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Summary of Final Rate Notice, Part C, and Part D Bid Review Memo

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

April 17, 2023

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Executive Summary

On March 31, 2023, CMS released the CY2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Final Announcement), which finalizes various proposals from the February 1, 2023, Advance Notice.

The key updates to the Advance notice include changes to the non-ESRD growth rate and 3-year transition of the v28 CMS-HCC model:

- The CY2024 fee-for-service (FFS) growth rate is calculated at 2.45%, which is thirty basis points higher than the proposed rate in the Advance Notice. The increase reflects both restatements of the trend as well as a 3-year phase-in of the IME/DGME adjustment.
- The CY2024 Total FFS USPCC Growth Percentage (Also called the National Per Capital Growth Percentage or NPCMAGP) is finalized at 1.6% (down from the 1.81% in the Advance notice). This percentage drives the pre-ACA benchmark, which caps the calculation of the benchmark. Approximately 57% of the benchmarks are capped for plans that have a star rating of 4 or higher.
- Instead of the full implementation of the proposed 2024 non-PACE CMS-HCC model, CMS is finalizing a 3-year phase in. For 2024, the risk scores will be calculated based on a blend of 67% of the 2020 model and the 33% of the 2024 model.
- The CAHPS survey weight, originally proposed to fully impact the frailty factors for FIDE SNPS, will be transitioned in over 3 years. This has resulted in an overall increase to the frailty factors for FIDE SNPS relative to what was originally proposed.

Part C Growth Rates

The non-ESRD FFS growth rate percentage for CY2024 is 2.45%. The Total UPSCC non-ESRD growth rate percentage is 1.6%. These both reflect over a 200-basis point reduction from the growth rates for 2023. The IME/DGME adjustment was originally estimated to affect the FFS growth rate by -2.13%. With the 3-year phase in, that IME/DGME estimate is now estimated to be (1/3 * -2.58%) or -0.86%.

The FFS Dialysis-only ESRD USPCC growth rate is 2.27% (down from almost 10% last year).

County-specific rates were updated as usual for changes to the average geographic adjustment (AGA) calculations, which Wakely estimates to imply a nationwide average benchmark change of -0.05%. Note that CMS estimates this change to be +0%. The county level charges can be significant, due to the new risk model impacting the FFS benchmarks by county.

Risk Scores and FFS Normalization

The CMS-HCC model used for CY2024 non-PACE non-ESRD will be a 67%/33% blend of the 2020 model and the newly introduced 2024 model, which is calibrated on ICD-10 diagnoses and reflects debated clinically based adjustments aimed at reducing excess payments to MA plans. FFS Normalization factors remain unchanged from the Advance Notice and will be 1.146 and 1.015 for the 2020 and 2024 models, respectively.

The coding pattern adjustment is set at the statutory minimum of 5.90%, which represents no change compared with CY2023.

No changes will be made to the Part C risk models used for payment in CY2024 for ESRD and PACE populations. FFS normalization factors have been updated for an additional year relative to the denominator years used for those models.

CMS is also not changing the 2023 RxHCC non-PACE or the 2020 Rx-HCC PACE model for Part D risk scores. The FFS normalization factors are updated for an additional year of trend and will be 1.063 and 1.084, respectively.

EGWPs

Plan sponsors will not need to file EGWP bid pricing tools (BPTs) for CY2024, as was the case in CY2023. CMS finalized the EGWP Bid-to-Benchmark Ratios as proposed in the Advance Notice.

Star Rating Changes

Various updates for the Star Rating measures are finalized. New areas related to “Extreme and Uncontrollable Circumstances” adjustments in 2022 include New Mexico, Kentucky, Puerto Rico, Florida, and South Carolina related to the wildfires, severe storms, hurricanes. The Tukey outlier deletion was also finalized. The methodologies for COVID-19 PHE will no longer be in effect for most measures. Overall impact from the change in star ratings is estimated to be -1.24% (estimate unchanged from the Advance Notice).

Medicare Part D - IRA

The changes from the Inflation Reduction Act to the Part D drug benefit will be implemented as described in the Advance Notice. The changes for CY 2024 include:

- Elimination of cost sharing for covered Part D drugs for beneficiaries in the catastrophic phase of coverage.

- Increased income limits from 135 percent of the federal poverty limit (FPL) to 150 percent of the FPL for the low-income subsidy program (LIS) under Part D for the full LIS benefit with a $0 deductible.
- Continuation of the policy to not apply the deductible for any Part D covered insulin product. Also, in the initial coverage phase and the coverage gap phase, cost sharing must not exceed the applicable copayment amount, which for CY 2024 is $35 for a month's supply of each covered insulin product.
- Continuation of the policy not to apply the deductible to any adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). Also, the statute requires these vaccines to be exempt from any co-insurance or other cost sharing, including cost sharing for vaccine administration and dispensing fees for such products, when administered in accordance with ACIP's recommendation, for beneficiaries in the initial coverage and coverage gap phases.
- Base beneficiary premium (BBP) growth will be held to no more than 6 percent by statute. The BBP for Part D in 2024 will be the lesser of the BBP for 2023 increased by 6 percent or the amount that would otherwise apply under the original methodology if the IRA were not enacted.

Overall MA Payment Impact

Wakely estimates that, on average, 2024 Part C standardized benchmarks will increase 1.5% over 2023 nationwide. This reflects the impact of the growth rate, change in star ratings and changes to applicable percentages (i.e., quartile rankings). We also estimate that the change in MA plan payment revenue for 2024 versus 2023 is expected to be -1.1%. This takes into account changes in Part C risk score adjustments, including the FFS normalization factor and the MA Coding Pattern adjustment.

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

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

Details regarding our calculations and assumptions are provided in the Wakely Analysis in the follow section this summary.

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

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

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

- Increase by 1.47% on a standardized (i.e., 1.00) risk score basis. This incorporates changes driven by FFS growth rate, rebasing/re-pricing, GME, KAC, VA DoD, IME, credibility, applicable percentage by county, average change in star ratings and quality bonus, and the impact of benchmark.
- Decrease by -0.73% on a risk-adjusted basis. The risk-adjusted increase incorporates the year-over-year impact of FFS normalization factors, MA Coding Pattern adjustment and the risk model revision. It does not include MA risk score coding trend.

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

- Change in 1.00 benchmarks.
- Impact of change in fee-for-service normalization factor.
- Assumption of no trend in raw risk scores.
- Average change in star ratings based on March 2023 enrollment Table 1 shows our estimates of the components that make up this change.

Table 1

Change in Blended Risk-Adjusted Benchmarks [1] 2023 to 2024	
Growth Rate	2.43%
Rebasing/Re-pricing	-0.05%
Applicable %	-0.02%
Star Rating/Quality Bonus	-0.97%
Benchmark Cap	0.10%
Total Benchmark Change	1.47%
FFS Normalization and Risk Model Revision	-2.16%
MA Coding Pattern	0.00%
Total Risk Score Change	-2.16%
TOTAL	-0.73%
[1] Based on March 2023 MA enrollment and Fall 2022 Star Ratings	

Below is a brief definition of each of the elements in Table 1.

Growth Rate. This is the impact of the FFS (+2.45%) growth rate and the following adjustment factors:

- *Direct Graduate Medical Education (GME).* CMS is required to remove costs directly related to graduate medical educate. The change to this adjustment from 2023 to 2024 had minimal impact (-0.02%) Note, this adjustment is attributable to FFS beneficiaries only. The adjustment for MA beneficiaries is made to the USPCC before the county level rates are calculated.

- *Veteran's Affairs and Department of Defense (VA and DoD).* The change in these carve out factors from 2023 to 2024 had a minimal impact (0.04%).

- *Credibility.* As FFS enrollment decreases, credibility adjustments are necessary when developing the rates used for MA payment. We anticipate more counties will require a credibility adjustment in future years. The change from 2022 to 2023 was immaterial (0.00%).

- *Kidney Acquisition Costs (KAC).* Due to the 21st Century Cures Act, CMS is required to remove kidney acquisition costs from the development of the MA payment rates. The change from 2023 to 2024 was immaterial (-0.02%).

- *Indirect Medical Education (IME).* Costs attributable to indirect medical education are also removed from the payment rates. The change from 2023 to 2024 was immaterial (-0.02%). Note, this adjustment is attributable to FFS beneficiaries only. The

adjustment for MA beneficiaries is made to the USPCC before the county level rates are calculated.

Rebasing/Re-pricing. The Average Geographic Adjustment (AGA) factors are derived via the compilation of five years of historical Medicare Parts A&B claim costs at the county level. For payment year 2024, historical claims from 2017 to 2021 are repriced to reflect the most current wage indices (Fiscal year 2023). Wakely calculated the overall impact to MA plans is -0.05%. The impact of the rebasing and re-pricing for 2024 payment rates varies significantly by region. This is in part driven by the change to the risk adjustment model for PY2024. Wakely observed significant variation by population type and geographic area.

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

Star Rating/Quality Bonus. Difference in quality bonus impact on benchmarks due to star rating changes between 2022 and 2023. This is based on a static enrollment mix, so it only reflects changes in average star ratings by contract, and not a shift in enrollment toward plans with higher or lower star ratings. In addition, it does not include terminated contracts or the potential for new contracts with a 3.5% bonus in 2023. The negative impact was expected for PY2024 as CMS removed some protections in place which kept MAO's star ratings equal greater than or equal to the 2019 measures for PY2023.

Benchmark Cap. The ACA formula requires that the final blended benchmark can be no greater than the pre-ACA benchmark. The impact of this cap can year-to-year as plans change star ratings, and as the NPCMGP trend differs from the FFS trend. The average impact is positive, although counties that are impacted by the benchmark cap should expect a more significant impact because the NPCMGP trend is 0.8% less than the FFS trend.

Part C Fee-for-Service (FFS) Normalization Factor and Risk Model Revision. The 2024 Part C FFS normalization was 1.127. For 2024, CMS is implementing a new Part C Risk Adjustment Model which uses a 2020 denominator year and will be phased in over 3 years. Based on the Fact Sheet, CMS estimates the overall change to both the risk adjustment model and FFS normalization will be -2.16%. Please note, Wakely observed significant variation across MAO's due to the impact of the new risk adjustment model.

Change in Coding Pattern Adjustment. The coding pattern adjustment for 2024 will be kept at - 5.90%, which is the minimum adjustment required by the Affordable Care Act. There will be no change from 2023.

Change in Bid and Rebate Amounts

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

If we assume that both 2023 and 2024 bids are 77% of the benchmark, then we estimate the change in Part C payments from 2023 to 2024 to be a decrease of -0.73% (see Table 2).

In order to properly estimate the impact of the various MA payment components addressed in the Final Rate Announcement, Medicare Advantage plans must consider the aggregate effect on actual payments from CMS, which is not necessarily the same as the change in benchmarks. As noted above, we estimate the change in risk-adjusted benchmarks to be -0.73%. If we include estimated changes in bid and rebate levels, then the impact to Part C revenue is - 1.11%. This estimate is based on the following assumptions:

- Plans bid at 77% of the benchmark in 2024. This is based on the published bid-to-benchmark ratios in the 2024 Final Rate Announcement.
- Annual risk score coding trend is 0% for a static population.
- Nationwide average star ratings, which result in an average rebate percentage of 67.4% in 2023 and 65.9% for 2024.
- No consideration for sequestration or insurer fee Table 2 shows the calculations underlying our estimates.

Table 2

Item	2023	2024	2024/2023
1.0 MA Benchmark [1]	$1,131.52	$1,148.10	1.47%
Raw Risk Adjustment Factor [2]	1.0000	1.0000	0.00%
Risk Score Model Change	1.0000	0.9570	-4.30%
FFS Normalization	1.1270	1.1023	2.24%
MA Coding Pattern Adjustment	0.9410	0.9410	0.00%
RAF after FFS Norm & Coding Pattern	0.8350	0.8169	-2.16%
Risk-Adjusted Benchmark	$944.78	$937.91	-0.73%
Assumed Risk-Adjusted Bid [3]	$727.48	$722.19	-0.73%
Savings (Benchmark less bid)	$217.30	$215.72	-0.73%
Rebate [4]	$146.54	$142.13	-3.01%
Risk-Adjusted Bid + Rebate	$874.01	$864.32	-1.11%
[1] Based on nationwide average MA enrollment by county as of March 2023			
[2] Assumed no trend in risk scores			
[3] Bid set at 77% of risk-adjusted benchmark			
[4] 67.4% for 2023 and 65.9% for 2023			

Attachment I: Final Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2024

The final 2024 MA and FFS growth rates are shown in Table 3 and are compared with the Advance Notice and the 2023 growth rates.

Table 3 – Comparison of 2023 and 2024 Growth Rates

Component	2024 Final	2024 Advance Notice	2023 Final
MA Growth %	1.60%	1.81%	4.75%
FFS Growth %	2.45%	2.15%	4.89%

The growth rates changed from the Advance Notice. CMS included several drivers of the changes from the Advance Notice:

- Additional CY2022 experience data that was lower than previously projected.
- Updated modeling to account for the effects of COVID-19 and other programmatic and demographic changes.

- Lower morbidity from excess COVID-related deaths.
- Lower total spending by explicitly modeling the shift of hip and knee replacements from inpatient to outpatient setting, and updated modeling of the effect of a greater share of dual beneficiaries enrolling in MA.

CMS is finalizing the technical update to remove MA-related indirect medical education and direct graduate medical education costs from the historical and projected expenditures supporting the final estimates of the non-ESRD FFS USPCCs. The technical update will be phased in over a 3- year period beginning with CY2024 ratebook. This technical adjustment is included in the growth rates in Table 3.

Table 4 – USPCC Technical Adjustment Phase In

Year	% of Adjustment Applied
2024	33%
2025	67%
2026	100%

As has been the case in past years, the year over year change in Part C benchmarks can vary significantly depending on geographic area, plan star rating and applicable percentage. Table 5 shows the top five and bottom five growth rates by State (these changes include changes due to repricing/rebasing, direct graduate medical education (GME), kidney acquisition costs (KAC), indirect medical education (IME), Veteran's affairs and Department of Defense, credibility factors, star rating, double bonus status, applicable percentage, and the benchmark cap.

Table 5 - States with Highest and Lowest Benchmark Change

Rank	State	Change
1	PR	3.5%
2	DC	3.5%
3	LA	3.2%
4	IN	3.0%
5	CA	2.7%
47	OR	-0.1%
48	WA	-0.5%
49	NH	-0.5%
50	WY	-0.6%
51	ID	-0.7%

Wakely performed a detailed analysis to estimate the expected change in risk adjusted revenue for payment year 2024. Details regarding our calculations and assumptions are provided in the Wakely Analysis located in the prior section of this summary.

Attachment II: Key Assumptions and Financial Information

As in past years, CMS published projections for the total United State Per Capita Costs (USPCCs) by year. Projections are provided for all Medicare services combined as well as more detailed projections by service category within Part A and Part B.

Table 6 shows the restatements, from the 2023 Announcement, of the estimated Part A + Part B non-ESRD FFS costs for 2022 through 2024. The decreased costs for 2022 and subsequent years lead directly to a lower growth rate than what would have been projected using the USPCC amounts from the 2023 Announcement. Note, in the 2023 Announcement CMS increased the expected per capita costs for 2022 and 2023 by about 2% from the 2022 Announcement estimates.

Table 6 – Non-ESRD FFS Cost Estimates – 2024 Final Announcement versus 2023 Final Announcement

Year	CY2024 Final Announcement	CY2023 Final Announcement	Restatement
2022	$971.74	$1,023.31	-5.0%
2023	$1,057.70	$1,078.63	-1.9%
2024	$1,105.10	$1,132.07	-2.4%

There are two primary drivers of the downward restatements:

1. A technical update to the calculation of the per-capita costs which removes the costs for indirect medical education and direct graduate medical education costs. In the Advance Notice, CMS indicated this would reduce the 2024 growth rate by 2.13%. In the Final Rate Announcement, CMS finalized the change over a three-year phase in, but they did not announce the final adjustment to the 2024 rates. If we assume there was no change from the Advance Notice, the adjustment would be -0.70%.

2. A downward restatement of CY2022 expenditures due to overestimating the amount of pent-up demand after COVID-19. CMS also mentioned there is lower morbidity due to excess deaths caused by COVID-19.

It is also interesting to note that CMS is continuing to project that Medicare Advantage enrollment will outpace the change in total Medicare beneficiaries for 2023 through 2026. In fact, FFS enrollment has been consistently decreasing since 2019 and is projected to continue to decrease from 2023 to 2024. Table 7 shows the annual changes in CMS's projected enrollment for these years.

Table 7 – Projected Annual Percentage Change in Medicare Enrollment

Year	Total	FFS	MA
2024	2.2%	-1.7%	5.7%
2025	2.5%	0.7%	3.9%
2026	2.5%	0.6%	4.0%

Attachment III: Responses to Public Comments

Section A. General Comments

CMS received a large number of comments in response to the CY 2024 Advance Notice, with many supporting the proposal and others expressing concerns about the impacts of the proposed updates. Commenters who supported the proposal emphasized that discretionary coding and perceived 'gaming' of codes is a key part of driving excess payments and applauded efforts to make the CMS-HCC risk adjustment model more accurate and less susceptible to discretionary coding. Commenters who did not support the proposed changes described the variety of impacts that would occur if CMS finalized the proposed changes, including that these proposals would disrupt care, place the health of sicker, lower-income enrollees at risk, and result in increased costs and reduced benefits for MA enrollees.

In response, CMS provided the following information:

> Protecting and strengthening Medicare for the sixty-five million Americans who have it now, and all the beneficiaries in the future, is a key priority for CMS. The updates proposed by CMS in the CY 2024 Advance Notice are technical, data-driven, and clinically based updates that improve the accuracy of payments to MA organizations, as required under the statute governing the MA program. CMS expects MA organizations that are committed to their MA business to have strong business plans, long term financial strength, and a business trajectory beyond a single year. Though plans will have different impacts for the policies finalized, the robust strength and competitiveness of the market and high level of choice ensure that the 3.32% nationally averaged update will result in maintained stability.

Section B. Estimates of the MA and FFS Growth Percentages for CY 2023

Notable comments and CMS responses on 2023 growth rates include the following:

TECHNICAL UPDATE TO USPCC BASELINE REGARDING MA-RELATED MEDICAL EDUCATION EXPENSES COMMENTS AND RESPONSES:

A large number of commenters expressed concern regarding the full implementation of the technical update to the USPCC baseline at one time and recommended that the change instead be phased in gradually over multiple years to minimize disruption to premiums and benefits.

In response, CMS decided the technical update will be phased in over a 3-year period beginning with 33% of this adjustment to the medical education costs applied to the USPCCs in 2024. CMS expects 67% of the 2025 medical education adjustment to be applied in 2025 and 100% of the 2026 medical education adjustment to be applied in 2026.Several commenters inquired about clarification regarding how the medical education costs being removed from the non-ESRD FFS growth rate for the technical change is different than the medical education costs removed from county-level benchmarks as an adjustment to the Average Geographic Adjustment (AGA).

In response CMS provided the following information:

> The adjustments to the USPCC and AGA pertain to two different groups of Medicare beneficiaries: the technical update to the non-ESRD FFS USPCC pertains to excluding IME and DGME costs associated with MA enrollees (paid directly by CMS to hospitals), whereas the county level adjustment to the AGA pertains to IME and DGME costs associated with FFS beneficiaries (paid directly by CMS to hospitals) to determine MA capitation rates as required by section 1853 of the Act. As stated on page 11 of the CY 2024 Advance Notice, the technical update has no impact on the exclusion of medical education costs from the AGAs used to develop the ratebook.

CONSOLIDATED APPROPRIATIONS ACT, 2023 (CAA, 2023) COMMENTS AND RESPONSES:

A couple of commenters requested confirmation regarding whether the impacts of the CAA, 2023 are included or excluded from the growth rates. The response from CMS indicates that growth rates provided did not reflect the impact of CAA, 2023, given the timing constraints of the recently enacted CAA, 2023, and the statutory timeframe for releasing the Advance Notice. The USPCCs and growth rates provided in the CY 2024 Rate Announcement do reflect the provisions of CAA, 2023.

INFLATION REDUCTION ACT (IRA) MEDICARE PART B PROVISIONS COMMENTS AND RESPONSES:

A commenter encouraged CMS to ensure that assumptions related to the cost of Part B Rebateable Drugs in the MA rate setting model accounts for the total cost incurred by MA

organizations and that they account for reductions in cost-sharing for beneficiaries such that the cost sharing does not exceed 20% of the net price after the application of the inflation rebate.

In response, CMS provided the following information:

> CMS assumed that prices for Part B drugs will not materially exceed the inflation-adjusted payment amounts under section 1847A(i) of the Act. Therefore, no adjustments to projected Part B FFS expenditures to account for inflation rebates for 2024 were necessary. Further, section 1853 of the Act sets forth how the MA capitation rates and benchmarks are set based on FFS per capita costs.

A commenter noted that the USPCCs for 2023 and thereafter reflect cost projections related to provisions of the IRA, including exclusion from the Part B deductible for insulin when it is furnished through durable medical equipment and a $35 cap on beneficiary cost sharing for insulin. The commenter noted that CMS had indicated in the CY 2024 Advance Notice that these provisions are expected to increase Part B FFS expenditures beginning with 2023 and requested more detail on the expected increase.

CMS responded that they estimate that the reduced cost sharing for Part B insulin associated with DME would reduce FFS beneficiary cost sharing by roughly $20-30 million during CY 2024, which increases Part B FFS expenditures.

COVID-19 COMMENTS AND RESPONSES:

Many commenters urged additional transparency regarding actuarial assumptions used to calculate the growth rates pertaining to the COVID-19 pandemic.

In response, CMS provided the following information:

> Several policies and legislative provisions were enacted during the public health emergency that increased spending. The public health emergency is assumed in the actuarial modeling to end in June 2023, when these effects are assumed to be eliminated.
>
> Actual Medicare FFS per capita spending has been consistently below the pre-pandemic projections throughout the public health emergency. Page 39 of the announcement compares the combined non-ESRD and ESRD FFS per capita spending by major provider category with what was assumed on a pre-pandemic basis for 2020 through the third quarter of 2022 for each category. CMS attributes the lower spending to a number of factors:
>
> 1. The deaths from COVID-19 have contributed to a lower average morbidity for the surviving population.

2. Over the last several years, a greater proportion of those dually eligible for Medicaid and Medicare have been enrolling in MA which has decreased the average FFS per capita cost for inpatient hospital, SNF, and home health spending.

3. The proportion of hip and knee replacement surgeries performed in the inpatient setting has dropped dramatically during the PHE, causing a greater shift in spending from the inpatient to outpatient setting than implicitly assumed in prior projection assumptions.

Assumptions for COVID-19 vaccine in CY 2024 are (i) 47% of beneficiaries will receive a COVID shot with 43%represented in Medicare FFS claims; (ii) average doses per utilizer: 1.3; and (iii) average cost per dose: $105.

ESRD GROWTH RATE COMMENTS AND RESPONSES:

A commenter requested that CMS provide additional detail and explanation into the significant historical restatements of the ESRD Dialysis-only FFS USPCC. CMS responded that The CY 2022 ESRD Dialysis-only FFS USPCC is lower in the CY 2024 Advance Notice and 2024 Rate Announcement than in the 2023 Rate Announcement due to reflection of actual incurred experience through 4th quarter 2022 in the CY 2024 Advance Notice and CY 2024 Rate Announcement; whereas, the CY 2022 ESRD Dialysis-only FFS USPCC in the CY 2023 Rate Announcement was projected based on actual incurred experience through 4th quarter 2020.

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

Several commenters expressed concerns about benchmark calculations imposed by the ACA and how it limits health plans' ability to improve coverage for enrollees including adding supplemental benefits and reducing cost sharing.

In response, CMS stated that they have not identified discretion under section 1853(n)(4) of the Act to eliminate application of pre-ACA rate caps or exclude the bonus payment from the cap calculation.

Section D. Calculation of Fee-for-Service Costs

Commenters raised concerns regarding the AGA methodology, specifically how CMS plans to incorporate the new risk model revisions. CMS indicated they will continue to use the CMS-HCC risk adjustment model being used for the payment year, including any blending/phasing-in of the risk adjustment models.

A couple of commenters expressed support for the use of five years of FFS experience. In addition, there were concerns regarding rebasing the rates for CY2024 pertaining to the potential for instability and disparities across counties, such as in Puerto Rico and Florida given the impact of natural disasters and COVID-19. CMS's response indicates that the use of five years of FFS experience mitigates annual fluctuations and anomalies in the data that may occur for a variety of reasons. CMS also notes that the impact of rebasing and repricing had a positive impact on the CY2024 MA rates in Puerto Rico.

There was an increased number of comments on whether it is appropriate for CMS to calculate the FFS costs used for Part C benchmark rates using Part A only and B only beneficiaries versus also including Part A and Part B only beneficiaries. CMS has included a similar response as in prior years and will not be making a change.

The Advance Notice sought public comment on the possibility of adjusting FFS experience in Puerto Rico to reflect to propensity of zero-dollar beneficiaries nationwide. CMS has updated the study to incorporate the Secretary's instructions. The zero-claim adjustment for Puerto Rico will be 4.4 percent for 2017 through 2021 and is included in the CY 2024 ratebook development.

There was also an increased number of comments regarding the Puerto Rico benchmark rates being significantly lower than the mainland. CMS did not make any additional changes for Puerto Rico for CY2024.

Section E. Direct Graduate Medical Education

CMS referred readers to Attachment III Section B for their responses to comments related to Direct Graduate Medical Education.

Section F. Organ Acquisition Costs for Kidney Transplants

CMS indicated that they would continue to monitor the amount of kidney acquisition costs to determine whether refinements and improvements to the methodology for the carve-out adjustment are warranted.

Section G. IME Phase Out

CMS referred readers to Attachment III Section B for their responses to comments related to IME phase out.

Section H. MA ESRD Rates

Commenters raised the concern that the current ESRD payment rates are not sufficient to cover associated costs and made different suggestions to change the payment calculation. Suggestions included utilizing smaller geographic areas, applying the quality bonus payment (QBP) or applicable percentages to ESRD rates, and adjusting rates to reflect the impact of the Maximum Out-of-Pocket (MOOP) requirement in the MA program.

CMS rejected these concerns and suggestions for 2024 and said it would continue to analyze whether "any refinements to the methodology may be warranted in future years." More specifically, CMS noted it believed that applying QBP, applicable percentage or MOOP adjustments would be inconsistent with Section 1853 of the Social Security Act.

Commenters encouraged CMS to expand the ESRD CSNP to include beneficiaries with chronic kidney disease (CKD). CMS noted that in the 2024 Policy and Technical Changes to the Medicare Advantage Program, they proposed to revise the ESRD CSNP to be "Chronic kidney disease (CKD)" with the following conditions: CKD requiring dialysis/ESRD, and CKD not requiring dialysis, but that this change would not be implemented in CY2024 in order to give CMS more time to collect data and information related to the structuring of the proposed CKD CSNP plan bid.

Section I. MA Employer Group Waiver Plans

Commentors recommended that CMS published bid-to-benchmark ratios for PPO and HMO separately. CMS rejected these recommendations by describing the methodology and its consistency with the individual market country level benchmarks.

Section J. CMS-HCC Risk Adjustment Model for CY2024

CMS has implemented a phase-in schedule for the CMS-HCC CY2024 risk adjustment model. The phase-in schedule is consistent with how CMS has approached model updates in the past. The phase-in schedule for how payment year risk scores will be calculated utilizing the two models is shown below.

Table 8

Payment Year	2020 CMS-HCC Model	2024 CMS-HCC Model
2024	67%	33%
2025	33%	67%
2026	0%	100%

CMS made it clear that the notice they provided commenters was sufficient and met statutory guidelines. They explicitly stated that the 21st Century Cures Act stipulation that requires 60-

days was only for specific items of which the change in the model was not one of them. They provided historical examples where they gave similar notice to what they provided commentors this year.

PREDICTIVE RATIOS

CMS provided an analysis highlighting the predictive ratios by risk decile across the 2024 and 2020 risk score models. The analysis was in response to commentors requesting more information on the predictive accuracy of the new risk score model. The predictive ratios have improved across all but one decile and highlights that the CY2024 risk scores model is more predictive than the CY2020 model.

R-SQUARED

CMS also provided the R-Squared for the 2024 model compared to the 2020 model as a way to highlight the predictive accuracy of the model. The R-squared was calculated for each demographic and has improved (or increased) from the 2020 model.

CMS disagreed with comments related to the reduction in number of ICD-10 codes being risk adjustable driving clinical behavior. CMS specifically noted that risk adjustment model is not intended to drive clinical behavior.

CMS described changes related to several specific diseases.

VASCULAR DISEASE

- HCC 107-108 was reconfigured into HCCs 263, 264, and 267.
- HCC 267 is new and is for “Deep Vein Thrombosis and Pulmonary Embolism”.
- Atherosclerosis of arteries of extremities was updated in the 2024 model to contain only primary codes that typically indicate more serious cases.
- Diagnosis for “other” and “unspecified” disease were mapped to non-payment HCCs.
- Diagnosis for manifestations or stages of diseases that are not consistently reliably predictive of future years costs are in the lower-level HCC 263 and the severe manifestations were put into the higher HCC 264.
- Treatment of Vascular disease group is consistent with treatment of coronary atherosclerosis disease group.

METABOLIC DISEASES

- Expanded to four HCCs, up from three HCCs in the 2020 model.
- HCC 49 is new and is to cover expensive Part B drug treatments.
- Some 2020 model HCC 23 conditions were moved to a non-payment HCC consistent with how CMS handles other conditions that are based on lab tests or showcased empirical overprediction.

HEART DISEASES

- Expanded to ten HCCs, up from five HCCs in the 2020 model.
- HCC85 (CHF) is now split into 5 HCCs (222-226).
- Hierarchy was implemented with HCC221 being the highest to HCC227 at the lowest.

BLOOD DISEASES

- Expanded to seven HCCs, up from three in the 2020 model.
- HCC 47 from the 2020 model is now split into HCC 114 and HCC 115, which allows for isolation of the costlier and more severe conditions.

AMPUTATION

- Reconfigured to cover initial complications or ongoing costs in the updated model.

NEUROLOGICAL DISEASES

- Expanded to twelve HCCs, up from eight in the 2020 model.
- HCC 75 from the 2020 model is now split into HCCs 193-196. HCC 194 (Guillain-Barre Syndrome) is non-payment. CMS notes certain costs are predicted in other HCCs and progressions of the condition will trigger HCC 193, which is a payment HCC.

DIABETES

- Expanded to four HCCs, up from three in the 2020 model.
- HCC 35 (Pancreas Transplant Status) was added to the top of the hierarchy.

- Certain drug induced diabetes codes were re-mapped to a non-payment HCC because these can be temporary/reversible and are variable in cost profile.
- Many diagnosis codes were moved to the lowest payment HCC due to empirical data on coding frequency, as well as coding considerations.

KIDNEY DISEASE

- Reduced to four HCCs, down from five in the 2020 model, HCC 138 was replaced with two, more granular HCCs.
- HCC 328 – Chronic Kidney Disease, Moderate (Stage 3B).
- HCC 329 – Chronic Kidney Disease, Moderate (Stage 3, Except 3B).
- The coefficients for these HCCs are set equal.
- HCCs 134 and 135 from the 2020 model were removed from the payment model.
- Costs will flow through to other conditions that led to dialysis (e.g., heart failure or sepsis).

PSYCHIATRIC DISEASES

- Expanded to five HCCs, up from four in the 2020 model.
- Many conditions included in HCC 59 from the 2020 model were moved to HCC 152 in the updated model. CMS noted that costs were underpredicted for this HCC.
- HCC 60 from the 2020 model was reconfigured to HCC 153 and moved up above non-psychotic depression/bipolar disorders in the hierarchy because of higher associated costs.
- Diagnoses for anorexia/bulimia nervosa were moved to HCC 153 in the new model, which were mapped to a non-payment HCC previously.
- HCC 59 from the 2020 model was reconfigured to HCC 154 and 155 in the new model.
- Diagnoses for mild, unspecified, remission, subsequent encounter, and sequala codes were re-mapped to non-payment codes.

MUSCULOSKELETAL DISEASES

- Expanded to three HCCs, up from two in the 2020 model.

- HCC 40 from the 2020 model was split into HCC 93 (Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders) and HCC 94 (Systemic Lupus Erythematosus and Other Specified Systemic Connective Tissue Disorders) in the updated model.
- Several non-payment diagnosis codes from the 2020 model were moved to HCC 93 in the updated model.
- Codes previously in a Vascular HCC were moved to HCC 94.
- Several conditions that were overpredicted were moved to a non-payment HCC.

Table 9 - Summary Statistics for the 2020 CMS-HCC and 2024 CMS-HCC Classifications

	2020 CMS-HCC Model	2024 CMS-HCC Model
FY22/23 ICD-10 codes - total	73,926	73,926
FY22/23 ICD-10 codes - mapped to payment HCCs	9,797 (13.3%)	7,770 (10.5%)
FY22/23 ICD-10 codes - mapped to non-payment HCCs	64,129 (86.7%)	66,156 (89.5%)
Added		209
No longer mapped in the 2024 CMS-HCC Model		2,236
No longer mapped - ICD-10 clinical updates		2,161 (96.6%)
No longer mapped - Principle-10 focused updates		75 (3.4%)
HCCs - total	204	266
HCCs - payment	86 (42.2%)	115 (43.2%)
HCCs - non-payment	118 (57.8%)	151 (56.8%)

MA RISK SCORE TREND

CMS clarified that the 4.44% MA risk score trend in the fact sheet represents a blend of the 2020 risk adjustment model and the updated model. The 2020 model has a risk score trend of 5% and the updated model has the 3.3% trend originally quoted in the Fact Sheet for the Advance Notice.

DISPROPORTIONATE IMPACTS TO SPECIFIC POPULATIONS

Several commenters raised concerns that certain populations would be disproportionately impacted by the updated model. Among those listed include dually eligible beneficiaries, vulnerable populations, beneficiaries in urban or rural areas, high-risk, chronically complex populations, minorities, low-income individuals, EGWPs, Puerto Rico plans, HPSAs, MUAs, ADI, SVI, and Opportunity and Enterprise zones. CMS gave a similar answer for most

concerns about disproportionate impacts to specific populations. To summarize these, CMS noted:

- Model features introduced in the past to adjust for population characteristics are still included in the updated model (e.g., separate dual models, count of conditions factor).
- The CMS-HCC model is a national model which includes many subgroups that capture variation in costs between these segmented populations.
- The goal of risk adjusted payments is to make accurate payments using the appropriate relative risk for a beneficiary.
- Beneficiary's clinical mix will contribute to the model impact on risk scores.
- The model updates result in changes to the relative costs of conditions, and therefore the resulting risk scores.
- Risk scores will change depending on a beneficiary's combination of diagnoses or the clinical profile of a plan's members.
- The model ensures that plans enrolling higher need beneficiaries receive higher payments, and therefore, do not believe beneficiaries will be disproportionately affected depending on region.
- D-SNP risk scores are 54% higher than non-SNPs.
- C-SNP risk scores are 47% higher than non-SNPs.
- MA risk score trend for dually eligible beneficiaries is 4.67% higher than for non-dually eligible beneficiaries.
- CMS also reiterates that considering risk score trend along with the impact of the updated risk adjustment model is key to predicting payments.
- CMS believes the impact of the new model and normalization for dually eligible beneficiaries are offset by average growth in MA risk scores.

HCC CONSTRAINT/REMOVAL IMPACT

Commenters had concerns about the removal or constraining of conditions, and how these would incentivize (or disincentivize) health management initiatives or have adverse impact on potential interventions in the onset of certain conditions. CMS responded with detail regarding their rigor in reviewing conditions with MA/FFS coding discrepancies and including clinical experts. Several conditions were removed that do not accurately predict the projected

cost of a beneficiary and constrain certain HCC coefficients to carry the same weight in the risk score. The HCC constraints (holding coefficients equal) include:

- All Diabetes HCCs (HCCs 36, 37, and 38). HCCs 17 and 18 are constrained in the current model. CMS notes that HCC 18 has a substantially higher prevalence in MA than FFS, and vis-versa with HCC 19. CMS believes the broadness of the clinical criteria for HCC 18 may be resulting in diminished capacity for the model to differentiate between disease severity. They believe constraining the Diabetes HCCs in the updated model allows costs for significant complications of diabetes to be captured in other payment HCCs (like chronic kidney disease or diabetic eye disease.
- Congestive Heart Failure HCCs (HCCs 224, 225, and 226). All CHF diagnoses are in a single HCC in the current model. This was split into five HCCs in the updated model. The most severe is not constrained, the less severe are constrained.

HCCs removed:

- HCC 47 (Protein-Calorie Malnutrition – HCC 21 in the 2020 CMS-HCC model). CMS cites data showing mild/unspecified malnutrition at a much higher rate in MA than FFS, while more severe malnutrition at a lower rate. Removal of this HCC is expected to result in costs shifting to other HCCs that may be the underlying cause (e.g., cancer and HIV).
- HCC 230 (Angina Pectoris – HCC 88 in the 2020 CMS-HCC model). CMS notes that clinicians and empirical data support that this HCC has diagnosis criteria that can lead to coding in situations with little or no significance. Other HCCs in this hierarchy are included in the updated model.
- HCC 265 (Atherosclerosis of Arteries of the Extremities, with Intermittent Claudication). CMS states that clinical characteristics of intermittent claudication are variable, and that the variation in coding and clinical implications suggest it is not a reliable predictor of cost.

OTHER COMMENTS

CMS responded to many commentors that stated the model impact would be more negative than the estimated industry impact CMS released in the advance notice. CMS disagreed and noted that the appropriate normalization was considered. They also reiterate that model impact depends on the clinical profiles of their enrollees.

CMS noted they are considering the implications of the updated risk adjustment model on the ACO Reach and Medicare Shared Savings Program initiatives.

APPROPRIATE PAYMENTS

There were multiple comments whose main theme was that CMS is no longer paying health plans appropriately. CMS disagrees, noting that the updates to the data provide more predictive power than previous. Additionally, they note that if risk-adjusted payments were set at inappropriate levels, Medicare Advantage would not be as attractive as FFS. CMS points to continued enrollment growth in MA plans across all beneficiary types, especially dually eligible members, as proof that this is not the case.

CMS notes that MedPAC, along with other independent studies, find that MA organizations are significantly overpaid, estimating overpayment of twenty-three billion in 2023.

RULEMAKING AUTHORITY

Commenters argued that CMS does not have the authority to amend payment policy through the Advance Notice, and that this proposal make fundamental changes to the Medicare Advantage program. CMS responds that updates to the risk adjustment model are ordinary, routine, and a necessary part of making sure the program runs smoothly and as intended.

NON-PAYMENT HCCS

Between the 2020 CMS-HCC model and the 2024 CMS-HCC model, 2,236 ICD-10 diagnosis codes no longer map to the model for payment and 209 were added. Additional information for the 2,236 codes that newly map to non-payment HCCs in the 2024 CMS-HCC model is provided below. These diagnosis codes generally fall into one of six categories:

1. Subsequent Encounter (codes ending in D) – 6%
2. Sequela (codes ending in S) – 40%
3. Drug-induced – 8%
4. Complication of Medical Care – 16%
5. Principle 10 only – 3%
6. Combination – 28%

In general, these HCCs were removed because CMS believes the risk adjustment model should focus on the costs of underlying health status risks rather than the side effects of health care (3 and 4), because the diagnoses are subject to discretionary coding (5), or because the costs are already captured in the primary diagnosis (1 and 2).

PRINCIPLE 10

CMS notes that the difference in prevalence of HCCs between FFS and MA was within one percentage point for all HCCs except the following:

1. HCC 18 – Diabetes with Chronic Complications
2. HCC 21 – Protein-Calorie Malnutrition
3. HCC 22 – Morbid Obesity
4. HCC 59 – Major Depressive, Bipolar, and Paranoid Disorders
5. HCC 85 – CHF
6. HCC 88 – Angina Pectoris
7. HCC 108 – Vascular Disease
8. HCC 111 – COPD
9. HCC 138 – Stage 3 CKD

As a result, CMS either removed these HCCs entirely, constrained the HCCs, or removed certain diagnoses that were mapping to them. The Final Notice provides significant detail about how and why these decisions were made. A representative example is that an OIG report found that only 27 of 200 severe malnutrition codes were correctly billed in FFS Medicare – all other codes should have used a less severe code, or no code at all. As a result, these diagnoses were excluded entirely.

PACE

Several commenters opposed CMS maintaining the 2017 risk model for PACE plans, suggesting instead that they switch to the currently used 2020 model. The rationale is that the 2017 risk model excludes several conditions which are prominent among the PACE population, most notably dementia. CMS states that because PACE plans do not submit encounters for all their services, moving to a model that was developed to calculate risk scores based on encounter data (not RAPS), would result in inaccurate risk scores and payment.

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

CMS did not receive comments on the CMS-HCC ESRD risk adjustment models for PACE organization for CY 2024. For ESRD beneficiaries in PACE plans, CMS will continue to sue the CY 2019 CMS-HCC ESRD risk adjustment models as proposed in the Advance Notice.

A commenter suggested using the ICD-10 diagnosis codes related to ESRD to trigger the use of the ESRD dialysis risk adjustment model. CMS noted the ICD-10 diagnosis codes do not reliably indicate ongoing dialysis. CMS will continue to rely on notification from the dialysis facility to apply the ESRD dialysis risk score model.

Section L. Frailty Adjustment for PACE Organizations and FIDE SNPs

For FIDE SNPs in CY 2024, CMS will update the frailty factors used to calculate frailty score using 67% of the frailty factors associated with the 2020 CMS-HCC risk adjustment model and 33% of the frailty scores calculated using the frailty factor associated with the CY 2024. The blended frailty score will be compared to the PACE level of frailty calculated in the same manner to determine whether the FIDE SNP has a similar average level of frailty as PACE.

For PACE organizations, CMS is proposing to continue use of the 2017 CMS-HCC model to calculate risk scores used to pay for Part A and B services in CY 2024. CMS will use the frailty factors associated with the 2017 CMS-HCC model to calculate frailty scores for PACE organizations in CY 2024. The PACE minimum is calculated using the same frailty factors as those used for FIDS SNPs so changes in the FIDS SNP frailty scores will be accompanied by a change in how the PACE minimum is calculated.

Table - 10 (UPDATED): Frailty Factors Associated with the 2024 CMS-HCC Model – FIDE SNPs

Activities of Daily Living (ADL)	Non Medicaid	Partial Medicaid	Full Medicaid
0	-0.066	-0.070	0.158
1-2	0.103	0.203	0.230
3-4	0.201	0.203	0.230
5-6	0.201	0.217	0.248

Section M. Medicare Advantage Coding Pattern Adjustment

CMS is finalizing the proposed MA coding pattern adjustment of 5.90% for CY2024. No change from Advance Notice.

Section N. Normalization Factors

CMS is finalizing the normalization factors for CY2024 as proposed in the Advance Notice.

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

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

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

Attachment IV: Responses to Public Comments on Part D Payment Policy

Attachment IV contains a summary of comments received by CMS on Part D Policy announcements in the Advance Notice and CMS's responses to these comments.

Section A – RxHCC Risk Adjustment Model

The Inflation Reduction Act of 2022 changed the structure of the Part D benefit. The most substantial changes occur in 2025, but in 2024 there are two plan design changes that will increase plan liability: the elimination of member cost sharing for all members in the catastrophic phase and cost-sharing caps on insulins and vaccines covered by Part D. Both changes reduce member cost sharing and increase plan liability. Comments on the RxHCC risk adjustment model suggest that CMS should not be using the 2023 RxHCC model for Part D risk adjustment in 2024, as the 2023 RxHCC model was calibrated on a different plan design and will therefore underestimate plan liability specifically for diabetics and members with conditions requiring expensive pharmaceutical therapies.

CMS acknowledged that the benefit changes occurring in 2024 will result in plan liability increases that will be unevenly distributed to a few disease states. However, because the IRA was enacted in August 2022, CMS did not have sufficient time recalibrate the RxHCC risk adjustment model for 2024. CMS does not expect the plan liability changes resulting from the IRA legislation to be "large," and further notes that the Part D risk corridor will reduce "some" of the plan design-induced losses to sponsors.

Section B – Sources of Diagnoses for Part D Risk Score Calculation for CY 2024

CMS will continue the policy adopted for the 2023 plan year for the sources of diagnoses for Part C and Part D risk adjustment; only risk adjustment-eligible diagnoses from encounter data and FFS claims will be used.

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

CMS clarified that for low-income members reaching the coverage gap, low-income cost-sharing subsidy will continue to cover the full cost of vaccines and insulins up to the lesser of the applicable copay or the nominal copay.

Section D – Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2024

Some commenters noted that due to changes in the pharmacy price concession rule, ingredient costs trends for drugs will not follow typical inflation trends in 2024. CMS stated that the 1860D of the Social Security Act mandates that the API and CPI must be used to update Part D benefit parameters.

Section E – Part D Calendar Year Employer Group Waiver Plans Prospective Reinsurance Amount

CMS will not be applying a trend factor to prospective reinsurance payments for 2024 but will consider a trend factor for future years.

Section F – Part D Risk Sharing

CMS stated that per 1860D of the Social Security Act, CMS cannot establish a risk corridor with narrower thresholds relative to the CY2011 thresholds.

Attachment V: Final Updated Part D Benefit Parameters for Defined Standard Benefit, Low Income Subsidy, and Retiree Drug Subsidy

Attachment V contains detailed calculations of the annual adjustments to the Part D Defined Standard benefit parameters. Two annual percentage adjustments are calculated to develop

the CY 2024 benefit parameters: the annual percentage increase (API) and the annual Consumer Price Index (CPI) increase. These adjustments are described below. The API is applied to all Part D parameters, except for copayments that apply to full benefit dual-eligible enrollees with incomes up to or at 100% FPL, which increase based on CPI.

Section A. Annual Percentage Increase in Consumer Price Index (CPI)

The CPI is defined as the annual percentage increase in the CPI, All Urban Consumers (all items, U.S. city average) as of September of the previous year.

Section B. Calculation Methodology

The API uses prescription drug event (PDE) data to calculate the per capita Part D costs from August 2021 to July 2022 divided by the per capita Part D costs from August 2020 to July 2021. Since PDE data are not yet available for 2022, the per capita costs for the latter time period are estimated using August 2021 to December 2021 PDE data. This calculation results in an estimated 5.80% annual increase in per capita costs. This increase is further adjusted based on revisions to prior years' estimates. The cumulative adjustment for prior year revisions is -0.68%. This results in a total 2023 API of 5.08%.

The CPI increase is based on the projected September 2022 CPI divided by actual September 2021 CPI, which results in an estimated increase of 4.17%. This increase is further adjusted based on revisions to prior years' estimates. The cumulative adjustment for prior year revisions is 3.13%. In total, this produces a 2023 CPI increase of 7.44%.

Section C. Annual Percentage Increase in Average Expenditures for Part D Drugs per Eligible Beneficiary (API)

The API is defined as the annual percentage increase in the average per capita expenditures for Part D for the 12-month period ending in July of the previous year.

Section D. Estimated Total Covered Part D Spending at Out-of-Pocket Threshold for Applicable Beneficiaries

The CY 2024 total covered Part D spending at out-of-pocket threshold for applicable beneficiaries is calculated to be $12,447.11 ($11,206.28 for 2023). This amount is calculated as the ICL plus 100 percent beneficiary cost sharing in the coverage gap divided by the weighted gap coinsurance factor. Further detail on these calculations and inputs is provided in the Final Notice.

Section E. Retiree Drug Subsidy Amounts

The Part D parameters, including the retiree drug subsidy amount, are each multiplied by the appropriate increase (CPI or annual percentage increase). For CY 2024, the retiree subsidy cost threshold is $545 (was $505 in 2023) and the cost limit is $11,200 (was $10,350 in 2022).

Attachment VI: Updates for Part C and D Star Ratings

Reminders for 2024 Star Ratings

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

Extreme and Uncontrollable Circumstances for 2024 Star Ratings

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

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

New Measures for 2024 Star Ratings

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

Removed Measures for 2024 Star Ratings

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

Existing Star Rating Measures with Changes for 2024

Controlling Blood Pressure – Weight increased from 1 to 3.

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

- CMS is considering including a "Universal Foundation" of quality measures across all Quality and Value-Based Care Strategy programs to support high quality care and serve as a standard for the health care system. The preliminary Adult Universal Foundation Measures include ten measures, six of which are currently included in Star Ratings.
    - Commenters generally supported the goal of aligning measures across programs.
    - Different measures were suggested to be added to the Universal Foundation set.
    - Concern was expressed regarding data systems being ready to support accurate data collection for some of the new measures.
- Optional Exclusions for HEDIS Measures (Part C) - For selected HEDIS measures, plans have the choice as to whether or not they applied optional exclusions. NCQA reviewed all applicable measures and is updating the following measures from optional exclusions to required exclusions:
    - Controlling Blood Pressure: The optional exclusions for pregnancy, end-stage renal disease/dialysis/nephrectomy/kidney transplant, and non-acute inpatient admissions are now required.
    - Colorectal Cancer Screening: The optional exclusions for colorectal cancer and total colectomy are now required.
    - Kidney Health Evaluation for Patients with Diabetes: The optional exclusions for polycystic ovary syndrome, gestational diabetes, and steroid-induced diabetes are now required.

- Care for Older Adults - Pain Assessment (Part C) – NCQA is considering retiring this measure in measurement year 2025. Most commenters opposed the retirement of this measure until a replacement measure has been introduced and evaluated.
- Care for Older Adults - Functional Status Assessment and Medication Review (Part C) – NCQA is considering developing new measures that may replace these measures and be reported for more than Special Needs Plans (SNPs). Commenters had mixed reactions to the widening of the population.
- Medication Adherence for Diabetes Medication / Medication Adherence for Hypertension (RAS Antagonists) / Medication Adherence for Cholesterol (Statins) Measures (Part D) – CMS proposed implementing sociodemographic (SDS) risk adjustment for these measures in 2028 Star Ratings.
- The following measures have non-substantive changes in 2025 star ratings and later:
    - Controlling Blood Pressure (Part C)
    - Colorectal Cancer Screening (Part C)
    - Kidney Health Evaluation for Patients with Diabetes (Part C)
    - Diabetes Care – Eye Exam (Part C)
    - Diabetes Care – Blood Sugar Controlled (Part C)
    - Breast Cancer Screening (Part C)
    - Statin Use in Persons with Diabetes (Part D)
    - Medication Adherence for Diabetes Medication / Medication Adherence for Hypertension (RAS Antagonists) / Medication Adherence for Cholesterol (Statins) Measures / Statin Use in Persons with Diabetes (Part D)
    - MTM Program Completion Rate for Comprehensive Medication Review (Part D)
- The following measures may be added to Star Ratings program through future rulemaking:
    - Depression Screening and Follow-Up (Part C)
    - Initiation and Engagement of Substance Use Disorder Treatment (Part C)
    - Timely Follow-up After Acute Exacerbations of Chronic Conditions (Part C)
    - Adult Immunization Status (Part C and D)

Display Measures

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

- Depression Screening and Follow-Up (Part C) – Measures the percentage of members who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. Most commenters supported adding this measure to the display page and eventually to Star Ratings, but concerns were raised regarding the availability of the data and the preparation of data systems needed to record the right information.

- Initiation and Engagement of Substance Use Disorder (SUD) Treatment (Part C) – This measure is an updated version of the Initiation and Engagement for Alcohol and Other Drug Abuse or Dependence Treatment measure that is currently on the display page. Commenters did not support adding this measure to Star Ratings due to concerns about confidentiality.

- Timely Follow-up After Acute Exacerbations of Chronic Conditions (Part C) – Assesses the percentage of acute events requiring an emergency department visit for six chronic conditions. Commenters had mixed reactions regarding this measure, with some suggesting it is duplicative of existing measures.

- Adult Immunization Status (Part C and D) – Assesses the receipt of influenza, Td/Tdap, zoster, and pneumococcal vaccines. Commenters had mixed reactions regarding this measure due to concerns about obtaining complete vaccination data.

- Concurrent Use of Opioids and Benzodiazepines, Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults, and Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults (Part D) – CMS proposed adding these measures in 2026 Star Ratings.

The following display measures will be updated for the 2023 measurement year based on PQA measure specification updates:

- Antipsychotic Use in Persons with Dementia, overall (APD) / Antipsychotic Use in Persons with Dementia, in Long-Term Nursing Home Residents (APD-LTNH) (Part D) – Most commenters were supportive of the measure specification updates to these measures.

- Initial Opioid Prescribing – Long Duration (IOP-LD) (Part D) – Most commenters supported this measure specification update.

Other Part D measures are expected to be aligned with PQA measure specifications in the future.

Potential New Measure Concepts and Methodological Enhancements for Future Years

- Health Equity (Part C and D) – Commenters supported the provision of confidential stratified reports to help identify disparities in case by LIS/DE and disability status and recommended releasing the stratified reports publicly.
- Chronic Pain Assessment and Follow-up (Part C) – Most commenters supported the concept of a new measure that assesses chronic pain and follow-up in Medicare enrollees aged sixty-five and older.
- Sexual Orientation and Gender Identity for HEDIS Measures (Part C) – Most commenters supported inclusivity updates to HEDIS measures where the eligible population is currently defined with gendered language.
- Identifying Chronic Conditions in HEDIS Measures (Part C) – Most commenters supported updates to the identification of those with chronic conditions. The updates would simplify identification of conditions and impact the following Star Ratings and display measures:
    - Diabetes Care – Eye Exam Diabetes Care – Blook Sugar Controlled
    - Follow-up After Emergency Department Visit for Patients with Multiple Chronic Conditions
    - Kidney Health Evaluation for Patients with Diabetes
- Blood Pressure Control (Part C) – Most commenters supported the development of a new blood pressure control measure that utilize the capabilities of digital quality measures and leverages standardized electronic clinical data.
- Kidney Health (Part C) – Commenters strongly supported the measure concepts for kidney health management related to person-centered outcomes, shared decision making, and preparedness for kidney failure.
- Social Connection Screening and Intervention (Part C) – Most commenters supported the development of a new measure that assesses the percentage of members aged sixty-five and older who were screened during the measurement period for social isolation, loneliness, or inadequate social support and received a corresponding intervention if they screened positive.

- Broadening the Mental Health Conditions Assessed by Health Outcomes Survey (HOS) (Part C) – Commenters had mixed reactions about broadening the mental health conditions assessed by HOS to include the 2-item measure of Generalized Anxiety Disorder (GAD-2).
- Measuring Access to Mental Health Care on HOS (Part C) – Most commenters did not believe that HOS is the right vehicle for this type of measure but supported the idea of measuring mental health care access.
- Addressing Unmet Health-Related Social Needs on HOS (Part C) – Commenters had mixed reactions about adding questions regarding screening and assistance with unmet social needs to HOS.

CAHPS (Part C and D)

CMS tested a web-based survey in an effort to increase CAHPS response rates. They intend to continue the web-based mode in the 2024 CAHPS survey implementation used for the 2025 Star ratings. Nearly all commenters supported this new mode, with a few concerns of introducing bias. After testing and evaluation, CMS does not believe there is a substantial risk of bias.

Questions on unfair or insensitive treatment were assessed as noted in the 2023 Advance Notice and Rate Announcement. The item is being considered as a potential display measure for the 2025 Star Ratings year. Nearly all commenters supported the intent of the question, with some concerns about controlling for factors that may affect responses. Non-substantive changes to the questions are being considered to the Getting Appointments and Care Quickly measure.

Attachment VII: Economic Information for the CY 2024 Rate Announcement

Attachment VII provides estimates of the net impact to the Medicare Trust Funds of changes to the Medicare Advantage and PACE plans for CY 2024. Items not identified in Attachment VII indicate a continuation of CY 2023 polies so have not been called out in this section of the final announcement. Following are changes from the CY 2024 Advance Rate Notice.

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

- Medicare Advantage and PACE non-ESRD Ratebook.

- Growth rate for 2024 FFS non-ESRD rates estimate: **2.45%, a change from 2.15% in the Advance Notice**
- Growth rate for 2024 MA non-ESRD rates estimate: 1.60%, a change from 1.81% in the Advance Notice.
- Effective growth rate for 2024 MA non-ESRD rates estimate: **2.28%, a change from 2.09% in the Advance Notice**.
- Net impact $8.1 billion cost to Medicare Trust Funds up from 7.3 billion in the Advance Notice.
- MA growth percentage used to calculate the 2024 PACE non-ESRD is estimated to be **1.60%, a change from 1.81% in the Advance notice**.
    - Net Impact $30 million cost to Medicare Trust Funds – no change from the Advance Notice.
- Continue the adjustment to the calculation of county benchmarks in Puerto Rico for the number of beneficiaries with zero claims.
    - Net impact $260 million cost to Medicare Trust Funds, down from $280 million in the Advance Notice.

- Medicare Advantage and PACE ESRD Ratebooks.
    - FFS growth percentage for the 2024 MA ESRD rates is estimated to be **2.27% a change from 2.68% in the Advance Notice**.
        - Net impact $440 million cost to Medicare Trust Funds, a change from $550 million in the Advance Notice.
- CMS-HCC Risk Adjustment Model.
    - CMS is proposing an updated Part C CMS-HCC risk-adjustment model for organizations other than PACE. A three (3)-year phase in beginning in CY 2024 when the risk score will be calculated as the sum of 33% of the risk score calculated with the updated model (the 2024 model and 67% of the risk score calculated with the current model (the 2020 model). This is a change from the Advance Notice which included no phase in period.
        - Anticipated impact on MA risk scores: **-2.16%, a change from -3.12% in the Advance Notice.**

- Represents **$7.6 billion net savings to the Medicare Trust fund in 2024, a change from $11.0 billion net savings in the Advance Notice.**

- Frailty Adjustment for FIDE SNPs.
  - CMS is calculating frailty scores for FIDS SNPs by blending 67% of the frailty scores used for CY 2023 and 33% of the frailty scores being finalized for CY 2024 that do not include the CAHPS survey weight.
    - This is a change from the Advance Notice which proposed to calculating frailty scores for FIDE SNPs using updated frailty factors associated with the proposed 2024 CMS-HCC model.
    - Relative to CY 2023 frailty factors, the impact is: -0.58%, which is a change from -15.68% in the Advance Notice.
    - This change represents a savings of less than $10 million, which is a change from $50 million savings in the Advance Notice.

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

No change from Advance Notice.