and CMS did not address how consideration for Principle 10 may interact with the coding pattern intensity factor. When the coding pattern was first introduced in the CY2010 Advance Notice[3], the stated intent was for CMS to make an adjustment to reflect "differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences." We would request that CMS explain whether the clinical modifications intended to minimize HCCs susceptible to discretionary coding overlap with the adjustment inherent in the coding pattern adjustment.

Impact of New Part C Risk Adjustment Model

In the Fact Sheet[4] published alongside the Advance Notice, CMS estimates that the "Risk Model Revision and Normalization" impact from 2023 to 2024 is -3.12%. During a February 23, 2023

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

[3]https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents-Items/2010Announcement

[4] https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-advance-notice-fact-sheet

Office of the Actuary (OACT) user group call, OACT clarified that the impact reflects a combination of the following:

- The change in risk model from 2020 CMS-HCC v24 to 2024 CMS-HCC v28.
- The change in FFS normalization factor.

On the same call, OACT indicated that the estimate was based on payment year 2021 risk scores (with 2020 diagnoses).

Since the intent of the -3.12% impact in the Fact Sheet was to assist the industry in understanding the year over year impact of the Part C risk adjustment model, we believe the v24 and v28 normalization factors used in this estimate were the published 2023 factor of 1.127 and proposed 2024 factor of 1.015, respectively.

To assist plans to independently assess the impact of the new model, CMS released risk scores for PY2021 based on the current model (2020 CMS-HCC v24), the new model (2024 CMS-HCC v28), and a hypothetical model (2024 CMS-HCC v27) that excludes Principle 10-focused clinical updates.

Based on an aggregation of HPMS scores across Wakely clients, we found that the average impact of the proposed risk score model was –3.7%. Please note the impact was calculated using the same methodology as CMS described in the fact sheet. Table 7 shows the impact of the proposed model in overall and by risk model segment.

Table 7 – Wakely Client Average 2024 CMC-HCC Risk Model Impact

Model Segment	v28/v24
Full Dual Benefit Aged	-6.7%
Full Dual Benefit Disabled	-3.6%
Institutional	3.2%
C-SNP New Enrollee	4.3%
New Enrollee	16.0%
Non-Dual Benefit Aged	-4.0%
Non-Dual Benefit Disabled	-4.4%
Partial Dual Benefit Aged	-8.9%
Partial Dual Benefit Disabled	-5.8%
Overall Dual	-6.4%
Overall Non-Dual	-3.9%
Overall New Enrollee	15.9%
All	**-3.7%**

Given CMS estimates the nationwide impact to be -3.1%, it would appear that the plans underlying our analysis are seeing a more negative impact.

In addition to the overall impact, other important results can be observed in Table 7.

- New enrollee scores are dramatically higher in the new model, reflecting an overall diminishing of the contribution of HCCs to risk scores. Note, Wakely client data includes less than 9% of beneficiaries on the new enrollee model.
- Full dual and partial dual aged segments show the biggest decrease in scores compared with the current model. About 26% of all beneficiaries for Wakely clients fall into this bucket. The overall impact to the dual model segments is -6.4%.
- The impact to beneficiaries on the community model (i.e excluding the impact on the new enrollee models) is -4.8%.

There was considerable variation in the impact by plan and by geographic region of the country. Tables 8 displays the percentiles of the overall risk score impact across the organizations. The percentiles were not weighted on enrollment.

Table 8 – Wakely Client Percentile 2024 CMC-HCC Risk Model Impact

Statistic	v28/v24
25th Percentile	-2.0%
50th Percentile	-0.3%
75th Percentile	2.1%
Average	-3.7%

- The variation of impact among the organizations and geographic regions in our data set are drastic. The distribution of the overall risk score impact is heavily weighted towards the left side of the curve. The variance across all organizations is 140% between the minimum and maximum change in risk scores.
- The widest variance is driven by the dual model segments which has an average impact of -6.4% and varies by about 165% between the minimum and maximum change in risk scores.
- The new enrollee model, which has the most positive impact, only varies by about 34% between the minimum and maximum change in risk scores.

Table 9 displays the average impact to overall risk scores by region.

Table 9 – Wakely Client 2024 CMC-HCC Risk Model Impact by Geographic Region

Region	v28/v24
Midwest	-0.5%
Northeast	1.1%
South	-4.9%
West	-4.2%
Puerto Rico	-10.9%

It should be noted that individual plans saw results well outside of these ranges.

An important caveat of the CMS analyses and comparable Wakely analyses in Tables 7 through 9 is that they are all based on PY2021 risk scores based on diagnoses submitted for 2020 dates of service. The COVID-19 pandemic had a dramatic impact on 2021 risk normalization factors, as evidenced by factors published in the Advance Notice (see Table 10 in the FFS Normalization section).

The choice by CMS to use 2021 risk scores to inform plans and the broader industry of the impact of the new risk model is questionable given the anomalous diagnosis and care delivery patterns during 2020. It will be important for plans to test other years of data, and it would have been more helpful if CMS had provided either 2022 or 2020 scores for additional perspective.

The proposed risk score model could also have a significant impact on the Part C benchmark rates. One of the main drivers of the county level benchmark calculation is the AGA factor. A county AGA factor is calculated by taking the five-year average of geographic indices divided by a five-year weighted average risk score. The risk scores are developed using the current payment year methodology (i.e. for PY2024 they use v28 model). A decrease in risk score would increase the AGA factor, and an increase in risk score would decrease the AGA factor. Given there is extreme variability in the proposed risk adjustment model depending on member mix and service area, the AGA factors have potential to change materially.

Frailty Factors for FIDE-SNPs

As described in the Advance Notice, CMS utilizes a frailty adjustment to risk scores to predict Medicare expenditures of community populations with functional impairments that are unexplained by the diagnoses in the CMS-HCC model. Frailty adjustments are applied for the Program for All-Inclusive Care for the Elderly (PACE) and Fully integrated special needs plans (FIDE-SNPs).

Frailty adjustments are directly tied to the underlying HCC model in that they are intended to predict expenditures unexplained by the given HCC model.

For CY2024, CMS is proposing to use the 2017 CMS-HCC model for PACE plans, and as such is proposing no change in the frailty adjustments in place for 2023. However, CMS is proposing to use the new 2024 CMS-HCC model for FIDE-SNPs, which necessitates an update of the frailty factor calculations.

In addition to using a new risk model for FIDE-SNPs, CMS is also proposing to re-calibrate the frailty adjustment factors using updated Consumer Assessment of Health Providers & Systems (CAHPS) survey data. The update will use 2018 CAHPS data versus 2014 data used for CY2023. Table 10 compares the proposed 2024 FIDE-SNP frailty adjustment factors with 2023.

Table 10 – Comparison of FIDE-SNP Frailty Adjustment Factors

CY2024: 2024 CMS-HCC Model - FIDE SNPs			
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
CY2023: 2020 CMS-HCC Model - FIDE SNPs			
ADL	Non-Medicaid	Partial Medicaid	Full Medicaid
0	(0.066)	(0.140)	(0.082)
1-2	0.102	0.000	0.217
3-4	0.227	0.142	0.282
5-6	0.227	0.142	0.282
CY2024 Proposed less CY2023			
ADL	Non-Medicaid	Partial Medicaid	Full Medicaid
0	(0.001)	0.045	0.082
1-2	0.003	0.102	(0.062)
3-4	(0.045)	(0.040)	(0.127)
5-6	(0.045)	0.173	(0.007)

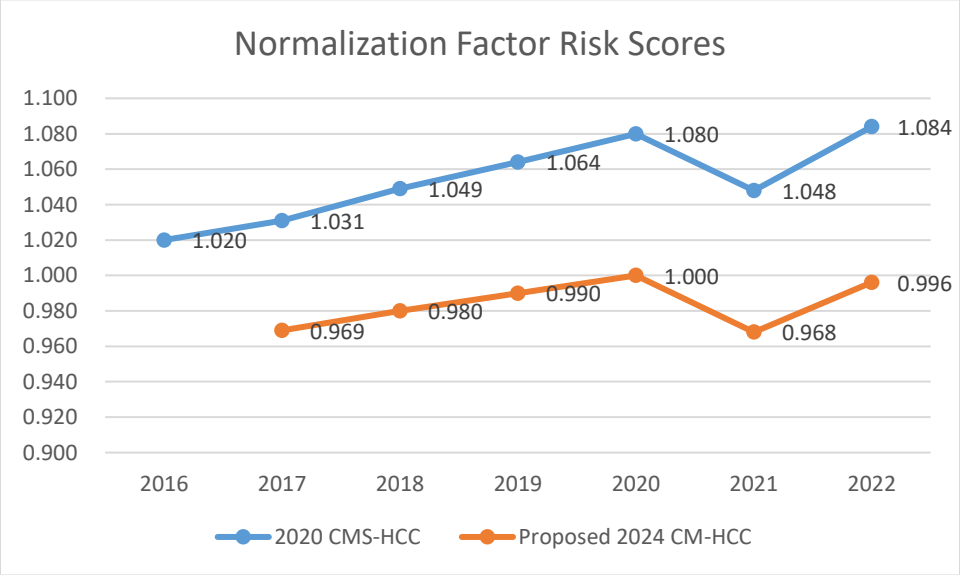
The proposed 2024 frailty adjustments in Table 10 clearly show a significant shift between the factors used for Partial Medicaid beneficiaries (increasing) and Full Medicaid (decreasing). CMS did not provide information on the potential aggregate impact of these changes, but it will be important for FIDE-SNPs to assess risk score impact since the Full Dual segments of the 2024 CMS-HCC model showed the biggest decrease in scores based on the Wakely analysis in Table 7.

Part C FFS Normalization Factor

The proposed new Part C risk adjustment model necessitates a revised FFS normalization factor. CMS is proposing a 2024 FFS normalization factor of 1.015 for the 2024 CMS-HCC v28 model.

Historically, CMS has calculated the FFS normalization factor by fitting a linear regression model to five years of historical Normalization Factor Risk Scores calculated for the given model to be in effect in the contract year. For CY2023, CMS would have normally used factors from 2017 through 2021 to calculate the FFS normalization factor; however, the 2021 score was much lower due to the impact of the COVID-19 pandemic on 2020 diagnoses (which drive 2021 risk adjustment factors), so CMS chose to continue to use a FFS normalization factor based on 2016 through 2020.

In the Advance Notice, CMS published Normalization Factor Risk Scores for the new proposed 2024 CMS-HCC v28 model as well as the current 2020 CMS-HCC v24 model. Both models continue to show a low 2021 factor; however, we also see that the 2022 factor is lower than would have been predicted by factors from 2020 and prior. The chart below shows the pattern of factors.



In determining the CY2024 FFS normalization factor, CMS chose to ignore the 2021 factor, but use the 2022 factor. CMS further states that if the current 2020 CMS-HCC v24 model had continued to be used, the FFS normalization factor would have been 1.146. This implies that CMS would have continued to use the 2016 through 2020 trend to derive the 2024 FFS normalization factor.

Table 11 compares the CMS proposed FFS normalization factor with implied factors if other historical periods were used instead.

Table 11 Normalization Factor Risk Scores and Implied FFS Normalization Factors

Year	Proposed 2024 CMS-HCC	2020 CMS-HCC
2016		1.020
2017	0.969	1.031
2018	0.980	1.049
2019	0.990	1.064
2020	1.000	1.080
2021	0.968	1.048
2022	0.996	1.084
Denominator Year	*2020*	*2015*
Annual Trend		
2016-2020	NA	1.53%
2018-2022	0.10%	0.54%
2018-2022, excluding 2021	0.38%	0.86%
Implied CY2024 FFS Normalization Factors		
2016-2020	NA	1.146
2018-2022	1.004	1.050
2018-2022, excluding 2021	**1.015[1]**	1.080
[1] CMS Proposed 2024 factor for v28		

The table above displays the underlying risk scores used in the normalization factor calculation. The trends CMS is proposing to use, which exclude the 2021 risk scores, are 0.38% for the proposed v28 and 0.86% for the v24 model. If CMS instead included the 2021 risk scores the underlying trends would decrease to 0.10% and 0.54% which lowers the overall FFS normalization factors. By excluding the 2021 risk scores, CMS is effectively dampening expected plan revenue by about 1.1% for the proposed v28 model and 2.9% for the v24 model.

The new risk model and exclusion of the 2021 risk score from the calculation raises several concerns:

2020 costs are used in the calculation of average geographic adjustment (AGA) factors underlying the FFS benchmarks. Given the varying impact of COVID and state government response by different regions of the country, it seems inconsistent to ignore 2020 data for risk scores and use it for AGA factor calculations.

The FFS normalization factors now used by CMS reflects a period of higher trend during 2017 through 2020 and a lower trend for 2022, even if 2021 is ignored. CMS could consider putting increased weight on the more recent data (i.e. 2022) to recognize that the trend experienced prior to the pandemic may no longer be applicable.

The new risk model uses 2020 as a denominator year. While this is based on 2019 diagnoses, it uses expenditures in a year that was significantly impacted by COVID. Utilization patterns, care

delivery, and average costs of services were likely anomalous in 2020 as compared with prior years.

Part D Changes

Part D Risk Adjustment Model

CMS is proposing no change to the 2023 RxHCC model for CY2024. The Inflation Reduction Act mandates two key changes in the 2024 Part D benefit parameters that necessitate an update to the RxHCC model. These are:

Liability in the catastrophic benefit phase increases from 15% to 20% for Medicare Advantage Organizations (MAOs).

MAOs will be required to cover insulins with a copay no greater than $35 for all benefit phases of Part D, including in the deductible phase.

In the Advance Notice, CMS noted that there was insufficient lead time after the IRA became law to develop new model. The lack of an updated RxHCC model will create a disconnect between Part D risk adjustment and the underlying expected plan liabilities for CY2024.

RxHCC FFS Normalization

The CY2024 RxHCC normalization factor is proposed to be 1.063. The CY2023 factor was 1.050. 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 used for CY2023 risk adjustment, which will use a five-year linear slope based on 2016-2020 factors. In proposing this approach, CMS is excluding the available factor from 2021, consistent with the approach taken on the Part C FFS normalization in the CY2023 Advance Notice.

Given the proposal to continue using the 2023 RxHCC model for CY2024, the update in RxHCC normalization factor implies a 1.2% negative impact on 2024 Part D risk scores.

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 the Advisory Committee on Immunization Practices (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 CY2024. If the BBP is calculated to be more than 6% above the CY2023 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.

Part D Benefit Parameters

Consistent with prior years, CMS is proposing updated Part D Defined Standard benefit parameters for CY2024. The proposed changes are as follows:

- $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)