Frequently Asked Questions (FAQ) on the Medicare Advantage 2024 Advance Notice

Each year, CMS is required to update Medicare Advantage (MA) payment rates and regularly conducts technical updates to risk adjustment in order to make improvements needed to keep MA payments up-to-date and accurate. CMS makes technical updates and improvements through the Advance Notice and Rate Announcement process for this purpose.

The proposed 2024 Advance Notice published on February 1, 2023 includes a series of routine technical updates, improvements, and recalibrations that would result in an increase to MA payments for plans in 2024. CMS has proposed a nearly 10% increase to MA payments over the last two years.

The technical updates in the Advance Notice include:

- A preliminary growth rate increase, which includes inflation; and
- Programmatic adjustments to modernize the risk adjustment model, including newer data and routine clinical adjustments to ensure Medicare payments accurately reflect what it costs to care for beneficiaries enrolled in MA plans.

There is a statutory requirement to provide a minimum 30-day comment period and release a final Rate Announcement by the first Monday in April. To comply with these requirements, comments are due March 6, 2023 and then, after consideration of comments received, CMS will issue a final Rate Announcement by April 3, 2023.

How would the proposed changes in the 2024 Advance Notice impact payments to MA plans?

MA payments are expected to increase by 1.03% from 2023 to 2024, as proposed. This is about a $4 billion increase in MA payments for next year. This increase includes consideration of the various elements that impact MA payment, such as growth rates, Star Ratings, risk adjustment model updates, and increases to risk scores because of coding trend. This proposed increase represents the average payment update, and thus there may be variation among plans in terms of their plan-specific payment impacts, including plans that would see a larger increase.

Has CMS made these types of updates to MA payments before?

Yes, these updates are in line with past payment updates to the MA program. Over the past few years, payment updates have been higher than average, but the proposed update for 2024 is within the range of recent updates. There have been multiple years (for example, 2014 and 2015) when the percent increase in MA payments was smaller than the 1.03% increase proposed for 2024.

Have these types of risk adjustment changes been made before?

Yes, the updates CMS is proposing for the risk model in 2024 are in line with the routine updates CMS has made in the past. For example, CMS recalibrated the MA risk adjustment model with updated data years and/or made additional revisions to the risk adjustment model for payment years 2007, 2009, 2013, 2014, 2017, 2019, and 2020. Additionally, MedPAC has noted that CMS routinely makes changes to the MA risk adjustment model, including by updating data years and diagnostic codes.[1]

How will the proposed changes impact beneficiaries' premiums and benefits in 2024?

Payment to MA plans would be 1.03% higher in 2024 than 2023, as proposed. If finalized, CMS anticipates stable premiums and benefits for beneficiaries in 2024, as seen previously in years with comparable updates. For example, in 2015, MA plans experienced a payment increase of 0.4% compared to 2014. Following those payment updates, the MA market remained stable. Historical experience shows plans compete in this highly competitive market to keep premiums down and maintain supplemental benefit levels, with beneficiary choice remaining strong.

Why are CMS's impact estimates different from those offered by some MA plans?

The Advance Notice includes an average proposed increase in MA plan payments of 1.03% for 2024. To accurately understand the impact of the Advance Notice for MA payments, it is critical that MA plans consider the total impact of all proposed policies and factors in the Advance Notice together, including, for example, the MA risk score trend. Additionally, because 1.03% reflects an average payment increase across the MA market, there would be variation among MA plans in terms of their specific payment impacts, including plans that will see a larger increase.

Why is CMS proposing to move to the *International Classification of Diseases* (ICD)-10 diagnosis coding system in the MA risk adjustment model?

Moving to the ICD-10 diagnosis coding system in the MA risk adjustment model would align the MA risk model with the coding classification system used throughout the U.S. health care system, which has been using ICD-10 instead of the outdated ICD-9 coding system since 2015. Additionally, the use of ICD-10 provides CMS with a greater level of precision and granularity than exists with ICD-9. This change would help ensure that MA plan payments more accurately reflect the costs of beneficiaries' care so that plans serving beneficiaries with greater health care needs receive appropriately higher payments.

Why does the Advance Notice update the data years in the MA risk adjustment model?

CMS routinely updates the data years used in the model generally every two to four years, as noted above. These proposed updates modernize and improve the accuracy of the risk adjustment model, which improves the accuracy of MA payments overall. The current MA risk adjustment model uses 2014 diagnosis data and 2015 FFS expenditure data. Now that 2018 diagnosis and 2019 expenditure data are available, the 2024 Advance Notice proposes using this more recent data to ensure that the model can continue to be as accurate as possible.

[1] The Medicare Payment Commission (MedPAC). June 2022 Report to the Congress: Medicare and the Health Care Delivery System, June 15, 2022.

Why does the Advance Notice eliminate some diagnosis codes?

These proposed adjustments in some codes help to ensure that the risk adjustment of MA payments better reflects a beneficiary's costs of care, which means MA plans serving beneficiaries with greater health care needs would receive appropriately higher payments. To be clear, the proposed model updates do not impact coverage of Medicare services or requirements for MA plans to deliver covered services; rather, these proposed changes improve the accuracy of payments made to MA plans for covering care for enrollees.

The majority of these changes are associated with the proposed transition to ICD-10 from the outdated ICD-9 coding system. As described above, the ICD-10 coding system includes more codes than ICD-9 because this updated system is more granular and precise. Not all of these more granular codes, however, are predictive of increased health care costs. To that end, CMS evaluated each ICD-10 code to see if the specific code was associated with higher health care costs. Applying longstanding principles of risk adjustment, CMS then proposed excluding codes that are not accurate predictors of increased costs, such as codes that are duplicative or discretionary and do not add incremental costs. These changes would help to spread MA payments to each diagnosis to more accurately reflect the cost of care, ensuring plans are not underpaid or overpaid for the care provided to enrollees.

Did CMS engage the clinical community on the proposed inclusion or exclusion of codes?

Yes, all codes in the proposed MA risk model were evaluated with clinical input, with a special focus on condition areas that underwent significant changes from ICD-9 to ICD-10. CMS received clinical input from a panel of physicians in various specialties and with relevant expertise, including internal medicine physicians and clinicians with specific expertise in coding and disease burden.

How would the proposed changes impact beneficiaries with depression?

Medicare, and thus MA plans, would continue to pay for the services beneficiaries need to treat depression. As noted above, the proposed model does not impact coverage of Medicare services or requirements for MA plans to deliver covered services. Under the 2024 Advance Notice, MA payments would more accurately reflect the costs of care associated with this condition. While some depression codes were removed from the model because they did not predict cost well or were duplicative or were related to diagnoses in remissions, more than 350 depression codes remain in the risk adjustment model.

How would the proposed changes impact beneficiaries with diabetes?

Under the proposed model updates, Medicare, and thus MA plans, will continue to pay for the services beneficiaries need to treat their diabetes. As part of updating the risk adjustment model, certain diabetes codes were removed because they are not reliable predictors of cost. Over 300 diabetes codes remain in the risk adjustment model. The proposed model would provide extra payments for patients with diabetes who have complications associated with diabetes, like chronic kidney disease, heart disease, and diabetic retinopathy. In addition, there are other payment factors, such as a condition count bump, that increases payment when beneficiaries have more co-morbidities. Thus, the 2024 Advance Notice proposals for this aspect of the MA risk model would provide a more targeted and accurate payment increase for a diabetic patient because it adjusts

MA payments according to the patient's full health profile, rather than using only a diabetes diagnosis as a proxy for increased health care costs. This approach would help ensure that higher payments are directed to diabetic patients with the greatest health care costs.

How would the proposed changes impact beneficiaries that are low-income, clinically complex in rural or underserved areas?

The proposals in the Advance Notice improve the accuracy of risk adjustment so plans are paid more accurately for complex individuals. Additionally, there are protective features built into the MA risk adjustment system to ensure plans who care for dually eligible individuals are paid adequately, and nothing in this proposal changes those features.

Specifically, for payment year 2017, CMS significantly improved the MA risk adjustment model's accuracy related to demographics, and specifically for duals, by creating new, customized versions of risk adjustment models based on Medicaid eligibility status and whether the individual was eligible for Medicare due to being 65 or older or due to disability status. This ensured that full dual-eligible beneficiaries have an entire risk adjustment system built around their specific risk factors. Those demographic improvements are not changing in our proposal for 2024, so we will continue to pay much more for someone who is dually eligible than someone who is not, even when they have the same diagnoses. These higher payments decrease incentives for plans to favor healthier enrollees or discriminate against sicker patients.

To the extent beneficiaries who are low-income or who are living in rural or underserved areas have greater health care needs, the proposed model would better compensate plans for that care. Furthermore, federal law protects most dually eligible individuals from any cost sharing for Medicare services, so specific plans changes in cost sharing cannot be passed onto those dually eligible beneficiaries.

What action is CMS taking to address overpayments to MA plans?

The proposed changes in the Advance Notice improve the accuracy of payments made to MA plans for covering care for enrollees and would help prevent overpayments.

Separate from the proposals in the 2024 Advance Notice, CMS also recently finalized policies for the Medicare Advantage Risk Adjustment Data Validation (RADV) Program. The RADV program is the primary audit and oversight tool to address improper payments in the MA program. CMS finalized RADV policies that support commonsense oversight of MA program payments. CMS will extrapolate RADV audit findings beginning with Payment Year 2018 as part of our statutory and fiduciary responsibilities to reduce and recover improper expenditures of taxpayer dollars. The policies finalized will also allow CMS to continue to focus its audits on those MA organizations identified as being at highest risk for improper payments.