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
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2024 Medicare Advantage Advance Notice

Summary and Analysis

March 6, 2023

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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)

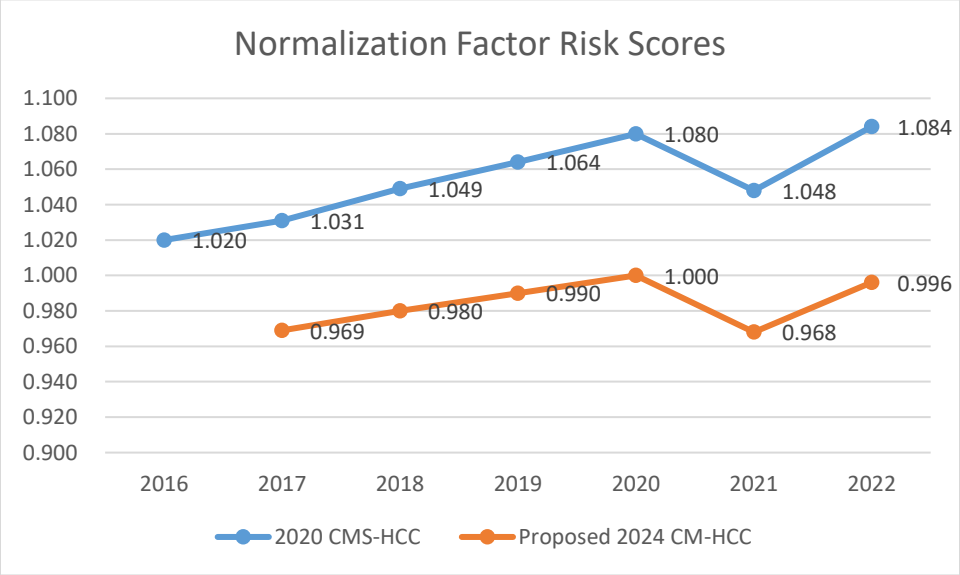
The proposed 2024 frailty adjustments in Table 10 clearly show a significant shift between the factors used for Partial Medicaid beneficiaries (increasing) and Full Medicaid (decreasing). CMS did not provide information on the potential aggregate impact of these changes, but it will be important for 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)