February 1, 2023

NOTE TO: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties

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

In accordance with section 1853(b)(2) of the Social Security Act (the Act), we are notifying you of planned changes in the Medicare Advantage (MA) capitation rate methodology and risk adjustment methodology applied under Part C of the Medicare statute for CY 2024. Also included with this notice is a discussion of the annual adjustments for CY 2024 to the Medicare Part D benefit parameters for the defined standard benefit, including those necessitated by the Inflation Reduction Act of 2022 (IRA) (Pub. L. 117-169). CMS will announce the MA capitation rates and final payment policies for CY 2024 no later than Monday, April 3, 2023, in accordance with section 1853(b) of the Act, as established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) and amended by the Securing Fairness in Regulatory Timing Act of 2015 (Pub. L. 114-106). The Advance Notice of Methodological Changes is published no fewer than 60 days before the publication of the Rate Announcement and provides a minimum 30-day period for public comment.

Attachment I of this document shows the preliminary estimates of the national per capita MA growth percentage and the national Medicare fee-for-service growth percentage, which are key factors in determining the MA capitation rates. Attachment II sets forth changes in the Part C payment methodology for CY 2024. Attachment III presents the annual adjustments to the Medicare Part D benefit parameters for the defined standard benefit, and sets forth the changes in the Part D payment methodology for CY 2024, including those necessitated by the IRA. Attachment IV applies standards for certain updates for the MA and Part D Star Ratings and solicits feedback on potential new measures, substantive and non-substantive updates to existing measures, and potential measure concepts. Attachment V contains economic information for significant provisions in the Advance Notice. Attachment VI presents the preliminary risk adjustment factors.

To submit comments or questions electronically, go to https://www.regulations.gov, enter the docket number "CMS-2023-0010" in the "Search" field, and follow the instructions for "submitting a comment."

Comments will be made public, so submitters should not include any confidential or personal information. It should be noted that CMS will not post on Regulations.gov public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. In order to receive consideration prior to the release of the final Announcement of CY 2024 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Rate

Announcement), comments on this Advance Notice must be received by 6:00 PM Eastern Time on Friday, March 3, 2023.

/ s /

Meena Seshamani, M.D., Ph.D.
Director, Center for Medicare

I, Jennifer Wuggazer Lazio, am a Member of the American Academy of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained in this Advance Notice. My opinion is limited to the following sections of this Advance Notice: The growth percentages and United States per capita cost estimates provided in Attachment I; the qualifying county determination, calculations of Fee for Service cost, direct graduate medical education carve-out, kidney acquisition cost carve-out, IME phase out, MA benchmarks, EGWP rates, and ESRD rates discussed in Attachment II; Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2024 described in Attachment III; and the economic information contained in Attachment V.

/ s /
Jennifer Wuggazer Lazio, F.S.A., M.A.A.A.
Director
Parts C & D Actuarial Group
Office of the Actuary

Attachments

2024 ADVANCE NOTICE
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Attachment I. Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2024

Each year in the Advance Notice, CMS updates its historical estimates of per capita Medicare costs based on recent data, and provides an estimate for an additional projection year. Specifically, CMS provides estimates of three separate United States Per Capita Costs (USPCCs) for each calendar year:

- Non-ESRD
  - **FFS USPCC**: the USPCC for Medicare Fee-for-Service (FFS) aged/disabled beneficiaries except those beneficiaries who are in End Stage Renal Disease (ESRD) status for payment purposes, i.e., those beneficiaries who are in dialysis, transplant, or functioning graft status. The FFS USPCC is used in the calculation of the specified amount, which is described in Attachment II Section A2 and is sometimes referred to as the "post Affordable Care Act (ACA)" rate methodology.
  - **Total USPCC**: the USPCC for Medicare Part C and FFS beneficiaries except those beneficiaries who are in ESRD status for payment purposes. The total USPCC is used in the calculation of the applicable amount, which is described in Attachment II Section A1 and is sometimes referred to as the "pre-ACA" rate methodology used to determine the "benchmark cap" for each county, as described in Attachment II Section A5.
- ESRD
  - **FFS Dialysis ESRD USPCC**: the USPCC for beneficiaries in FFS with ESRD who are in dialysis status (i.e., "Dialysis ESRD").[1]

Based on these estimates, CMS calculates the change, or growth, in each of the USPCCs for the upcoming year. In this Notice, we provide growth percentages from 2023 to 2024. These growth percentages represent the year-over-year changes to the factors used to calculate the MA payment rates, or benchmarks, as discussed below. Throughout this document, we use the terms "benchmark" and "county rate" interchangeably, and the term "service area benchmark" indicates the bidding benchmark for an MA plan based on its specific service area.

The MA county rates are based on the specified amount as described in Attachment II Section A2 below. Section 1853(n)(2)(A) of the Social Security Act ("the Act") defines the specified amount as the base amount multiplied by the applicable percentage for the area (set under section 1853(n)(2)(B) through (D)). Section 1853(n)(4) requires that the benchmark for an area for a

[1] Dialysis ESRD USPCCs are trended from a base year using the trend in total ESRD net of an adjustment factor for dialysis-only.

year (including increases for quality bonus percentages) be capped at the level of the applicable amount, as defined at section 1853(k)(1) and described in Attachment II Section A1.

The county rates for Programs of All-Inclusive Care for the Elderly (PACE) are established using the applicable amount as determined under section 1853(k)(1). This amount is calculated without excluding indirect medical education (IME) amounts under section 1853(k)(4) (as required by section 1894(d)(3)), or organ acquisition costs for kidney transplants, as discussed in Attachment II Section C of this document.

Section A. Data and Assumptions Supporting USPCCs

Background

In this section of the CY 2024 Advance Notice, we provide details and descriptions regarding the development of the USPCCs. Unless otherwise stated, the data and methodologies described in this section are past and present practice. The historical and projected USPCC baseline is based on the most recent program experience and actuarial projections prepared by the Office of the Actuary (OACT). The data is tabulated and projected separately for Medicare Part A and Medicare Part B on a quarterly basis. Enrollment and expenditures are summarized on an incurred basis.

Historical Enrollment

Historical total Medicare enrollment is developed from CMS' administrative records. Historical Medicare Advantage enrollment is tabulated from the Monthly Membership Report (MMR[2]) data files.

The enrollment and expenditures are summarized separately for total Medicare and Medicare Advantage and apportioned to non-ESRD and ESRD categories based on Medicare status code (MSC):

- Non-ESRD: MSC 10 (aged without ESRD) and MSC 20 (disabled without ESRD)
- ESRD: MSC 11 (aged with ESRD), MSC 21 (disabled with ESRD), and MSC 31 (ESRD only)

Historical Medicare FFS enrollment is calculated as the difference between total Medicare enrollment and Medicare Advantage enrollment.

[2] For more information on the MMR, refer to the Plan Communication User Guide available at https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide.

Projected Enrollment

Total Medicare enrollment projections are generally based on certain percentages of the Social Security Administration's (SSA's) population projections. These percentages have been stable over time. For Part A, the projected number of aged beneficiaries averages 98 percent of the Social Security area population aged 65 and older. The disabled enrollment projection is slightly more than the portion of SSA's disabled beneficiary population that has been on the rolls for at least 2 years, because an individual is eligible for Part A even if they have had 2 non-consecutive years of disability. For Part B, the aged enrollment averages 92 percent of the Social Security area population aged 65 and older. The Part B disabled enrollment is 92 percent of the Part A disabled enrollment.

The increase in the Medicare Advantage projected enrollment is based on an enrollment model which incorporates the historical growth in penetration rates to estimate the MA enrollment growth rates for future years. Projected Medicare FFS enrollment is calculated as the difference between projected total Medicare enrollment and projected Medicare Advantage enrollment.

Historical Benefit Expenditures

The primary source for historical FFS claims is the National Claims History (NCH) file.[3] Additional sources of FFS expenditures include payments to providers based on cost reports, payments for pass through costs, and payment adjustments authorized by law or in connection with participation in the Medicare Shared Savings Program or Innovation Center models or demonstrations or Advanced Alternative Payment Models. Using completion factors developed from recent program experience, historical experience for more recent years is grossed up to account for claims incurred but not paid.

Historical MA expenditures are tabulated from the Monthly Membership Report (MMR) files, which contain enrollment and plan payment information. The historical experience for more recent years is grossed up to reflect estimated outstanding risk adjustment reconciliations.

Projected Benefit Expenditures

Projected expenditures for FFS beneficiaries are developed separately for each type of service reflected in the NCH file, cost report settlements, pass through costs, and payments in the Medicare Shared Savings Program or Innovation Center models or demonstrations or Advanced Alternative Payment Models [4].

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[3] For more information on the NCH, refer to the System of Records Notice available at https://www.hhs.gov/foia/privacy/sorns/09700558/index.html.

[4] Attachment II Section B3 contains additional information regarding the Medicare Shared Savings Program and Innovation Center models and demonstrations, and Advanced Alternative Payment Models.

The projection of NCH costs is based on reimbursements or allowed charges incurred per beneficiary during the base calendar year (CY). For the 2024 Advance Notice USPCCs, the base year was CY 2021 for most services.

The projections take into account various trends including:

- Unit cost changes tied to market baskets and productivity adjustments, fee schedule updates, or the consumer price index (CPI). These updates are based on economic assumptions provided by the Office of Management and Budget (OMB).
- Utilization and intensity of services, which are generally based on historical trends.
- Impact of changes in population mix as measured by age, sex, and time-to-death.
- Changes in Medicare coverage due to legislation, regulation, and national coverage determinations (NCDs).

Projected cost report settlements and pass through costs are developed as a percentage add-on basis to the NCH costs and are projected to remain at the same percentage level throughout the projection.

Innovation Center model or demonstration payments are projected based on the estimates developed for each individual Innovation Center model or demonstration and any historical experience of each model or demonstration.

Medicare Advantage per capita historical bids, rebates, and benchmarks are summarized on an incurred basis by Medicare Status Code, insurance market (EGWP, individual/non-EGWP), and coverage type (HMO, LPPO, RPPO, SNP, etc.). Projections are performed separately for payments from the Part A and Part B Trust Funds. Aggregate projected payments are calculated as the projected per capita costs times the projected enrollment.

CY 2021 is the base year for the Medicare Advantage experience reflected in the Advance Notice 2024 baseline. The 2022 and 2023 risk-adjusted benchmarks, bids, and rebates are estimated based on the growth rates that are derived from the summarized 2022 and 2023 bids and using plans' projections of enrollment and risk scores. Trends in per capita bids for 2024 and later are tied to the per capita FFS growth rates, or the non-ESRD FFS USPCC and the per capita benchmark increases. Trends in the MA benchmarks reflect the FFS growth rates, adjustment to MA risk scores for differences in diagnosis coding between MA and FFS beneficiaries, projected changes in ACA quality bonus (county-specific), and projected phase-out of IME (county-specific).

The Medicare FFS unit cost increases supporting the USPCCs for 2022–2024 will be available on the CMS website at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Trends.

Adjustments from the Baseline to Develop the USPCC Baseline

There are several adjustments made to the baseline to develop the USPCC projection. Given that MA bids do not include coverage for hospice, expenditures to hospices are excluded from the USPCCs. Also, per section 1853(c)(1)(D)(i) of the Act, incentive payments under sections 1848(o) and 1886(n) of the Act[5] for adoption and meaningful use of certified EHR technology are not included in the USPCCs. Additionally, claim expenditures in the NCH for cost plan enrollees are removed from the non-ESRD FFS USPCC. Finally, the MA ratebook and MA bids are presented on a pre-sequestration basis and, accordingly, the historical and projected sequestration reduction is added back to the USPCC baseline.

Proposed Technical Update to Medical Education Payments in the Non-ESRD USPCC Baseline

Section 1886(d)(11) of the 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 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.

Historically, the tabulation of non-ESRD FFS USPCCs has included both IME and DGME costs paid to inpatient facilities on behalf of MA enrollees because the inpatient cost report experience supporting the baseline modeling did not separately identify these payments from those made on behalf of FFS enrollees. Consequently, MA organizations (MAOs) had been effectively paid for these admissions-related costs, even though CMS, and not MAOs, had been paying these costs associated with MA enrollees directly to hospitals.

The baseline development and modeling supporting the USPCCs has now been updated to separate these payments and identify the historical and projected costs of IME and DGME paid to inpatient facilities by CMS associated with services furnished to MA enrollees.

We are proposing to remove these MA-related IME and DGME costs from the historical and projected expenditures supporting the non-ESRD FFS USPCCs beginning with the CY 2024 ratebook.

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[5] Sections 1848(o) and 1886(n) of the Act provide for incentive payments under the Medicare FFS program for eligible professionals and eligible hospitals, respectively, for meaningful use of certified EHR technology (CEHRT). 2016 was the final year that eligible professionals, as well as eligible hospitals outside of Puerto Rico, could earn incentive payments under these provisions; eligible hospitals in Puerto Rico could earn incentive payments for meaningful use of CEHRT through 2021. Sections 1848(a)(7) and 1886(b)(3)(B)(ix) require a reduction in Medicare FFS payments for eligible professionals and eligible hospitals that are not meaningful users of certified EHR technology, starting in 2015 for eligible professionals and eligible hospitals outside of Puerto Rico and in 2022 for eligible hospitals in Puerto Rico. 2018 was the final year that eligible professionals who were not meaningful users of CEHRT could be subject to negative payment adjustments under section 1848(a)(7).

The effects of the proposed change on the USPCCs reflected in Section B of this document include:

- First, the proposed change lowers the 2024 non-ESRD FFS USPCC and the corresponding non-ESRD FFS growth percentage by 2.13 percent. This growth percentage is used in the calculation of the specified amount for all counties.
- Second, the proposed change lowers the 2024 non-ESRD Total USPCC and the corresponding MA growth percentage by 1.06 percent. This growth percentage is used in the calculation of the applicable amounts which serve as a cap on the specified amount for a subset of affected counties.

The proposed change is not expected to have any impact on the 2024 dialysis ESRD USPCC.

The changes being proposed in this section have no impact on the exclusion of medical education costs from the Average Geographic Adjustment (AGAs) used to create the ratebook, since the adjustment proposed in this section is limited to the USPCCs. Refer to Attachment II, sections C1 (Direct Graduate Medical Education) and C3 (Indirect Medical Education) for descriptions of the adjustments pertaining to the FFS experience and projections used to develop the ratebook.

Section B. 2024 Growth Percentage Estimates

The MA growth percentage, as defined at section 1853(c)(6), reflects the growth in per capita costs for non-ESRD beneficiaries enrolled in either FFS or MA, excluding expenditures attributable to sections 1848(a)(7), 1848(o), 1886(b)(3)(B)(ix), and 1886(n) of the Act, based upon estimates of the total USPCC. The MA growth percentage is also referred to as the total growth percentage and the National Per Capita MA Growth Percentage. The MA growth percentage is used in calculating the applicable amount for a county, as required under section 1853(k)(1).

The non-ESRD FFS growth percentage reflects the growth in per capita costs based upon estimates of the FFS USPCC. As required by section 1853(n)(2)(E)(ii)(II) of the Act, the FFS USPCC calculated under section 1853(c)(1)(D) is used to calculate the specified amount in years in which CMS elects to rebase the adjusted average FFS per capita cost. CMS intends to rebase as part of the calculation of the rates for 2024.

The ESRD growth percentage reflects the growth in per capita costs based on the ESRD FFS USPCC. MA ESRD rates are determined by applying an historical average geographic adjustment to a projected FFS dialysis-only ESRD USPCC.

Table I-1 below provides the current estimate of the change in the three USPCC estimates. The percentage change in each USPCC is shown as the current projected USPCC for 2024 divided by the prior projected USPCC for 2023.

Table I-1. Increase in the USPCC Growth Percentage for CY 2024

	Total USPCC – Non-ESRD	FFS USPCC – Non-ESRD	FFS Dialysis-only ESRD USPCC
Current projected 2024 USPCC	$1,158.53	$1,101.81	$9,582.65
Prior projected 2023 USPCC	$1,137.92	$1,078.63	$9,332.69
Percent increase	1.81%	2.15%	2.68%

The current estimate of the MA growth percentage* (or change in the Total USPCC non-ESRD) for aged and disabled enrollees combined in CY 2024 is 1.81 percent. This estimate reflects an underlying trend change for CY 2024 in per capita cost of 3.57 percent and, as required under section 1853(c)(6)(C) of the Act, adjustments to the estimates for prior years as indicated in the table below.

Table I-2 below provides additional detail on the estimates for the change in the Total USPCC or national per capita MA growth percentage for aged/disabled beneficiaries.

Table I-2. Increase in the MA Growth Percentage for 2024

	Prior Increases	**Current Increases**			**MA Growth Percentage for 2024 With §1853(c)(6)(C) adjustment****
	2003 to 2023	**2003 to 2023**	**2023 to 2024**	**2003 to 2024**	
Aged+Disabled	109.238%	105.678%	3.573%	113.028%	1.81%

* The MA growth percentage is also known as the National Per Capita MA Growth Percentage and is equal to change in the total USPCC non-ESRD.

** (1 + current increases for 2003 to 2024) divided by (1 + prior increases for 2003 to 2023) minus 1.

Section C. USPCC Estimates

Table I-3 compares last year's estimate of the total non-ESRD USPCC with current estimates for 2003 to 2026; Table I-4 compares last year's FFS non-ESRD USPCC estimates with current estimates; and Table I-5 compares last year's dialysis-only ESRD USPCC estimates with current estimates. In addition, these tables show the current projections of the USPCCs through 2026. Caution should be employed in the use of this information. It is based upon nationwide averages, and local conditions can differ substantially from conditions nationwide. None of the data presented here pertain to the Medicare prescription drug benefit.

The tabulation of FFS costs supporting the USPCCs includes payments made outside the Medicare FFS claim systems, such as provider settlements via cost reports, Innovation Center model and demonstration payments, Medicare Shared Savings Program shared savings settlements, Advanced Alternative Payment Model incentive payments, and other adjustments. Also included in the USPCCs are the cost impacts of program changes enacted through known legislation, regulation, and NCDs applicable for the contract year (2024). Attachment II Section B contains additional information regarding the calculation of FFS costs.

Our estimates for the USPCCs for 2020 and subsequent years reflect the projected cost impacts related to the COVID-19 pandemic, including estimates for applicable costs related to COVID-19 vaccination and changes in utilization of health care services. These USPCCs also reflect estimated cost impacts of changes in MA coverage created by legislation. Section 6003 of the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127), which amended section 1852(a)(1)(B) of the Act, prohibits MA organizations from requiring cost-sharing in excess of Medicare FFS cost-sharing for testing for COVID-19 and specified testing-related services during the COVID-19 public health emergency (PHE). This, in effect, eliminates MA cost-sharing for COVID-19 testing for that period because there is no cost-sharing under Medicare FFS for the testing and there is no cost sharing for the specified testing-related services during the same period. Section 6003 also prohibits MA plans from applying prior authorization or any other utilization management requirement with respect to COVID-19 clinical diagnostic laboratory tests and specified COVID-19 testing-related services furnished during the COVID-19 PHE. In addition, Section 3713 of the CARES Act, which amended section 1852(a)(1)(B) of the Act, prohibits MA organizations from requiring cost-sharing in excess of Medicare FFS cost-sharing (which is zero) for a COVID-19 vaccine and its administration described in section 1861(s)(10)(A) of the Act; this limitation on cost sharing is not limited to the PHE and, therefore, will apply in 2024.

Our estimates for the USPCCs for 2022 and subsequent years reflect the projected cost impacts related to the provisions of the IRA that are effective in those years. For example, section 11101 of Subtitle B of the IRA requires manufacturers of a "Part B rebatable drug"[6] to pay a rebate if 106 percent of the lesser of the drug's average sales price or wholesale acquisition cost for a calendar quarter exceeds the inflation-adjusted payment amount;[7] this provision applies for each calendar quarter beginning on or after January 1, 2023. In addition, if 106 percent of the lesser of the drug's average sales price or wholesale acquisition cost for a calendar quarter exceeds the inflation-adjusted payment amount, then, beginning April 1, 2023, beneficiary coinsurance is to be based on the inflation-adjusted payment amount. Also, Section 11407 of the IRA requires,

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[6] Per Section 1847A(i)(2), a "Part B rebatable drug" is defined as a single source drug or biological including biosimilars (excluding a qualifying biosimilar biological product); a drug or biological with average annual spending less than $100 per individual user (as determined by the Secretary) and preventive Part B vaccines are excluded from this definition.

[7] The inflation-adjusted amount is the payment amount in the benchmark quarter (in general, the calendar quarter beginning July 1, 2021) increased by CPI-U.

beginning July 1, 2023, the Medicare Part B deductible does not apply for insulin furnished through an item of durable medical equipment covered under Medicare's durable medical equipment benefit, and beneficiary cost sharing for a month's supply of insulin is not to exceed $35.

Section 11407 of the IRA is projected to increase Part B FFS expenditures for 2023 and subsequent years because Medicare will pay for the reduced beneficiary financial responsibility for insulins. Section 11101 is projected to have a negligible downward impact on Part B FFS expenditures for 2023 and subsequent years.

The USPCCs and growth rates in the CY 2024 Rate Announcement will reflect the provisions of the Consolidated Appropriations Act, 2023 (P.L. 117-328). However, given the timing constraints of the recently enacted Consolidated Appropriations Act, 2023 (P.L. 117-328) and the statutory timeframe for the Advance Notice, it was not feasible to incorporate the provisions of this specific legislation in the USPCCs and growth rates provided in this CY 2024 Advance Notice.

Table I-3. Comparison of Current & Previous Estimates of the Total USPCC – Non-ESRD

	Part A		Part B		Part A + Part B		
Calendar year	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Ratio
2003	$296.18	$296.18	$247.66	$247.66	$543.84	$543.84	1.000
2004	314.08	314.08	271.06	271.06	585.14	585.14	1.000
2005	334.83	334.83	292.86	292.86	627.69	627.69	1.000
2006	345.30	345.30	313.70	313.70	659.00	659.00	1.000
2007	355.44	355.44	330.68	330.68	686.12	686.12	1.000
2008	371.90	371.90	351.04	351.04	722.94	722.94	1.000
2009	383.91	383.91	367.49	367.35	751.40	751.26	1.000
2010	383.93	383.93	376.34	376.12	760.27	760.05	1.000
2011	387.73	387.73	385.30	385.12	773.03	772.85	1.000
2012	377.37	377.37	391.93	391.76	769.30	769.13	1.000
2013	380.03	380.03	398.72	398.54	778.75	778.57	1.000
2014	370.23	370.23	418.36	418.18	788.59	788.41	1.000
2015	373.86	373.99	435.00	434.95	808.86	808.94	1.000
2016	377.62	377.61	444.28	444.14	821.90	821.75	1.000
2017	383.09	382.91	459.37	459.08	842.46	841.99	1.001
2018	388.12	388.06	489.86	489.43	877.98	877.49	1.001
2019	400.79	400.21	522.14	521.77	922.93	921.98	1.001
2020	403.91	402.19	522.78	522.62	926.69	924.81	1.002
2021	409.36	412.79	570.23	573.53	979.59	986.32	0.993

	Part A		Part B		Part A + Part B		
Calendar year	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Ratio
2022	434.28	447.39	608.20	624.52	1,042.48	1,071.91	0.973
2023	460.52	469.56	658.04	668.36	1,118.56	1,137.92	0.983
2024	461.85	488.33	696.68	707.07	1,158.53	1,195.40	0.969
2025	482.12	509.50	733.99	744.57	1,216.11	1,254.07	0.970
2026	504.54		778.44		1,282.98		

Table I-4. Comparison of Current & Previous Estimates of the FFS USPCC – Non-ESRD

	Part A		Part B		Part A + Part B		
Calendar year	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Ratio
2010	$366.33	$371.20	$374.30	$373.99	$740.63	$745.19	0.994
2011	366.01	371.15	383.17	382.92	749.18	754.07	0.994
2012	351.45	356.97	390.70	390.45	742.15	747.42	0.993
2013	357.79	363.75	394.49	394.24	752.28	757.99	0.992
2014	357.66	364.24	409.16	408.89	766.82	773.13	0.992
2015	362.10	369.37	428.06	427.73	790.16	797.10	0.991
2016	363.69	371.57	433.62	433.36	797.31	804.93	0.991
2017	364.96	373.64	448.57	448.06	813.53	821.70	0.990
2018	367.68	377.84	474.50	473.79	842.18	851.63	0.989
2019	372.16	383.05	501.24	500.77	873.40	883.82	0.988
2020	361.53	372.68	474.18	473.99	835.71	846.67	0.987
2021	372.41	388.34	552.81	546.76	925.22	935.10	0.989
2022	388.17	424.46	580.21	598.85	968.38	1,023.31	0.946
2023	415.61	448.03	630.33	630.60	1,045.94	1,078.63	0.970
2024	430.65	465.39	671.16	666.68	1,101.81	1,132.07	0.973
2025	448.93	484.86	706.48	701.28	1,155.41	1,186.14	0.974
2026	468.98		748.20		1,217.18		

Table I-5. Comparison of Current & Previous Estimates of the ESRD Dialysis-only FFS USPCC

	Part A		Part B		Part A + Part B		
Calendar year	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Ratio
2010	$2,952.75	$2,952.75	$3,881.39	$3,881.39	$6,834.14	$6,834.14	1.000
2011	2,862.38	2,862.38	3,908.01	3,908.01	6,770.39	6,770.39	1.000

	Part A		Part B		Part A + Part B		
Calendar year	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Ratio
2012	2,774.49	2,774.49	3,944.59	3,944.59	6,719.08	6,719.08	1.000
2013	2,794.19	2,794.19	4,088.66	4,088.66	6,882.85	6,882.85	1.000
2014	2,784.52	2,784.52	4,115.70	4,115.70	6,900.22	6,900.22	1.000
2015	2,775.84	2,775.84	4,060.87	4,060.87	6,836.71	6,836.71	1.000
2016	2,895.91	2,895.91	4,081.27	4,081.27	6,977.18	6,977.18	1.000
2017	2,883.27	2,883.27	4,102.66	4,102.66	6,985.93	6,985.93	1.000
2018	2,952.21	2,952.21	4,526.09	4,526.09	7,478.30	7,478.30	1.000
2019	3,040.74	3,040.74	4,614.18	4,614.18	7,654.92	7,654.92	1.000
2020	3,082.55	3,082.55	4,542.51	4,542.51	7,625.06	7,625.06	1.000
2021	3,304.83	3,264.12	4,749.34	5,025.52	8,054.17	8,289.64	0.972
2022	3,419.34	3,646.65	4,778.95	5,279.76	8,198.29	8,926.41	0.918
2023	3,722.82	3,890.68	5,229.81	5,442.01	8,952.63	9,332.69	0.959
2024	3,932.34	4,057.82	5,650.31	5,648.71	9,582.65	9,706.53	0.987
2025	4,194.77	4,242.66	6,709.71	6,426.56	10,904.48	10,669.22	1.022
2026	4,475.66		7,256.31		11,731.97		

These estimates are preliminary and could change when the final rates are announced in the Announcement of CY 2024 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies. Further details on the derivation of the national per capita MA growth percentage and the FFS growth percentage will also be presented in the Rate Announcement.

Section D. Loading for Claims Processing Costs

Section 1853(c)(1)(D) of the Act provides that the adjusted average per capita cost (AAPCC) for the year involved, which is the basis for the calculation of the USPCC, is determined under section 1876(a)(4) of the Act. As defined in section 1876(a)(4) of the Act, the AAPCC (and accordingly the USPCCs) include administrative costs incurred by the Medicare Administration Contractors (MACs) described in sections 1816 and 1842, which is incorporated into the calculation as an adjustment. Consistent with past practice, this "loading" adjustment is developed as the ratio of MAC administrative costs to Medicare benefit payments for the most recent completed fiscal year. Consistent with past years, we will continue the methodology that the loading for the total non-ESRD USPCC include both FFS and Part C expenditures in the denominator of the calculation. In order to better align the costs included in the numerator and denominator, we will continue to include, as adopted for the 2023 rates, only FFS expenditures (as opposed to both FFS and Part C expenditures) in the denominator of the loading adjustment calculation for the FFS non-ESRD and FFS ESRD USPCCs. Table I-6 contains the proposed 2024 USPCC loading adjustment for claims processing costs.

Table I-6. USPCC Loading Adjustment for Claims Processing Costs

Expenditure Category	Cash Benefits FY 2022 (000)	MAC Expenses FY 2022 (000)	Claims Processing Loading	USPCC basis
PART A				
FFS	$201,311,668	$220,320	0.001094	FFS USPCC
Part C	$177,387,460	n/a	n/a	n/a
Total	$378,699,128	$220,320	0.000582	Total USPCC
PART B				
FFS	$215,088,289	$602,505	0.002801	FFS USPCC
Part C	$244,696,554	n/a	n/a	n/a
Total	$459,784,843	$602,505	0.001310	Total USPCC

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

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

Section 1853(n)(2) of the Act requires that, in determining the specified amount, CMS use as the base amount the amount described in section 1853(c)(1)(D) for a rebasing year or, for years that are not a rebasing year, the base amount from the previous year increased by the national per capita MA growth percentage. Section 1853(c)(1)(D)(ii) requires CMS to rebase the county FFS rates, which form the basis of the specified amount described in Section A2 below, periodically but not less than once every three years. When the rates are rebased, CMS updates its estimate of each county's FFS costs using more current FFS claims information. CMS intends to rebase the county FFS rates for 2024 using FFS claims data from 2017 through 2021. CMS has rebased the rates every year since 2012, and has discussed in previous Rate Announcements that we anticipate rebasing the rates each year. Given that MA rates are based on FFS costs, CMS believes it is important to update the FFS per capita cost estimates using the most current FFS data available. (Please note that throughout this document, the terms "benchmark" and "county rate" are used interchangeably, and the term "service area benchmark" indicates the bidding target for an MA plan based on its specific service area.) Section 1853(n)(4) requires that the benchmark for an area for a year (including increases for quality bonus percentages) be capped at the level of the applicable amount, as defined at section 1853(k)(1).

PACE payment rates are not developed using the specified amount, per section 1853(n)(5) of the Act, but are developed using the applicable amount, as defined at section 1853(k)(1), as discussed below.

A1. Applicable Amount

The applicable amount is the rate established under section 1853(k)(1) of the Act. As CMS intends to rebase the rates in 2024, the applicable amount for 2024 is the greater of: (1) the county's 2024 FFS cost or (2) the 2023 applicable amount increased by the CY 2024 National Per Capita Medicare Advantage Growth Percentage. As discussed in Section A5, section 1853(n)(4) of the Act requires that the benchmark (determined taking into account the application of the QBP percentage) for each county must be capped at the county's applicable amount.

A2. Specified Amount

Under section 1853(n)(2)(A) of the Act, the specified amount is based upon the following formula:

(2024 FFS cost minus (IME phase-out amount and kidney acquisition costs)) × (applicable percentage + applicable percentage quality increase)

Where:
FFS cost is adjusted to exclude costs attributable to payments under sections 1848(o), 1886(n), and 1886(h), as described in more detail below in section B;

IME phase-out amount is the amount of indirect costs of medical education that is required to be phased out as specified at section 1853(k)(4) and section 1853(n)(2)(A)(i) and (F);

Kidney acquisition costs are the standardized costs for payments for organ acquisitions for kidney transplants that are required to be excluded, beginning 2021, as specified at section 1853(k)(5) and section 1853(n)(2)(A)(i) and (G);

Applicable percentage is a statutory percentage applied to the county's base payment amount, as described at section 1853(n)(2)(B); and

Applicable percentage quality increase, referred to in this document as the quality bonus payment (QBP) percentage, is a percentage point increase to the applicable percentage for a county in a qualifying plan's service area as provided in section 1853(o).

Section 1853(n)(2)(B) and (C) of the Act requires CMS to determine applicable percentages for a year based on county FFS rate rankings for the most recent year that was a rebasing year. To determine the CY 2024 applicable percentages for counties in the 50 States and the District of Columbia, CMS will rank counties from highest to lowest based upon their 2023 average per capita FFS rate adjusted to exclude the IME phase out and payments for kidney acquisition. The 2023 rates are used because 2023 is the most recent rebasing year prior to 2024. CMS will then place the rates into four quartiles. For the territories, CMS will assign an applicable percentage to each territory county based on where the territory county rate falls in the quartiles established for the 50 States and the District of Columbia.

CMS is publishing the 2024 applicable percentages by county with the Advance Notice at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html. Each county's applicable percentage is assigned based upon its quartile ranking, as follows:

Table II-1. FFS Quartile Assignment

Quartile	Applicable Percentage
4th (highest)	95%
3rd	100%
2nd	107.5%
1st (lowest)	115%

Section 1853(n)(2)(D) of the Act provides that, beginning in 2013, if there is a change in a county's quartile ranking for a payment year compared to the county's ranking in the previous year, the applicable percentage for the area for the year shall be the average of: (1) the applicable percentage for the previous year and (2) the applicable percentage for the current year. For both years, CMS will calculate the applicable percentage that would otherwise apply for the area for the year in the absence of this transitional provision. For example, if a county's ranking changed from the second quartile to the third quartile, the applicable percentage would be 103.75 percent for the year of the change – the average of 107.5 percent and 100 percent (see Table II-1 above).

A3. Quality Bonus Payment Percentage

The Act provides for CMS to make quality bonus payments to MA organizations that meet quality standards measured under a five-star quality rating system. In this document, we refer to this quality bonus as the *QBP percentage* instead of using the statutory term *applicable percentage quality increase*. The QBP percentage is a percentage point increase to the applicable percentage for each county in a qualifying plan's service area, before multiplying the percentage by the FFS rate for the year to determine the specified amount.

Table II-2 shows the QBP percentage for each Star Rating. Plans with fewer than four stars will not receive a QBP percentage increase to the county rates, and plans with four or more stars will receive a QBP percentage increase in the calculation of the county rates, as set forth in sections 1853(n) and 1853(o) of the Act. See Section A6 for rebate percentages.

Table II-2. Percentage Add-on to Applicable Percentage for Quality Bonus Payments

Star Rating	QBP Percentage
Fewer than 4 stars	0%
4, 4.5, and 5 stars	5%

An MA plan's Star Rating is the rating assigned to its contract applying the 5-star rating system (based on the data collected under section 1852(e) of the Act) specified in §§ 422.160 through

422.166.[8] The contract rating is applied to each plan under that contract. MA plans with a Star Rating of four or more stars will bid against their service area benchmarks that include the 5-percentage point QBP add-on to the applicable percentage for the benchmark in each county in the service area. MA plans with a Star Rating of fewer than four stars will bid against service area benchmarks that do not include QBP add-ons to the county rates, with the exceptions of new MA plans and low enrollment plans. As discussed below, all benchmarks (determined after application of the QBP percentage) are capped at the section 1853(k)(1) applicable amount per section 1853(n)(4) of the Act.

New MA Plans

New MA plans are treated as qualifying plans that are eligible to receive a QBP percentage increase to the county rates, except that the QBP percentage will be 3.5 percentage points, per section 1853(o)(3)(A)(iii)(I)(cc) of the Act and §§ 422.166(d)(2)(v) and 422.258(d)(7)(v)(C). That is, new MA plans will bid against a service area benchmark that reflects a 3.5 percentage point increase to the applicable percentage used to set the benchmark for each county in the plan's service area. Per section 1853(o)(3)(A)(iii)(II) of the Act and § 422.252, for the purpose of determining a QBP percentage, the term "new MA plan" refers to an MA plan offered by a parent organization that has not had another MA contract in the preceding three-year period.

Per § 422.166(d)(2)(vi), for a parent organization that has had a contract with CMS in the preceding three-year-period, any new MA contract (and MA plans under that contract) under that parent organization will receive an enrollment-weighted average of the Star Ratings earned by the parent organization's existing MA contracts.

Low Enrollment Plans

Low enrollment plans do not receive a quality Star Rating under the 5-star rating system (specified in §§ 422.160 through 422.166) but are treated as qualifying plans for purposes of the QBP. *See* 42 CFR §§ 422.166(d)(v) and 422.258(d)(7)(iv). Section 1853(o)(3)(A)(ii)(II) of the Act, as implemented at § 422.258(d)(7)(iv)(B), provides that for 2013 and subsequent years, CMS shall develop a method for determining whether an MA plan with low enrollment is a qualifying plan for purposes of receiving an increase in payment under section 1853(o). We apply this determination at the contract level, and thus determine whether a contract (meaning all plans under that contract) is a qualifying contract. Pursuant to § 422.252, a low enrollment contract is one that could not undertake Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcome Survey (HOS) data collections because of a lack of a sufficient number of enrollees (that is, fewer than 500 enrollees) to reliably measure the performance of the health plan.

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[8] All regulatory cites are to Title 42 of the Code of Federal Regulations unless otherwise noted.

Section 1853(o)(3)(A)(ii) of the Act does not address the amount of the increase for low enrollment contracts. We intend to continue the current policy that low enrollment contracts be included as qualifying contracts that receive the QBP percentage of 3.5 percentage points, similar to the QBP percentage increase applied to new MA plans. We discussed the basis of this policy in detail in the 2018 Advance Notice (pages 12-13) (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2018.pdf).

Contract Consolidations and QBP

Section 1853(o)(4) of the Act was amended by the Bipartisan Budget Act of 2018 to add subsection (D) regarding the determination of star ratings for consolidating MA plans, which is implemented for MA plans at § 422.162(b)(3) for contract consolidations approved on or after January 1, 2019. When two or more contracts for health and/or drug services of the same plan type under the same legal entity are combined into a single contract at the start of a contract year, the rating used to determine QBP status ("QBP rating") for the first year following the consolidation will be the enrollment weighted average of what would have been the QBP ratings of the surviving and consumed contracts, using the contract enrollment in November of the year the Star Ratings were released. For the second year after consolidation, CMS will determine QBP status based on the consolidated contract's Star Ratings displayed on Medicare Plan Finder, which will be calculated as provided in § 422.162(b)(3)(iv)(B).

A4. Qualifying County Bonus Payment

Beginning with contract year 2012, pursuant to section 1853(o)(2) of the Act and § 422.258(d)(7)(ii), the QBP percentage is doubled for a qualifying plan located in a "qualifying county." A qualifying county is a county that meets the following three criteria:

(1) has an MA capitation rate that, in 2004, was based on the amount specified in section 1853(c)(1)(B) for a Metropolitan Statistical Area with a population of more than 250,000;

(2) as of December 2009, had at least 25 percent of MA-eligible beneficiaries residing in the county enrolled in a MA plan; and

(3) has per capita FFS County spending for the year (2024) that is less than the national monthly per capita cost for FFS for the year (2024).

See section 1853(o)(3)(B) of the Act and § 422.258(d)(7)(ii).

Example: As described in section A3, a plan with a rating of 4.5 stars will have 5 QBP percentage points added to the applicable percentage of each county in its service area. For each county that meets the three criteria stated above in that plan's service area, that percentage will be doubled so that an additional 5 percentage points will be added to that county's applicable percentage for a total increase of 10 percentage points. If this qualifying county otherwise has an applicable percentage of 95 percent, this is increased to 105 percent to reflect the quality bonus

payment percentage for that county. As discussed in section A5 below, all benchmarks are capped at the section 1853(k)(1) applicable amount (determined after application of the QBP percentage) per section 1853(n)(4) of the Act.

CMS will publish a complete list of qualifying counties with the final 2024 Rate Announcement. The listing will contain all counties that meet all three criteria stated above. Two of the three elements for determining a qualifying county (2004 urban floors (Y/N) for each county, and 2009 Medicare Advantage penetration rates) can be found in the 2023 Rate Calculation Data file (columns AB and AD) on the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html. The 2024 FFS rates, which are necessary for the third criterion, are not available at the time this Advance Notice is published. The FFS rates and the national average FFS spending amount will be published in the final 2024 Rate Announcement.

A5. Cap on Benchmarks

Section 1853(n)(4) of the Act requires that the benchmark (determined by taking into account the application of the QBP percentage) for a county must be capped at the level of the county's applicable amount determined under section 1853(k)(1). This provision requires that the QBP increase be included in the benchmark before the comparison is made to determine if the cap is applied. Thus, for all counties, post-QBP percentage rates are capped at the section 1853(k)(1) applicable amount.

While we appreciate the concerns stakeholders have raised in connection with the cap on benchmarks, CMS believes that section 1853(n)(4) of the Act prevents elimination of the cap or excluding the bonus payment from the cap calculation.

A6. Rebate

Under section 1854(b)(1)(C)(v) of the Act, except for Medical Savings Account (MSA) plans, the level of rebate for each plan is based on the plan's Star Rating. Rebates for each plan are calculated as a percentage of the amount by which the risk-adjusted service area benchmark exceeds the risk-adjusted bid. Under § 422.266(b), plans may use rebates to pay for mandatory supplemental benefits and/or to buy down beneficiary premiums for Part B and/or Part D prescription drug coverage. Pursuant to section 1854(b)(1)(C)(v), which is implemented in § 422.266(a)(2)(ii), the rebate percentages apply based on a plan's Star Rating, as shown in Table II-3.

Table II-3. MA Rebate Percentages

Star Rating	Rebate Percentage
4.5+ Stars	70%
3.5 to < 4.5 stars	65%
< 3.5 stars	50%

Section 1854(b)(1)(C)(vi)(II) of the Act requires that, for purposes of determining the rebate percentage, a new MA contract under a new parent organization will be treated as having a Star Rating of 3.5 stars for 2012 and subsequent years. *See* also § 422.266(a)(2)(iv). The statute is silent on the rebate percentage to assign to low enrollment plans in years after 2012. We view this as a gap in the statute, particularly in light of the direction in section 1853(o)(3)(A)(ii) to treat low enrollment plans as qualifying plans for purposes of the QBP percentage. As we have in prior years, CMS intends to treat low enrollment plans as having a Star Rating of 3.5 stars for purposes of determining the rebate percentage, therefore rebates for each low enrollment plan are calculated as 65% of the amount by which the risk-adjusted service area benchmark exceeds the risk-adjusted bid.

Section B. Calculation of Fee for Service Cost

B1. Introduction

The FFS per capita cost for each county is the product of (1) the national FFS per capita cost, or United States per-capita cost (USPCC), and (2) a county-level geographic index called the average geographic adjustment (AGA). Each year, CMS strives to improve the development of the AGAs and estimated FFS per capita costs with refinements to how these figures are calculated.

We will continue to incorporate refinements developed and used in prior years to update the claims data used to calculate the AGAs and to continue the repricing of historical data in the AGA calculation to reflect changes in FFS payment rules. CMS will reprice historical hospital inpatient, hospital outpatient, skilled nursing facility, and home health claims to reflect the most currently available wage indices, and re-tabulate physician claims with the most currently available Geographic Practice Cost Index. We will also reprice historical claims to account for legislative and regulatory changes made to uncompensated care payments. Repricing historical claims used for the AGAs, in conjunction with rebasing rates, ensures that the FFS rates for each county reflect the most current FFS fee schedules and payment rules.

We will continue a refinement to the methodology used in the ratebook development to include Health Professional Shortage Areas (HPSAs) bonus payments. Specifically, we will tabulate the HPSA bonuses by county of residence for years 2017–2021 and add these values to our ratebook

FFS expenditures. The HPSA bonuses are disbursed quarterly to providers and are not reflected in the standard claim files.

With this Advance Notice, we are releasing the 2021 FFS cost data by county used in the development of the 2024 ratebook. This data is available on the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data.html. These data do not reflect adjustments for Innovation Center models and demonstrations and the Medicare Shared Savings Program and Advanced Alternative Payment Models, and do not reflect adjustments for claim repricing for the most current available Medicare FFS payment rules and parameters.

B2. AGA Methodology

In the first step of the AGA methodology, CMS will add the 2021 cost and enrollment data to, and drop the 2016 cost and enrollment data from, the historical claims experience used to develop new geographic cost indices for each county. As a result, the five-year rolling average will be based on non-hospice Medicare FFS claims data from 2017–2021. CMS will then perform a series of adjustments to the historical Medicare FFS data to estimate FFS rates per county, explained below as successive steps.

For Puerto Rico, CMS will continue to include five years (2017–2021) of historical claims and enrollment only for beneficiaries with Part A and Part B enrollment at the time of the dates of service for the FFS claim. While most Medicare beneficiaries are automatically enrolled in Part B and must opt out to decline it, beneficiaries in Puerto Rico must take affirmative action to opt in to Part B coverage. CMS continues to believe it is appropriate to adjust the FFS rate calculation in Puerto Rico used to determine MA rates so that it is based on beneficiaries who are enrolled in both Part A and Part B in order to produce a more accurate projection of FFS costs per capita in Puerto Rico.

In the second step, CMS will reprice the historical inpatient, hospital outpatient, skilled nursing facility, and home health claims from 2017–2021 to reflect the most current (i.e., FY 2023) wage indices, re-tabulate physician claims with the most current Geographic Practice Cost Indices, and reprice Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims to reflect updated methodologies in accordance with the final rule[9] which appeared in the Federal Register on December 28, 2021 which consolidates CMS-1687-F, CMS-1738-F and CMS-5531-F. The single payment amount schedules to be used for repricing off-the-shelf knee and back braces are available on the CMS website at: https://dmecompetitivebid.com/cbic/cbicr2021.nsf/DocsCat/84U18RR1ER and the January 2023 fee schedules for repricing other DMEPOS items are accessible on the CMS website at:

[9] The final rule is available at: https://www.federalregister.gov/documents/2021/12/28/2021-27763/medicare-program-durable-medical-equipment-prosthetics-orthotics-and-supplies-dmepos-policy-issues.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.

We will continue to adjust the uncompensated care payments (UCP) represented in the 2017–2021 claims to reflect the requirements of the most recent final rule (here, the FY 2023 Inpatient Prospective Payment System (IPPS) final rule). The repricing will include the new supplemental payment for certain hospitals in Puerto Rico and certain Indian Health Service / Tribal hospitals consistent with the final 2023 IPPS rule. Repricing for Puerto Rico inpatient claims will continue to reflect the Consolidated Appropriations Act, 2016 (Pub. L. 114-113, Division O, section 601), which amended section 1886(d)(9)(E) of the Act.

We will continue to use, as the source of the county designation of beneficiaries used in the summarization of the risk scores, the county assignment used for the ratebook FFS claims and enrollment. For contract years 2016 and earlier, the county assignment for each FFS beneficiary was based on the ZIP code associated with the beneficiary's mailing address. Beginning with the 2017 ratebook, we used the county of residence provided by the Social Security Administration, which is the same county assignment as the ratebook FFS claims and enrollment.

The statutory component of the Regional MA benchmarks for RPPOs will also continue to be based on this county designation of beneficiaries. Under our implementation of section 1858(f)(2) of the Act, the standardized RPPO benchmark for each MA region includes a statutory component consisting of the weighted average of the county capitation rates across the region for each appropriate level of Star Rating. The enrollment weights for the statutory component will reflect this county designation of beneficiaries.

As in prior years, (1) CMS will make additional adjustments to the FFS costs described below, and (2) the average of each county's five-year geographic indices, based on the adjusted claims data, will be divided by the county's average five-year risk score in order to develop the AGA for that county. Consistent with the development of prior years' ratebooks, the risk scores used to standardize the non-ESRD and ESRD ratebooks will be based on the risk adjustment model used for the applicable contract year (2024) payment.

B3. Adjustments for Medicare Shared Savings Program and Innovation Center Models and Demonstrations, and Advanced Alternative Payment Models

Medicare Shared Savings Program and Innovation Center Models and Demonstrations

As indicated in Table II B3-1, we will continue to adjust historical FFS experience to incorporate shared savings and losses or episode savings and losses experienced under the Medicare Shared Savings Program and Innovation Center models and demonstrations. We will update the experience years used for this adjustment as noted on Table II B3-1. All adjustments of this type apply to only the non-ESRD ratebook except the model(s) noted as ESRD in Table II B3-1.

Table II-B3-1. The Medicare Shared Savings Program and Innovation Center Models and Demonstrations with Ratebook Adjustments

Program/Models and Demonstrations	Experience Years		Payment Type
	2023 Ratebook	2024 Ratebook	
Medicare Shared Savings Program	2016–2020	2017-2021	Shared savings / shared losses
Comprehensive Care for Joint Replacement (CJR)	2016–2020	2017-2021	Episode savings / losses
Next Generation ACO (NGACO)	2016–2020	2017-2021	Shared savings / shared losses
Oncology Care Model (OCM)	7/1/2016–2020	2017-2021	Episode savings / losses
Bundled Payments for Care Improvement (BPCI)	2016–2018	2017-2018	Episode savings / losses
Bundled Payment for Care Improvement Advanced (BPCI Advanced)	10/1/2018–2020	10/1/2018-2021	Episode savings / losses
Medicare-Medicaid Financial Alignment Initiative Managed FFS Model	2016–2019	2017-2020	Shared savings
Vermont Medicare ACO Initiative	2018–2020	2018-2021	Shared Savings / shared losses
Maryland Primary Care Program	2019	2019-2020	Performance-based Incentive Payment
Global and Professional Direct Contracting / ACO Realizing Equity, Access, and Community Health (GPDC/ACO REACH)	None	2021 (began 4/1)	Shared savings / shared losses
Next Generation ACO (NGACO)	2016–2020	2017-2021	Population-based payment
Vermont Medicare ACO Initiative	2018–2020	2018-2021	Population-based payment
Maryland Primary Care Program	2019–2020	2019-2021	Population-based payment
Primary Care First	None	2021	Population-based payment
Global and Professional Direct	None	2021 (began 4/1)	Population-based payment

Program/Models and Demonstrations	Experience Years		Payment Type
	2023 Ratebook	2024 Ratebook	
Contracting / ACO Realizing Equity, Access, and Community Health (GPDC/REACH)			
Comprehensive Primary Care Plus (CPC+)	2017–2020	2017-2021	Comprehensive Primary Care Payments
Comprehensive Primary Care Plus (CPC+)	2017–2020	2017-2021	Performance-based Incentive Payment
Comprehensive Primary Care Plus (CPC+)	2017–2020	2017-2021	Care Management Fees
Maryland Primary Care Program	2019–2020	2019-2021	Care Management Fees
ESRD			
Comprehensive ESRD Care (CEC)	2016–2019	2017-2020	Shared savings / losses
Next Gen ACO (NGACO)	2016–2020	2017-2021	Population-based payment
Vermont Medicare ACO Initiative	2018–2020	2018-2021	Population-based payment
Global and Professional Direct Contracting / ACO Realizing Equity, Access, and Community Health (GPDC/REACH)	None	2021	Population-based payment

Notes:

- 2018 shared savings payments for "Vermont Medicare Accountable Care Organization (ACO) Initiative" are included with Next Generation ACO
- In the 2021 Rate Announcement, "Vermont Medicare ACO Initiative" was labeled "Vermont All-Payer ACO", and payments were not actually made in 2017 but began in 2018 and were reported under the program "Next Generation ACO."

The key aspects of these adjustments are:

- The adjustments reflect an allocation of the savings and losses based on the distribution of the participating entity's aligned beneficiaries by county of residence. The adjustments

applied to the non-ESRD ratebook exclude experience for beneficiaries in ESRD status as of July 1 of the experience year. (The adjustments for the model(s) noted as ESRD in Table II B3-1, which are applied to the ESRD ratebook in a similar manner as the non-ESRD cohort, include experience for beneficiaries in ESRD status.)

- Under the models noted as using "population-based payments" in Table II B3-1, participants receive a monthly fee that ultimately offsets a percentage reduction in FFS payments to certain providers and suppliers aligned with participants over the same year. For each affected claim, the reduction amount represents the portion of the payment that has effectively been rerouted to the ACO via the population-based payment and is therefore added back to the reduced FFS amount so that the total reimbursement amount is represented.
- Under the CPC+ models, participants receive quarterly payments that replace a percentage of FFS claim amounts for each affected claim. The "comprehensive primary care payments" are included with claim costs to compile the total reimbursement amount.
- In the ratebooks for contract years 2020 and earlier, the allocation of the Medicare Shared Savings Program and Innovation Center model and demonstration payment adjustments between the Part A and Part B Trust Funds was based on the Part A and Part B proportion of the FFS USPCC for each calendar year. Consistent with the actual payments by the Trust Fund, we intend to continue with the approach started for CY 2021 ratebook to allocate the entire amount of the following payments for all experience years to the Part B Trust Fund: (i) Oncology Care Model episode savings / losses, (ii) Comprehensive Primary Care Plus comprehensive primary care payments, performance-based incentive payments, and care management fees, (iii) Maryland Primary Care Program care management fees and population-based payments, and (iv) Primary Care First population-based payments. The remaining Medicare Shared Savings Program and Innovation Center model and demonstration payment adjustments will continue to be allocated in the MA ratebook calculations between the Part A and Part B Trust Funds based on the Part A and Part B proportion of the FFS USPCC for each calendar year.

Further information on the Medicare Shared Savings Program may be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram. Further information on the Innovation Center models and demonstrations may be found at: https://innovation.cms.gov/.

Although we considered whether to adjust the FFS claims experience for care management fees, per-beneficiary-per-month fees, and/or advance payment of shared savings paid to providers for other Innovation Center models conducted in 2017–2021 period,[10] we intend to continue prior

[10] Information about the various Innovation Center models is available in the Report to Congress available at: https://innovation.cms.gov/data-and-reports/2021/rtc-2020.

policy and will not take fees of this type into account in our adjustments to historical FFS experience when such fees or payments were not funded from Medicare Parts A or B Trust Funds.

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.

A-APMs can include: 1) models under section 1115A of the Act (other than a health care innovation award), 2) the shared savings program under section 1899, 3) demonstrations under section 1866C of the Act, and 4) demonstrations required by federal law when these alternative payment models meet the criteria specified in § 414.1415, including requiring the use of Certified Electronic Health Record Technology (CEHRT), making payment based on quality measures, and requiring assumption of a more than nominal amount of financial risk. The QP performance period occurs two years prior to payment of the APM incentive. QPs determinations are made for each eligible clinician at the Taxpayer Identification Number (TIN) / National Provider Identifier (NPI) level. The first QP performance year was 2017, and the first APM incentive payments were made to QPs in 2019.

APM incentive payments are calculated and paid as specified in § 414.1450. The amount of the APM incentive payment is equal to 5 percent of the QP's estimated aggregate payments for covered professional services as defined in 1848(k)(3)(A) of the Act furnished during a base year which is the calendar year immediately preceding the payment year. Base year estimated aggregate payments and the corresponding APM incentive payment are calculated for each QP using all of their TIN/NPI combinations.

The applicable periods for APM incentive payments made to date are:

QP performance year	2017	2018	2019	2020
Base year	2018	2019	2020	2021
Payment year	2019	2020	2021	2022

We are proposing to include with the ratebook historical experience the APM incentive payments disbursed in years 2019 through 2021. The APM incentive payments will be added to ratebook FFS experience for the payment year. For example, the APM incentive payments made in 2019 will be added to 2019 ratebook FFS experience. The APM incentive payment adjustment will be allocated based on the distribution of claim expenditures by county of beneficiary residence for the base year expenditures for each TIN/NPI. Excluded from the adjustment will be the small proportion, less than 0.50 percent, of incentive payments for providers with no base

period experience, given there is no basis for allocation of payments by beneficiary residence for such providers. The adjustment will apply to both non-ESRD and dialysis populations.

Further information on the Advanced Alternative Payment Models may be found at: https://qpp.cms.gov/apms/advanced-apms.

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

For the past seven years, the Secretary has directed the Office of the Actuary to adjust the FFS experience for beneficiaries enrolled in Puerto Rico to reflect the nationwide propensity of beneficiaries with zero claims. For the CY 2017–2023 Rate Announcements, the Office of the Actuary evaluated experience exclusively for beneficiaries who were enrolled in both Parts A and B ("A&B beneficiaries") and were not dually eligible for Veterans Affairs (VA) coverage. The study for setting the CY 2023 rates analyzed experience for calendar years 2016 through 2020 and only considered FFS beneficiaries enrolled mid-year. On average, 15.3 percent of A&B Puerto Rico FFS beneficiaries were found to have no Medicare Part A or Part B claim reimbursements per year. This compares to a nationwide non-territory proportion of 6.4 percent of A&B FFS beneficiaries found to have no Medicare Part A claim reimbursements and no Medicare Part B claim reimbursements per year. Based on the Secretary's direction, the Puerto Rico FFS weighting of enrollment and risk scores for the zero-claim cohort was adjusted to reflect the nationwide proportion of zero-claim beneficiaries. The resulting impact was measured as an average increase in the standardized per-capita FFS costs in Puerto Rico of 4.7 percent for 2016 through 2020. Accordingly, a 4.7 percent adjustment was then applied to the pre-standardized Puerto Rico FFS rates supporting the CY 2023 ratebook development.

We are considering whether a similar adjustment should be applied for 2024. The Office of the Actuary will perform an analysis that is similar to the prior analysis but with an updated five years of data: 2017–2021. We welcome comments regarding a similar update to Puerto Rico's experience in the development of the 2024 FFS rates. We will review the results of this study and any comments that we receive, and we will specify in the final Rate Announcement any adjustment that we determine may be necessary based on those results and comments.

We are aware of concerns raised by stakeholders regarding the FFS data used to establish MA benchmarks in Puerto Rico. As discussed in the CY 2017 Advance Notice, the law requires that MA benchmarks be based on a county's average Medicare FFS per-capita cost, and there is no evidence that FFS costs in Puerto Rico are higher than the costs observed in the FFS claims data, and thus no basis for overhauling Puerto Rico's Medicare Advantage benchmarks. As we stated originally in the CY 2017 Rate Announcement and in Rate Announcements for several years since, we believe that the FFS data in Puerto Rico is sufficient for establishing accurate MA benchmarks. The CY 2020 Advance Notice Part II (page 21) and Rate Announcement (pages 27

and 28)[11] included discussion and analysis of trends in the FFS data, and concluded that our methodology of using five years of FFS experience mitigates annual fluctuations and anomalies in the data that may occur for a variety of reasons and provides for stability in the rates. Our findings and conclusions remain applicable.

B5. Additional Adjustments

The following adjustments are made after the AGA is calculated:

- Direct Graduate Medical Education: removed from FFS county costs (as directed by section 1853(c)(1)(D)(i) of the Act), described in more detail in Section C1.
- Credibility: for counties with fewer than 1,000 members, blend county experience with that of others in the market area.
- Veterans Affairs (VA) and Department of Defense (DoD): apply an adjustment to FFS per capita costs for beneficiaries dually enrolled in VA and/or the DoD health programs (the Uniformed Services Family Health Plan (USFHP) and/or the Veterans Health Administration (VHA)) pursuant to section 1853(c)(1)(D)(iii) of the Act. The VA/DoD adjustment for the 2024 rates will be based upon an updated study that uses FFS data from calendar years 2016–2020. The methodology for the study and adjustment is described in more detail in the CY 2022 Advance Notice Part II (pages 27-28).
- Organ Acquisition Costs for Kidney Transplants: removed from FFS costs, described in more detail in Section C2.
- Indirect Medical Education: removed from FFS county costs (section 1853(n)(2)(F) of the Act) as described in more detail in Section C3.

Note that incentive payments for adoption and meaningful use of certified electronic health record (EHR) technology are not included in the claims used to develop the FFS costs and therefore no explicit adjustment is needed to exclude these payments from the FFS costs to comply with section 1853(c)(1)(D) of the Act.

Section C. Adjustments to the AGAs

Section C1. Direct Graduate Medical Education

See Attachment I Section A regarding medical education expenses in USPCCs.

Section 1853(c)(1)(D)(i) of the Act requires the exclusion of costs attributable to payments under section 1886(h), that is payments for DGME, from the FFS per capita costs used for developing the Medicare Advantage ratebooks.

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[11] The CY 2020 Advance Notice Part II and Rate Announcement can be found at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.

Please note that some ratebook files and other CMS data reference graduate medical expenses, or GME. In the context of the MA ratebooks, DGME and GME refer to the same item and are used interchangeably.

The steps involved in the calculation of the DGME carve-out for CY 2024 are the same as used for CY 2023 and are as follows:

a. Identify on the Medicare cost reports (Form CMS-2552-10) those expenditures to be excluded from the MA ratebooks (that is, those costs on the report that are attributable to payments made under section 1886(h)):
    1. Part A DGME: Cost report worksheet E-4, line 49, column 1
    2. Part B DGME: Cost report worksheet E-4, line 50, column 1

b. Identify cost report fields reflected on the Direct Medical Education per diem field on the provider specific file (PSF) for each Provider State based on the jurisdiction of each Medicare Administrative Contractor (MAC). This data is available on the CMS website at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents. The two-digit state code corresponds to the first two digits of the inpatient provider ID.

c. Using the information from "a" and "b", tabulate for each provider and calendar year:
    1. Expenditures to be removed from MA rates (item a)
    2. Expenditures represented in DGME field in provider specific file (item b)
    3. Proportion of DGME PSF values to be excluded from rates (c1 / c2)

d. Accumulate DGME PSF values by county and calendar year:
    1. Multiply the DGME per diem amount on PSF times the number of covered days for each inpatient admission.
    2. Accumulate d1 by county of beneficiary residence

e. Calculate DGME exclusion for each county and calendar year: d2 × c3

The DGME carve-out factors for the 2024 rates will be published with the 2024 Rate Announcement.

Section C2. Organ Acquisition Costs for Kidney Transplants

Section 17006(b) of the 21st Century Cures Act amended section 1853(k) and (n) of the Act to exclude CMS' estimate of the standardized costs for payments for organ acquisition for kidney transplants from MA benchmarks starting in 2021. Section 1853(k)(5) of the Act, implemented in § 422.306(d), provides for the exclusion of these costs from the applicable amount and section 1853(n)(2)(A)(i), implemented in § 422.258(d), provides for the exclusion from the base amount (used to calculate the specified amount). Further, section 17006(c) of the 21st Century Cures Act

amended sections 1851(i) and 1852(a)(1)(B); the amendments, implemented[12] in § 422.100(c)(1) and § 422.322, require FFS coverage of organ acquisition costs for kidney transplants incurred by MA beneficiaries and exclude coverage of organ acquisitions for kidney transplants from the benefits that MA plans must provide to their enrollees. As discussed in the CY 2021 final rule (CMS-4190-F) (85 FR 33825) and 2021 Advance Notice, we apply the carve-out from the FFS costs when developing ESRD MA rates as well.

The 21st Century Cures Act did not require Medicare FFS coverage of organ acquisition costs for kidney transplants received by PACE participants. Therefore, as noted in the CY 2021 final rule (85 FR 33824–25), PACE organizations must continue to cover organ acquisition costs for kidney transplants consistent with the requirement in section 1894(b)(1)(A)(i) of the Act that PACE organizations provide all Medicare-covered items and services. Accordingly, CMS will continue to include the costs for kidney acquisitions in PACE payment rates–both the PACE county rates and the PACE ESRD rates–unlike for MA benchmarks.

The steps involved in the calculation of the Kidney Acquisition Cost (KAC) carve-out for CY 2024 are the same as used for CY 2023 and are as follows:

a. Identify on the Medicare Cost Reports (Form CMS-2552-10) those expenditures that are related to organ acquisition costs. This will be used in the next step to calculate the proportion of organ acquisition costs that represents kidney acquisition costs (that is, the proportion of costs on the report that is attributable to payments made under section 1881(d) of the Act), which is to be excluded from the MA ratebooks:
    1. Cost report worksheet D-4 (Heart), line 69, column 1
    2. Cost report worksheet D-4 (Intestine), line 69, column 1
    3. Cost report worksheet D-4 (Islet), line 69, column 1
    4. Cost report worksheet D-4 (Kidney), line 69, column 1
    5. Cost report worksheet D-4 (Liver), line 69, column 1
    6. Cost report worksheet D-4 (Lung), line 69, column 1
    7. Cost report worksheet D-4 (Pancreas), line 69, column 1

b. Using information from "a", tabulate for each provider and calendar year the proportion of organ acquisition costs[13] that are applicable to kidneys: a4 / (a1 + a2 + a3 + a4 + a5 + a6 + a7).

c. Identify the Organ Acquisition Cost (OAC) per diem field on the inpatient PSF for each Provider State based on each MAC's jurisdiction (this data is available on the CMS website at: https://www.cms.gov/Medicare/Health-

[12] See the CY 2021 final rule (CMS-4190-F) (85 FR 33796, 33824–26) titled "Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program."

[13] Note that the sum of a1 through a7 is the same value as reported on Cost Report Worksheet E, Part A, line 55. Therefore, the proportion of organ acquisition costs that are applicable to kidneys could alternatively be computed by dividing a4 by Cost Report Worksheet E, Part A, line 55.

Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents) and date of admission. The two-digit state code corresponds to the first two digits of the inpatient provider ID.

d. Accumulate KAC PSF values by county and calendar year:
    1. Calculate the per admission KAC carveout as the OAC per diem amount on PSF (item "c") × KAC proportion of OACs (item "b") × number of covered days for each inpatient admission.
    2. Accumulate d1 by county of beneficiary residence.

The KAC carve-out factors for the 2024 rates will be published with the 2024 Rate Announcement.

As described above, the approach to exclude costs for kidney acquisitions from MA benchmarks by county and from MA ESRD rates utilizes data from the Medicare cost reports and the inpatient PSF. These data sources do not include section 1881(d) expenditures for coverage of living donor expenses beyond what is reflected in the kidney acquisition cost center and paid on a pass-through basis in the Medicare FFS program. Per section 1853(k)(5) and (n)(2)(G) of the Act, the 1881(d) expenses are required to be included in the carve out of kidney acquisition costs from the benchmark amounts. Accordingly, we will tabulate from the FFS claim records the living donor expenses associated with kidney transplants and add those amounts to the KAC amounts derived from the cost reports. Per statute and as codified in §§ 422.100(c)(1) and 422.322(d), beginning in 2021, MAOs are not responsible for coverage of organ acquisition costs for kidney transplants incurred by MA beneficiaries, including coverage under section 1881(d) of living kidney donor expenses, which will be reimbursed by the Medicare FFS program.

When developing the CY 2024 rates, we will continue to apply the KAC adjustment subsequent to the application of the IME adjustment, consistent with the adjustment order used beginning with the CY 2022 ratebook.

Section C3. IME Phase Out

See Attachment I Section A regarding medical education expenses in USPCCs.

Section 161 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275) amended section 1853(k)(4) of the Act to require CMS to phase out IME amounts from MA capitation rates. Section 1853(n)(2)(F) applies the same phase-out to FFS costs in the calculation of the specified amount in setting MA rates. Payment to teaching facilities for IME expenses associated with MA plan enrollees will continue to be made under FFS Medicare. Section 1894(d)(3) of the Act provides that the IME payment phase-out does not apply to PACE capitation rates.

For purposes of making this adjustment, we will first calculate the FFS rates including the IME amount. This initial amount will serve as the basis for calculating the IME reduction that we will carve out of the rates. The absolute effect of the IME phase-out on each county will be

determined by the amount of IME included in the initial FFS rate. Under section 1853(k)(4)(B)(ii) of the Act, the maximum reduction for any specific county in 2024 is 9.0 percent of the FFS rate. To help plans identify the impact, CMS will separately identify the amount of IME for each county rate in the 2024 MA ratebook. We will continue to publish the rates with and without the IME reduction for the year.

Section D. MA ESRD Rates

Pursuant to section 1853(a)(1)(H) of the Act, CMS establishes "separate rates of payment" with respect to ESRD beneficiaries enrolled in MA plans. As we stated in the 2012 Rate Announcement (page 32), it is in keeping with our understanding of the legislative intent to more closely align MA payment rates with FFS costs that the MA ESRD rates are also based on FFS costs. We currently set MA ESRD rates on a state basis (that is, at the state level instead of the county level), using updated FFS costs each year, and intend to continue that policy and our existing methodology for setting MA ESRD rates.

We will use the 2017-2021 FFS expenditures and enrollment data for beneficiaries in dialysis status for each state to develop the CY 2024 MA ESRD rates. For each year, we compute the FFS dialysis per capita costs (for Part A and Part B items and services for beneficiaries in dialysis status) by state. The geographic indices for each year are calculated by dividing the state per capita cost by the total per capita cost of the nation. The five-year weighted average of the geographic indices is standardized by dividing by the five-year average risk scores (calculated using the risk adjustment model for CY 2024 payment). This standardized five-year weighted average is the average geographic adjustment (AGA), which represents the ratio of historical FFS dialysis per capita costs by state to national FFS dialysis per capita costs. We calculated the 2021 FFS ESRD dialysis USPCC based on the 2021 data described above in Attachment I, Section A, and, using trend factors, develop the prospective 2024 FFS ESRD dialysis USPCC. The 2024 MA ESRD rates are determined by multiplying the 2024 FFS ESRD dialysis USPCC by the state AGA.

We will continue to incorporate refinements developed and used in prior years regarding the repricing of historical data in the AGA calculation for the MA ESRD rates. Similar to the non-ESRD rate methodology, we intend to reprice the ESRD historical inpatient, hospital outpatient, skilled nursing facility, and ESRD PPS claims from 2017–2021 to reflect the most current (i.e., FY 2023) wage indices, and re-tabulate physician claims with the most current (i.e., CY 2023) Geographic Practice Cost Indices. We will continue to adjust the UCPs represented in the 2017–2021 claims to reflect the requirements of the most recent final rule. The adjustments will also include shared savings and shared losses performance-based payments made under the CEC model, and population-based payments under the Next Gen ACO, Vermont Medicare ACO Initiative, and GPDC/REACH as described in section B3 of this document, as well as incentive payments under Advanced Alternative Payment Models. Pursuant to section 1853(k)(5), (n)(2)(A)(i) and (n)(2)(G), MA benchmarks for 2021 and subsequent years exclude organ

acquisition costs for kidney transplants (described in detail in Section C above). As noted in the CY 2021 final rule (CMS-4190-F) (85 FR 33796, 33825) and in the CY 2021 Rate Announcement, the exclusion of KACs is also applied to the MA ESRD rates for 2021 and subsequent years. In addition, the 2024 MA ESRD rate is adjusted by removing the GME expenses and the gradual phase-out of IME expenses, consistent with adjustments made for the non-ESRD MA rates that are discussed in sections B and C of this document.

We will publish a file with the CY 2024 Rate Announcement that includes the key components of the rate development, similar to the rate calculation data supporting the MA non-ESRD county rates.

As stated in section C, CMS will continue to include organ acquisition costs for kidney transplants in the PACE rates, including PACE ESRD rates, and the IME payment phase-out does not apply to PACE capitation amounts. Therefore, for 2024, the ESRD rates for PACE organizations will continue to include KACs and IME amounts.

Stakeholders have raised concerns regarding ESRD payment adequacy and accuracy in recent years, in light of the increase in ESRD enrollment in MA plans as a result of the 21st Century Cures Act, which allows beneficiaries with ESRD to enroll in MA plans starting in 2021. More specifically, MAOs have expressed concerns that MA ESRD rates are inadequate to cover the costs of ESRD beneficiaries enrolled in MAOs. Stakeholders have encouraged CMS to exercise its authority to adjust the MA ESRD rates, in order to more accurately reflect the costs to MAOs to cover this population. We stated in the CY 2022 Rate Announcement that "we do not find [a number of the] … specific suggestions to be consistent with our interpretation of section 1853 of the Act as a whole—that the legislative intent is for us to more closely align MA payment rates with FFS costs—and the statutory requirements for MA ESRD rate calculation." However, we also stated that we would "continue to analyze these issues and consider whether, consistent with the statutory requirements for setting MA ESRD rates in section 1853(a)(1)(H) of the Act, any refinements to the methodology may be warranted in future years to ensure appropriate ESRD payment rates." One recommendation suggested by a number of commenters was to develop MA ESRD rates at a geographic level that was smaller than state level, in order to address geographic differences in costs, and we have conducted an analysis to explore this recommendation.

In the CY 2023 Advance Notice, we provided details of this analysis, where we calculated ESRD dialysis rates for Core-Based Statistical Areas (CBSAs) while continuing to use the same data and methodology currently used for MA ESRD statewide rates. We determined which counties are part of each CBSA (either Metropolitan or Micropolitan Statistical Area), and calculated a new ESRD CBSA rate based on the data of all of the counties in that CBSA in the same state. Similar to the state designation with the current MA ESRD rates, the CBSA was based on the beneficiary's residence. For counties that are not part of a CBSA, the new ESRD CBSA rate was calculated based on the data of all of the non-CBSA counties in the state. We also applied a credibility adjustment to account for CBSAs with small ESRD enrollment, fewer than

2,700 member months, and restandardized the CBSA rates so that each state's share of the average geographic adjustment (AGA) remains constant. In the CY 2023 Advance Notice, we explained that preliminary analyses suggested some potentially concerning impacts on medically underserved urban areas and we stated that further exploration is needed to better determine specific impacts and that CMS would continue our analyses.

In keeping with that statement, to assess the health equity impact of the ESRD rate changes, we have now further studied the proposed rate changes based on the area deprivation index[14] (ADI) of each county. A low ADI indicates a low level of socioeconomic deprivation and is associated with positive health outcomes for beneficiaries in a county, while a high ADI indicates a high level of socioeconomic deprivation and is associated with negative health outcomes. When comparing the new CBSA rates in that analysis for CY 2022 rates to the published state rates for CY 2022, we found that, on average, the MA ESRD rates for CBSAs with a relatively low ADI increased whereas the CBSA-level rates decreased for areas with a relatively high ADI. Given these findings, we are not proposing to change the geographic level at which we apply our methodology for updating the MA ESRD rates for CY 2024, and plan to continue our use of statewide MA ESRD rates.

Section E. Location of Network Areas for Private Fee-for-Service (PFFS) Plans in Plan Year 2025

Section 1852(d)(4) of the Act requires MA organizations offering certain non-employer MA PFFS plans in network areas to enter into signed contracts with a sufficient number of providers to meet the access standards applicable to coordinated care plans. Specifically, non-employer MA PFFS plans that are offered in a network area (as defined in section 1852(d)(5)(B)) must meet the access standards described in section 1852(d)(4)(B) through written contracts with providers. These PFFS plans may not meet access standards by establishing payment rates that are at least the rates that apply under Medicare FFS and having providers deemed to be contracted as described in § 422.216(f).

Network area is defined in section 1852(d)(5)(B) of the Act, for a given plan year, as an area that the Secretary identifies (in the announcement of the proposed payment rates for the previous plan year under section 1853(b)(1)(B)) as having at least two network-based plans (as defined in section 1852(d)(5)(C)) with enrollment as of the first day of the year in which the Announcement is made. We intend to publish the list of network areas for plan year 2025 with the CY 2024 Rate

[14] See https://www.neighborhoodatlas.medicine.wisc.edu/.

Announcement. We will make this list available on the CMS website at: https://www.cms.gov/Medicare/Health-Plans/PrivateFeeforServicePlans/NetworkRequirements.

Section F. MA Employer Group Waiver Plans (EGWP)

We intend to continue to waive the Bid Pricing Tool bidding requirements for all MA employer/union-only group waiver plans (EGWPs) for 2024.[15] As a condition of this waiver of the bidding requirements and the waivers otherwise provided to MA EGWPs, CMS will establish MA EGWP payment amounts using the same methodology for 2024 as was used for 2023. As has been the case since 2017, for 2024, Part C entities offering EGWPs will not be required to submit Part C bid pricing information in the Part C Bid Pricing Tool. CMS has authority under section 1857(i) of the Act to waive or modify requirements that hinder the design of, the offering of, or the enrollment in employment-based Medicare plans offered by employers and unions to their members. Waiving the requirement to submit Part C bid pricing information facilitates the offering of Part C plans for employers and unions seeking to establish high quality coverage for their Medicare-eligible retirees by avoiding the cost and administrative burden of submitting the complex bids required from non-EGWPs. We refer the reader to the detailed discussion of our rationale and responses to commenters' questions in the CY 2017 Rate Announcement, Attachment III, Section F (pages 27–44) for additional information, and to the responses to questions received by the Office of the Actuary that are available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/ActuarialBidQuestions.

F1. Bid-to-Benchmark Ratio

In connection with the continuation of this waiver, for 2024, CMS will continue to use the payment methodology for MA EGWPs that was finalized in the CY 2023 Rate Announcement. For 2024, we will use bid-to-benchmark ratios based on 2023 bids and weighted by February 2023 enrollment, which is generally consistent with how we have developed these EGWP payments since 2019. With the exception of the 2022 bid-to-benchmark ratio which was weighted by January 2021 enrollment, bid-to-benchmark ratios have been weighted by the February enrollment of each year since 2019. For 2024, the bid-to-benchmark ratio will be weighted by February 2023 enrollment.

As a result of feedback from the industry on the CY 2022 bid cycle, CY 2023 was the first year that CMS published preliminary bid-to-benchmark ratios for EGWPs in the Advance Notice. MA organizations indicated that having this information early provides valuable information in their negotiations with employer/union groups to create more accurate benefit and premium

[15] As stated in the Medicare Managed Care Manual, Ch. 9, § 10.2., in addition to EGWPs, employer/union group health plan sponsors may choose to enroll their Medicare beneficiaries in individual MA plans. These MA plans do not qualify for the employer/union group health plan waiver of bidding requirements described in this section.

quotes for their MA EGWP enrollees. However, these ratios are based on 2023 bids and weighted by January 2023 enrollment instead of the February 2023 enrollment that we intend to use for the final ratios; these preliminary ratios are not final and could differ from the ratios that are ultimately published in the Rate Announcement so we recommend that caution be used in reviewing them. The preliminary bid-to-benchmark ratios are as follows:

Applicable Percentage	Bid to Benchmark Ratio
0.95	78.5%
1	77.2%
1.075	76.7%
1.15	76.9%

The payment methodology for MA EGWPs relies on bid-to-benchmark ratios, as described below, that reflect average bid amounts, weighted by plan enrollment. The calculations for the bid-to-benchmark (B2B) ratios for CY 2024 would therefore be as follows:

> First: [(Weighted Average of the Intra-Service Area Rate Adjustment (ISAR) Adjusted County Bid Amounts for 2023 Individual Market Plan Bids by February 2023 Actual Enrollment)/(Weighted Average of the County Standardized Benchmarks for 2023 Individual Market Plans by February 2023 Actual Enrollment)] = 2023 Individual Market B2B Ratios by Quartile.[16]
>
> Second: The 2023 individual market B2B ratios will be calculated separately for HMO plan types and PPO plan types by quartile.[17] The PPO B2Bs by quartile will be weighted by the total proportion of EGWP PPO plan type enrollment, and the HMO B2Bs by quartile will be weighted by the total proportion of EGWP HMO plan type enrollment to result in the final B2B ratios for 2024 by quartile.

As has been in effect since 2017, for 2024:

- The B2B ratios will be applied to each of the published 5%, 3.5%, and 0% quality bonus percentage county ratebook rates for the payment year to establish Part C base payment amounts for EGWPs based on their Star Rating, for each county.
- In order to calculate a county rebate payment, each county-level EGWP Part C base payment amount will be compared to the corresponding published 5%, 3.5%, and 0%

[16] As in prior years, territories will not be included in the weighted average B2B ratios, but they will be assigned the weighted average of the quartile within which their counties fall. To determine the CY 2024 applicable percentages, CMS ranks counties from highest to lowest based on their 2023 average per capita FFS costs and places the rates into four quartiles. When calculating the 2023 B2B ratios, CMS will group counties by the 2023 unblended quartiles and will then apply these B2B ratios to the 2024 unblended quartiles.

[17] Consistent with how we have developed EGWP payments since 2019, HMO and HMOPOS plans have been combined into an "HMO plan type" and LPPO and RPPO plans have been combined into a "PPO plan type." "HMO" Health Maintenance Organization, "HMOPOS" Health Maintenance Organization Point of Service, "PPO" Preferred Provider Organization, "LPPO" Local Preferred Provider Organization, "RPPO" Regional Preferred Provider Organization. "PFFS" Private Fee-for-Service individual market plans are excluded from these calculations.

quality bonus percentage county benchmarks for the payment year (2024), which include adjustments for qualifying counties, to determine the amount of savings. The savings amount will be multiplied by the corresponding rebate percentage to determine the Part C EGWP county-level rebate amount.

- The EGWP Part C base payment amount will be added to the Part C EGWP rebate amount to establish the county-level local EGWP total payment amount.
- The total payment amount will be risk adjusted using beneficiary-specific risk scores. Therefore, the formula applied for local EGWP payment on a per-beneficiary basis would be: (Base County Payment Rate + County Rebate) × Beneficiary-Level Risk Score.

For RPPO EGWPs, the weighted-average B2B ratios will continue to be calculated as described above. To establish the Part C base RPPO EGWP payment amount, we will then also continue to apply the same methodology as described above.

In order to calculate the RPPO EGWP rebate amounts, these percentages will continue to be applied for each county within a region to the published payment year regional benchmarks to establish the savings amount and rebate amounts by Star Rating and quartile.

The RPPO EGWP Payment Formula continues to be (Base County Payment Rate + Regional Rebate) × Beneficiary-Level Risk Score, where each is calculated as follows:

- Base County Payment Rate = Bid to Benchmark Ratio × 2024 MA Monthly Capitation Rate
- Regional Rebate = (1 − Bid to Benchmark Ratio) × 2024 Regional Rate × Rebate Percentage
- The 2024 Regional rate is based on a blend of the statutory and bid component. As with non-EGWPs, if there is no bid component of the 2024 Regional rate (i.e., no individual bids in a region), then the EGWP rate will be based solely on the statutory component.

As has been the case since 2017, for 2024, there will be no Part C Regional PPO EGWP bids to include in the calculation of the MA regional benchmarks. The statutory components of the regional standardized A/B benchmarks will continue to be published each year as part of the Announcement of Medicare Advantage Payment Rates. CMS will also continue to publish the final MA regional standardized A/B benchmarks in late summer, which will reflect the average bid component of the regional benchmark based on non-EGWP bid submissions.

F2. MA Rebates and Part B Premium Buy-Down

CMS will continue to waive the requirement that MA EGWPs must specify how they are allocating MA rebate dollars (other than the buy-down of the Part B premium) for 2024. However, the limits set forth in § 422.266 regarding how the MA rebate may be used have not been waived and therefore continue to apply for EGWPs. CMS does not distinguish the amount to be allocated for rebates in calculating payments to MA EGWPs; however, if the MA EGWP

elects to treat part of the payment as an MA rebate, how the rebate portion of the payment may be used is subject to the requirements at § 422.266. Thus, an EGWP could designate no part of its payment from CMS as MA rebates, or it could designate a portion of its payment as MA rebates and apply these designated rebate amounts to pay for mandatory supplemental benefits in accordance with § 422.266(b)(1) or to buy down Part B or Part D premiums in accordance with § 422.266(b)(2) and (b)(3). However, the MA EGWP could not use MA rebates to pay for optional supplemental benefits, as this is prohibited by § 422.266(b)(1).

For 2024, we will also continue the existing policy permitting MA EGWPs to buy down Part B premiums for their enrollees using a portion of the Part C payment that the MA EGWP has designated as MA rebates.

As has been the case since 2020, MA EGWPs will be subject to the same maximum Part B buy-down amount as non-EGWP plans. That is, EGWPs may only buy down the Part B premium up to the maximum amount displayed in the CY 2024 MA Bid Pricing Tool Worksheet 6. Additionally, as with non-EGWP plans, the Part B premium buy-down amount cannot vary among beneficiaries enrolled in an EGWP. The Part B buy-down amount applies to every beneficiary under the plan ID. Therefore, if an EGWP would like to reduce the Part B premium for one employer group under the plan ID by $5 and reduce the Part B premium for another employer group by $10, then the MA organization must establish two separate EGWP plan IDs (i.e., two separate Plan Benefit Packages [PBPs]), each with the specific amount to buy-down the Part B premium. In this example, the PBP for plan 801 would contain a $5 buy-down amount, and the PBP for plan 802 would contain a $10 buy-down amount.

We will continue to collect a Part B premium buy-down amount in the EGWP's Plan Benefit Package (PBP) submission to CMS. Any MA EGWP that chooses to use a portion of its payment to buy down the Part B premium must apply such Part B premium buy-down amount consistently to every beneficiary enrolled in the EGWP, in accordance with uniformity of benefit rules, which are not waived in connection with buy-downs of Part B premiums. Those MA EGWPs that choose to designate a portion of their payment as MA rebates to buy down the Part B premium for their enrollees will have that amount reduced from their capitated payment. For example, if an MA EGWP determines that under its benefit offering there will be a $5 reduction to each enrollee's Part B premium, $5 per member per month will be entered into the requisite field in the PBP, and then $5 will be subtracted from the monthly capitated amount. For local MA EGWPs, this is reflected in the payment formula described above as follows:

$$\text{Total Payment} = (\text{Base County Payment Rate} + \text{County Rebate}) \times \text{Beneficiary Level Risk Score} - \textit{Part B Buy Down Amount}.$$

MA EGWPs will continue to be prohibited from separately refunding Part B premiums for their enrollees outside of this process.

F3. Additional Adjustments

The following rules will continue to apply as they have since 2017 under the EGWP payment methodology:

- MA EGWPs will not receive capitation payments for hospice care. For more information about how an MA enrollee electing hospice affects payments to MA plans, please see § 422.320.
- MA EGWPs will continue to be paid using the ESRD ratebook for their ESRD beneficiaries in Transplant and Dialysis status and the individual market MA ratebook for those beneficiaries in Functioning Graft status, in keeping with the current payment policy for non-EGWP MA organizations.
- Consistent with how CMS pays capitation for Part B-only enrollees in the non-EGWP context, Part B-only MA EGWPs will continue to receive only the Part B portion of the EGWP payment amount, which is determined by multiplying it by the Part B percentage of the MA rate.
- MA EGWP MSA plans will continue not to submit Bid Pricing Tools for 2024, but the 2024 local EGWP payment rates will continue to not be applied to EGWP MSA plans. The monthly prospective payments for EGWP MSAs will be based on the following formula: 2024 MA Monthly Capitation County Rate × beneficiary risk score – 1/12 of the Annual MSA Deposit Amount. The 2024 Annual MSA Deposit Amount must be submitted in the appropriate Plan Benefit Package field. Consistent with individual market MSA plans, MA EGWP MSA plans are not able to use a portion of the Part C payment to buy down the Part B premium.

Notwithstanding the payment policies described above, entities offering MA EGWPs must continue to meet all of the CMS requirements that are not otherwise specifically waived or modified, including, but not limited to, submitting information related to plan service areas, plan benefit packages, and formularies in accordance with the rules for 2024. MA organizations must continue to make a good faith effort in projecting CY 2024 member months for each plan and place the amount in the appropriate section of the CY 2024 Plan Benefit Package (PBP) submissions to CMS.

Section G. CMS-HCC Risk Adjustment Model for CY 2024

For CY 2024, CMS proposes to implement a revised version of the CMS-HCC risk adjustment model. This proposed model has the same structure as the 2020 CMS-HCC risk adjustment model currently used for payment in that it has eight model segments as first

implemented for payment for CY 2017[18] and condition count variables as first implemented for payment for CY 2020.[19] It incorporates the following technical updates: (1) updated data years used for model calibration, (2) updated denominator year used in determining the average per capita predicted expenditures to create relative factors in the model, and (3) a clinical reclassification of the hierarchical condition categories (HCCs) using the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes. In addition, as part of the clinical reclassification, CMS conducted an assessment on conditions that are coded more frequently in MA relative to FFS. This assessment is consistent with Principle 10 of CMS's longstanding model principles, described in more detail initially in the December 2000 report titled, "Diagnostic Cost Group Hierarchical Condition Category Models for Medicare Risk Adjustment (Final Report)."[20] As a result of this assessment, in addition to the technical updates, the proposed model includes additional constraints and the removal of several HCCs in order to reduce the impact on risk scores of MA coding variation from FFS. Refer to Table II-4 below for a list of HCC differences between the current and proposed CMS-HCC risk adjustment models. We propose to use this revised CMS-HCC model in Part C payment for aged/disabled beneficiaries enrolled in MA plans beginning with payment year 2024.

CMS regularly updates risk adjustment models to reflect more recent utilization and cost patterns. In addition, CMS periodically conducts clinical revisions of the model to update and revise the composition of the condition categories to reflect more recent changes in disease patterns, treatment methods, and coding practices, as well as compositional changes within the Medicare population. As discussed in the 2018 and 2021 Reports to Congress on Risk Adjustment in Medicare Advantage,[21] CMS has been conducting analyses on the CMS-HCC models for reclassification purposes and in preparation for changing to risk adjustment payment models calibrated on ICD-10-CM (also referred to as ICD-10) diagnoses. For CY 2023, CMS finalized an RxHCC model calibrated on ICD-10-CM.

The proposed model, accounting for all the changes to the model described in more detail below in Table II-4, results in more appropriate relative weights for the HCCs in the model because they reflect more recent utilization, coding and expenditure patterns in FFS Medicare, as well as revised HCCs that are constructed to reflect clinical cost patterns associated with ICD-10 codes, the classification system that is currently being used by providers. Beneficiary risk scores or plan average risk scores may change depending on each

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[18] CY 2017 Advance Notice and CY 2017 Rate Announcement.

[19] CY 2020 Advance Notice, Part I and CY 2020 Rate Announcement.

[20] Diagnostic Cost Group Hierarchical Condition Category Models for Medicare Risk Adjustment (Final Report)

[21] 2021 Report to Congress: Risk Adjustment in Medicare Advantage; 2018 Report to Congress: Risk Adjustment in Medicare Advantage.

individual beneficiary's combination of diagnoses or the clinical profile of a plan's enrollee population.

Risk score differences between the current model and the proposed model will occur for several reasons. Specifically, revisions to the models result in changes in the marginal cost attributable to each HCC, relative to the change in the average cost (i.e., denominator used to set the relatives), and can alter the relative factor associated with each HCC, and with the relative values among HCCs. In addition, changes in the relative factors will result from changing from HCCs that were created using the ICD-9 classification system to HCCs that were created using the ICD-10 classification system, as well as from the addition or deletion of HCCs to or from the model.

The discussion of the risk adjustment model updates in this Advance Notice includes the relative factors for the proposed model (Attachment VI, Tables VI-1, VI-2, and VI-3) and a table comparing the HCCs for the current model and the proposed model (Attachment II, Table II-4). In addition, CMS has posted preliminary ICD-10 to HCC mappings on the CMS Risk Adjustment Webpage, https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/RiskOtherModel-Related. CMS also regularly provides additional plan-specific information outside the Advance Notice discussion to supplement plan review of risk adjustment model revisions.

Model Recalibration

Data Year Update

CMS calibrated the current CMS-HCC risk adjustment model (the 2020 CMS-HCC model) using FFS claims for the years 2014 and 2015. Specifically, the current model is calibrated using 2014 diagnoses and 2015 expenditures. CMS conducted an evaluation and sensitivity analysis to determine if coding to the ICD-10 classification system is stable enough for model calibration by calibrating the current model (2020 CMS-HCC model) on multiple successive years of more recent data and reviewing the resulting relative coefficient patterns for stability. We found that the ICD-10 classification system is sufficiently stable for this purpose; 2018/2019 coefficients were stable relative to 2017/2018 coefficients. The proposed CMS-HCC risk adjustment model is calibrated using 2018 diagnoses and 2019 expenditures.

The model sample comprises all beneficiaries who have at least one month in FFS in the prediction year (2019) and all twelve months in FFS in the prior year (2018). Model coefficients for HCCs are estimated by regressing the total annualized expenditure for Medicare Parts A and B benefits for each beneficiary onto their demographic factors and hierarchical condition categories, as indicated by their diagnoses. Expenditures used are annualized for each beneficiary, meaning that for beneficiaries who are in Medicare for less than 12 months in the prediction year, we calculate what expenditures would be for the entire year using their partial year experience.

Denominator Year Update

In order to use the risk adjustment model to calculate risk scores for payment, we create relative factors for each demographic factor and HCC in the model. The relative factors are used to calculate risk scores for individual beneficiaries. We create relative factors by dividing all the dollar coefficients by the average per capita predicted expenditures for a specific year (referred to herein as the "denominator year"). The denominator year has been 2015 since the CMS-HCC model implemented for payment year 2017. The denominator year for the proposed model will be updated to 2020 (2019 diagnoses for a 2020 cohort of beneficiaries); the denominator is $10,402.34.

Model Reclassification

Clinical Update using ICD-10 Diagnosis Codes

The HCC diagnostic classification system begins by classifying over 72,000 ICD-10-CM diagnosis codes into approximately 1,500 diagnostic groups (DXGs). Each ICD-10-CM code maps to exactly one DXG, which represents a well-specified medical condition. DXGs are further aggregated into 204 condition categories. Condition categories describe a broader set of similar diseases. Although they are not as homogeneous as DXGs, diseases within a condition category are related clinically and with respect to cost. Consistent with prior model calibrations, hierarchies are imposed by CMS among related condition categories, so that a beneficiary's risk score includes only the most severe manifestation among related diseases. Hierarchies allow for payment based on the most serious conditions when less serious conditions also exist. After imposing hierarchies, condition categories become Hierarchical Condition Categories, or HCCs. In developing risk models, CMS imposes hierarchies in all model calibrations so that if a person has more than one condition category in a hierarchy, only the highest (most severe) condition category in the hierarchy will be assigned as the HCC for calculating the risk score.[22]

For 2024, we are proposing to implement a model that incorporates a clinical revision of the HCCs, using ICD-10 codes to create the HCCs for the first time. Previous versions of the CMS-HCC model used ICD-9 codes to create the HCCs. In addition to using more recent data and denominator year in recalibrating the model, the new CMS-HCC model will reflect a reclassification by which CMS, in consultation with a panel of outside clinicians, rebuilt the condition categories to reflect diagnosis coding under the ICD-10-CM diagnosis classification system. Underlying diagnosis to HCC mappings were evaluated to ensure that

[22] 2020 Advance Notice, Part 1.

diagnosis codes map to condition categories with similar clinical characteristics and cost patterns. To guide the reclassification process, we applied our longstanding 10 Principles of Risk Adjustment that were used to create the original CMS-HCC diagnostic classification system.[23] Both the panel of clinicians and analyses of cost data informed CMS's creation of the revised condition categories. These new categories reflect more clinical specificity and validity (i.e., greater level of detail that allows more precision in the identification of specific conditions) available through ICD-10 coding. Because the model is calibrated on more recent data using the same ICD classification system that is currently being utilized to code diagnoses in clinical settings, the model will better reflect recent cost and utilization patterns. The new categories and updated HCCs will also reflect possible changes to physician coding patterns that have developed as a result of the transition to ICD-10 that the current model does not.

Changes to the condition categories – including additions, deletions, and revisions – are based on each condition category's ability to predict costs for Medicare Parts A and B benefits. Condition categories that do not predict costs well – for example, because the coefficient is small, the t-value is low, a small number of beneficiaries have the certain condition, or the condition does not have well-specified diagnostic coding – are not included in the model.

We estimated coefficients for condition categories and demographic factors by regressing the total expenditures for Medicare Parts A and B benefits for each beneficiary onto their demographic factors and condition categories, as indicated by their diagnoses. Resulting dollar coefficients represent the marginal (additional) cost of the condition or demographic factor (for example, age/sex group, Medicaid status, disability status) in predicting per capita FFS costs.

Principle 10-Focused Clinical Updates

Among the revisions in the proposed model are several updates that resulted from the CMS review of conditions that focused on Principle 10. For conditions in the model where coding in MA was highest relative to FFS, CMS reviewed these conditions with our clinical experts for evaluation against the model principles because we believe that this coding differential indicates conditions where there may be discretionary coding variation.

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[23] Advance Notice of Methodological Changes for Calendar Year (CY) 2004 Medicare+Choice (M+C) Payment Rates; 2021 Report to Congress on Risk Adjustment in Medicare Advantage (section 2.3 provides further details on the Principles of Risk Adjustment).

The review is consistent with our evaluation of condition categories, and the underlying ICD-10 diagnosis code to HCC mappings, against risk adjustment model development Principle 10. Principle 10 is a longstanding principle that is used as part of the standard evaluation of all of the risk adjustment models.[24]

> ***Principle 10*** *- Discretionary diagnostic categories should be excluded from payment models. Diagnoses that are particularly subject to intentional or unintentional discretionary coding variation or inappropriate coding by health plans/providers, or that are not clinically or empirically credible as cost predictors, should not increase cost predictions. Excluding these diagnoses reduces the sensitivity of the model to coding variation and coding proliferation.*

As there is variation in the coding of discretionary conditions – meaning that the coding of these conditions is likely not consistent across the industry – including them in the risk adjustment model can lead to distortion of the marginal costs estimated by the model, reducing the ability of the HCCs in the model to predict stable costs and accurately predict those costs in alignment with the severity of the condition.

With a focus on principle 10, CMS identified a number of diagnoses and condition categories that we determined should be reclassified based on both relative coding in MA versus in FFS and based on clinical input regarding the degree of discretion to code each condition. Specifically, in consultation with clinician input regarding appropriate classification of identified conditions, this reclassification involved moving some discretionary diagnosis codes from condition categories included in the CMS-HCC model to condition categories not included in the model, removing from the model several condition categories that do not accurately predict the projected cost of a beneficiary, and constraining HCCs to be equal to each other so that they carry the same weight in the risk score. These updates serve to maintain the integrity of the condition categories in the model. The updates of this type are as follows (note that the HCC numbers are for the proposed model):

- HCC constraints (i.e., hold the coefficients of the HCCs equal to each other such that each HCC carries the same weight):
    - Constrained all Diabetes HCCs (HCC 36, 37, and 38).
    - Constrained Congestive Heart Failure HCCs (HCCs 224, 225, and 226).
- HCC removals:
    - HCC 47 Protein-Calorie Malnutrition.

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[24] Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model.

- HCC 230 Angina Pectoris.
- HCC 265 Atherosclerosis of Arteries of the Extremities, with Intermittent Claudication.

We propose to include these additional updates in the CMS-HCC model for 2024 to more specifically apply Principle 10. These changes will limit the sensitivity of the model to coding variation, thereby maintaining the integrity of the condition categories in the model and their ability to accurately predict costs. In addition, these changes are consistent with public comments that CMS has received in response to the Advance Notice in the past.[25] More information can be found in the Economic Information section (Attachment V, Section A4).

Technical specifications of proposed model

The proposed 2024 CMS-HCC model has 115 payment HCCs, up from 86 in the current model. This increase in HCCs is due to newly-created HCCs added to the model and the splitting of several existing HCCs resulting from changes in the structure and clinical specificity of codes from ICD-9 to ICD-10, as well as changes in clinical concepts for some conditions.

Since the proposed model reflects a clinical revision using ICD-10 codes, and incorporates new diagnosis-to-HCC-mappings, the proposed model has been assigned a new version number, specifically Version 28 (V28). Differences in the HCCs in the current (V24) CMS-HCC risk adjustment model (also known as the 2020 CMS-HCC model) and HCCs in the proposed V28 model are noted in Table II-4 below.

Table II-4 lists the HCCs in the proposed model (V28) compared to the current model (V24), organized by disease group. The HCCs in the current model were created using the ICD-9 classification system as the basis. On October 1, 2015, the industry moved from using the ICD-9 classification system to using ICD-10. In order to transition to ICD-10 for payment, CMS mapped ICD-10 diagnosis codes into HCCs that were created using the ICD-9 classification system to calculate risk scores. The proposed model has HCCs that were created using the ICD-10 classification system, resulting in HCCs that directly align with the diagnostic classification system currently in use by the industry. The ICD-to-HCC mappings files, available on the CMS Risk Adjustment webpage, have an exhaustive list of HCCs in V24 and/or V28 and the underlying mappings to ICD-10 codes. Note that HCCs with the same, or similar, label in V24 and V28 may have differences in the underlying ICD-10 codes that map to the HCC, meaning that the same, or similar, HCC label does not necessarily imply that the HCC is unchanged from V24 to V28. Similarly, V24 and V28 disease groups may not

[25] See Section L of the 2023 Rate Announcement.

have the same underlying ICD code mappings. There are hierarchical relationships among some HCCs, such that a beneficiary may not be able to have all of the HCCs in a disease group in a given year.

Table II-4. HCC Differences Between the Current and Proposed CMS-HCC Risk Adjustment Models, by Disease Group

2020 model (V24)	Proposed model (V28)
• 86 payment HCCs • 9,797 FY22/FY23 ICD-10 diagnosis codes mapped to an HCC for payment	• 115 payment HCCs • 7,770 FY22/FY23 ICD-10 diagnosis codes mapped to an HCC for payment
Infectious Disease Group: 3 HCCs • HCC 1 (*HIV/AIDS*) • HCC 2 (*Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock*) • HCC 6 (*Opportunistic Infections*)	**Infectious Disease Group: 3 HCCs** • HCC 1 (*HIV/AIDS*) • HCC 2 (*Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock*) • HCC 6 (*Opportunistic Infections*)
Neoplasm Disease Group: 5 HCCs • HCC 8 (*Metastatic Cancer and Acute Leukemia*) • HCC 9 (*Lung and Other Severe Cancers*) • HCC 10 (*Lymphoma and Other Cancers*) • HCC 11 (*Colorectal, Bladder, and Other Cancers*) • HCC 12 (*Breast, Prostate, and Other Cancers and Tumors*)	**Neoplasm Disease Group: 7 HCCs** • HCC 17 (*Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic*) • HCC 18 (*Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid*) • HCC 19 (*Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers*) • HCC 20 (*Lung and Other Severe Cancers*) • HCC 21 (*Lymphoma and Other Cancers*) • HCC 22 (*Bladder, Colorectal, and Other Cancers)* • HCC 23 (*Prostate, Breast, and Other Cancers and Tumors*)
Diabetes Disease Group: 3 HCCs • HCC 17 (*Diabetes with Acute Complications*) • HCC 18 (*Diabetes with Chronic Complications*) • HCC 19 (*Diabetes without Complication*)	**Diabetes Disease Group: 4 HCCs** • HCC 35 (*Pancreas Transplant Status*) • HCC 36 (*Diabetes with Severe Acute Complications*) • HCC 37 (*Diabetes with Chronic Complications*) • HCC 38 (*Diabetes with Glycemic, Unspecified, or No Complications*)
Metabolic Disease Group: 3 HCCs • HCC 21 (*Protein-Calorie Malnutrition*) • HCC 22 (*Morbid Obesity*)	**Metabolic Disease Group: 4 HCCs** • HCC 48 (*Morbid Obesity*) • HCC 49 (*Specified Lysosomal Storage Disorders*)

Table II-4. HCC Differences Between the Current and Proposed CMS-HCC Risk Adjustment Models, by Disease Group	
2020 model (V24)	**Proposed model (V28)**
• HCC 23 (*Other Significant Endocrine and Metabolic Disorders*)	• HCC 50 (*Amyloidosis, Porphyria, and Other Specified Metabolic Disorders*) • HCC 51 (*Addison's and Cushing's Diseases, Acromegaly, and Other Specified Endocrine Disorders*)
Liver Disease Group: 3 HCCs • HCC 27 (*End-Stage Liver Disease*) • HCC 28 (*Cirrhosis of Liver*) • HCC 29 (*Chronic Hepatitis*)	**Liver Disease Group: 5 HCCs** • HCC 62 (*Liver Transplant Status/Complications*) • HCC 63 (*Chronic Liver Failure/End-Stage Liver Disorders*) • HCC 64 (*Cirrhosis of Liver*) • HCC 65 (*Chronic Hepatitis*) • HCC 68 (*Cholangitis and Obstruction of Bile Duct Without Gallstones*)
Gastrointestinal Disease Group: 3 HCCs • HCC 33 (*Intestinal Obstruction/Perforation*) • HCC 34 (*Chronic Pancreatitis*) • HCC 35 (*Inflammatory Bowel Disease*)	**Gastrointestinal Disease Group: 5 HCCs** • HCC 77 (*Intestine Transplant Status/Complications*) • HCC 78 (*Intestinal Obstruction/Perforation*) • HCC 79 (*Chronic Pancreatitis*) • HCC 80 (*Crohn's Disease (Regional Enteritis)*) • HCC 81 (*Ulcerative Colitis*)
Musculoskeletal Disease Group: 2 HCCs • HCC 39 (*Bone/Joint/Muscle Infections/Necrosis*) • HCC 40 (*Rheumatoid Arthritis and Inflammatory Connective Tissue Disease*)	**Musculoskeletal Disease Group: 3 HCCs** • HCC 92 (*Bone/Joint/Muscle/Severe Soft Tissue Infections/Necrosis*) • HCC 93 (*Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders*) • HCC 94 (*Systemic Lupus Erythematosus and Other Specified Systemic Connective Tissue Disorders*)
Blood Disease Group: 3 HCCs • HCC 46 (*Severe Hematological Disorders*) • HCC 47 (*Disorders of Immunity*) • HCC 48 (*Coagulation Defects and Other Specified Hematological Disorders*)	**Blood Disease Group: 7 HCCs** • HCC 107 (*Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero*) • HCC 108 (*Sickle Cell Disorders, Except Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero; Beta Thalassemia Major*) • HCC 109 (*Acquired Hemolytic, Aplastic, and Sideroblastic Anemias*) • HCC 111 (*Hemophilia, Male*) • HCC 112 (*Immune Thrombocytopenia and Specified Coagulation Defects and Hemorrhagic Conditions*)

Table II-4. HCC Differences Between the Current and Proposed CMS-HCC Risk Adjustment Models, by Disease Group	
2020 model (V24)	**Proposed model (V28)**
	• HCC 114 (*Common Variable and Combined Immunodeficiencies*) • HCC 115 (*Specified Immunodeficiencies and White Blood Cell Disorders*)
Cognitive Disease Group: 2 HCCs • HCC 51 (*Dementia With Complications*) • HCC 52 (*Dementia Without Complication*)	**Cognitive Disease Group: 3 HCCs** • HCC 125 (*Dementia, Severe*) • HCC 126 (*Dementia, Moderate*) • HCC 127 (*Dementia, Mild or Unspecified*)
Substance Use Disorder Disease Group: 3 HCCs • HCC 54 (*Substance Use with Psychotic Complications*) • HCC 55 (*Substance Use Disorder, Moderate/Severe, or Substance Use with Complications*) • HCC 56 (*Substance Use Disorder, Mild, Except Alcohol and Cannabis*)	**Substance Use Disorder Disease Group: 5 HCCs** • HCC 135 (*Drug Use with Psychotic Complications*) • HCC 136 (*Alcohol Use with Psychotic Complications*) • HCC 137 (*Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications*) • HCC 138 (*Drug Use Disorder, Mild, Uncomplicated, Except Cannabis*) • HCC 139 (*Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications*)
Psychiatric Disease Group: 4 HCCs • HCC 57 (*Schizophrenia*) • HCC 58 (*Reactive and Unspecified Psychosis*) • HCC 59 (*Major Depressive, Bipolar, and Paranoid Disorders*) • HCC 60 (*Personality Disorders*)	**Psychiatric Disease Group: 5 HCCs** • HCC 151 (*Schizophrenia*) • HCC 152 (*Psychosis, Except Schizophrenia*) • HCC 153 (*Personality Disorders; Anorexia/Bulimia Nervosa*) • HCC 154 (*Bipolar Disorders without Psychosis*) • HCC 155 (*Major Depression, Moderate or Severe, without Psychosis*)
Spinal Disease Group: 3 HCCs • HCC 70 (*Quadriplegia*) • HCC 71 (*Paraplegia*) • HCC 72 (*Spinal Cord Disorders/Injuries*)	**Spinal Disease Group: 3 HCCs** • HCC 180 (*Quadriplegia*) • HCC 181 (*Paraplegia*) • HCC 182 (*Spinal Cord Disorders/Injuries*)
Neurological Disease Group: 8 HCCs • HCC 73 (*Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease*) • HCC 74 (*Cerebral Palsy*)	**Neurological Disease Group: 12 HCCs** • HCC 190 (*Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease, Spinal Muscular Atrophy*) • HCC 191 (*Quadriplegic Cerebral Palsy*) • HCC 192 (*Cerebral Palsy, Except Quadriplegic*)

Table II-4. HCC Differences Between the Current and Proposed CMS-HCC Risk Adjustment Models, by Disease Group	
2020 model (V24)	**Proposed model (V28)**
• HCC 75 (*Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy*) • HCC 76 (*Muscular Dystrophy*) • HCC 77 (*Multiple Sclerosis*) • HCC 78 (*Parkinson's and Huntington's Diseases*) • HCC 79 (*Seizure Disorders and Convulsions*) • HCC 80 (*Coma, Brain Compression/Anoxic Damage*)	• HCC 193 (*Chronic Inflammatory Demyelinating Polyneuritis and Multifocal Motor Neuropathy*) • HCC 195 (*Myasthenia Gravis with (Acute) Exacerbation*) • HCC 196 (*Myasthenia Gravis without (Acute) Exacerbation and Other Myoneural Disorders*) • HCC 197 (*Muscular Dystrophy*) • HCC 198 (*Multiple Sclerosis*) • HCC 199 (*Parkinson and Other Degenerative Disease of Basal Ganglia*) • HCC 200 (*Friedreich and Other Hereditary Ataxias; Huntington Disease*) • HCC 201 (*Seizure Disorders and Convulsions*) • HCC 202 (*Coma, Brain Compression/Anoxic Damage*)
Arrest Disease Group: 3 HCCs • HCC 82 (*Respirator Dependence/Tracheostomy Status*) • HCC 83 (*Respiratory Arrest*) • HCC 84 (*Cardio-Respiratory Failure and Shock*)	**Arrest Disease Group: 3 HCCs** • HCC 211 (*Respirator Dependence/Tracheostomy Status/Complications*) • HCC 212 (*Respiratory Arrest*) • HCC 213 (*Cardio-Respiratory Failure and Shock*)
Heart Disease Group: 5 HCCs • HCC 85 (*Congestive Heart Failure*) • HCC 86 (*Acute Myocardial Infarction*) • HCC 87 (*Unstable Angina and Other Acute Ischemic Heart Disease*) • HCC 88 (*Angina Pectoris*) • HCC 96 (*Specified Heart Arrhythmias*)	**Heart Disease Group: 10 HCCs** • HCC 221 (*Heart Transplant Status/Complications*) • HCC 222 (*End Stage Heart Failure*) • HCC 223 (*Heart Assist Device/Artificial Heart*)[26] • HCC 224 (*Acute on Chronic Heart Failure*) • HCC 225 (*Acute Heart Failure (Excludes Acute on Chronic)*) • HCC 226 (*Heart Failure, Except End Stage and Acute*) • HCC 227 (*Cardiomyopathy/Myocarditis*) • HCC 228 (*Acute Myocardial Infarction*) • HCC 229 (*Unstable Angina and Other Acute Ischemic Heart Disease*)

[26] HCC 223 Heart Assist Device/Artificial Heart contains six ICD-10 codes for presence or complications of heart assist device and artificial heart. To capture only beneficiaries with heart failure (versus an acute condition), HCC 223 is further restricted to beneficiaries who also have an ICD-10 code mapping to heart failure HCCs 224, 225, or 226. Beneficiaries without a heart failure code will not be assigned to HCC 223. Beneficiaries with codes for heart transplant status/complications or for end stage heart failure will be assigned to HCC 221 Heart Transplant Status/Complications or HCC 222 End Stage Heart Failure, respectively. Coefficients (relative risk factors) for HCC 223 and HCC 222 are constrained equal.

Table II-4. HCC Differences Between the Current and Proposed CMS-HCC Risk Adjustment Models, by Disease Group	
2020 model (V24)	**Proposed model (V28)**
	• HCC 238 (*Specified Heart Arrhythmias*)
Cerebrovascular Disease Group: 4 HCCs • HCC 99 (*Intracranial Hemorrhage*) • HCC 100 (*Ischemic or Unspecified Stroke*) • HCC 103 (*Hemiplegia/Hemiparesis*) • HCC 104 (*Monoplegia, Other Paralytic Syndromes*)	**Cerebrovascular Disease Group: 4 HCCs** • HCC 248 (*Intracranial Hemorrhage*) • HCC 249 (*Ischemic or Unspecified Stroke*) • HCC 253 (*Hemiplegia/Hemiparesis*) • HCC 254 (*Monoplegia, Other Paralytic Syndromes*)
Vascular Disease Group: 3 HCCs • HCC 106 (*Atherosclerosis of the Extremities with Ulceration or Gangrene*) • HCC 107 (*Vascular Disease with Complications*) • HCC 108 (*Vascular Disease*)	**Vascular Disease Group: 3 HCCs** • HCC 263 (*Atherosclerosis of Arteries of the Extremities with Ulceration or Gangrene*) • HCC 264 (*Vascular Disease with Complications*) • HCC 267 (*Deep Vein Thrombosis and Pulmonary Embolism*)
Lung Disease Group: 5 HCCs • HCC 110 (*Cystic Fibrosis*) • HCC 111 (*Chronic Obstructive Pulmonary Disease*) • HCC 112 (*Fibrosis of Lung and Other Chronic Lung Disorders*) • HCC 114 (*Aspiration and Specified Bacterial Pneumonias*) • HCC 115 (*Pneumococcal Pneumonia, Empyema, Lung Abscess*)	**Lung Disease Group: 7 HCCs** • HCC 276 (*Lung Transplant Status/Complications*) • HCC 277 (*Cystic Fibrosis*) • HCC 278 (*Idiopathic Pulmonary Fibrosis and Lung Involvement in Systemic Sclerosis*) • HCC 279 (*Severe Persistent Asthma*) • HCC 280 (*Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders*) • HCC 282 (*Aspiration and Specified Bacterial Pneumonias*) • HCC 283 (*Empyema, Lung Abscess*)
Eye Disease Group: 2 HCCs • HCC 122 (*Proliferative Diabetic Retinopathy and Vitreous Hemorrhage*) • HCC 124 (*Exudative Macular Degeneration*)	**Eye Disease Group: 2 HCCs** • HCC 298 (*Severe Diabetic Eye Disease, Retinal Vein Occlusion, and Vitreous Hemorrhage*) • HCC 300 (*Exudative Macular Degeneration*)
Kidney Disease Group: 5 HCCs • HCC 134 (*Dialysis Status*) • HCC 135 (*Acute Renal Failure*) • HCC 136 (*Chronic Kidney Disease, Stage 5*) • HCC 137 (*Chronic Kidney Disease, Severe (Stage 4)*)	**Kidney Disease Group: 4 HCCs** • HCC 326 (*Chronic Kidney Disease, Stage 5*) • HCC 327 (*Chronic Kidney Disease, Severe (Stage 4)*) • HCC 328 (*Chronic Kidney Disease, Moderate (Stage 3B)*)

Table II-4. HCC Differences Between the Current and Proposed CMS-HCC Risk Adjustment Models, by Disease Group	
2020 model (V24)	**Proposed model (V28)**
• HCC 138 (*Chronic Kidney Disease, Moderate (Stage 3)*)	• HCC 329 (*Chronic Kidney Disease, Moderate (Stage 3, Except 3B)*)
Skin Disease Group: 5 HCCs • HCC 157 (*Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone*) • HCC 158 (*Pressure Ulcer of Skin with Full Thickness Skin Loss*) • HCC 159 (*Pressure Ulcer of Skin with Partial Thickness Skin Loss*) • HCC 161 (*Chronic Ulcer of Skin, Except Pressure*) • HCC 162 (*Severe Skin Burn or Condition*)	**Skin Disease Group: 7 HCCs** • HCC 379 (*Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone*) • HCC 380 (*Chronic Ulcer of Skin, Except Pressure, Through to Bone or Muscle*) • HCC 381 (*Pressure Ulcer of Skin with Full Thickness Skin Loss*) • HCC 382 (*Pressure Ulcer of Skin with Partial Thickness Skin Loss*) • HCC 383 (*Chronic Ulcer of Skin, Except Pressure, Not Specified as Through to Bone or Muscle*) • HCC 385 (*Severe Skin Burn*) • HCC 387 (*Pemphigus, Pemphigoid, and Other Specified Autoimmune Skin Disorders*)
Injury Disease Group: 5 HCCs • HCC 166 (*Severe Head Injury*) • HCC 167 (*Major Head Injury*) • HCC 169 (*Vertebral Fractures without Spinal Cord Injury*) • HCC 170 (*Hip Fracture/Dislocation*) • HCC 173 (*Traumatic Amputations and Complications*)	**Injury Disease Group: 6 HCCs** • HCC 397 (*Major Head Injury with Loss of Consciousness > 1 Hour*) • HCC 398 (*Major Head Injury with Loss of Consciousness < 1 Hour or Unspecified*) • HCC 399 (*Major Head Injury without Loss of Consciousness*) • HCC 401 (*Vertebral Fractures without Spinal Cord Injury*) • HCC 402 (*Hip Fracture/Dislocation*) • HCC 405 (*Traumatic Amputations and Complications*)
Complications Disease Group: 1 HCC • HCC 176 (*Complications of Specified Implanted Device or Graft*)	**Complications Disease Group: 0 HCCs**
Amputation Disease Group: 1 HCC • HCC 189 (*Amputation Status, Lower Limb/Amputation Complications*)	**Amputation Disease Group: 1 HCC** • HCC 409 (*Amputation Status, Lower Limb/Amputation Complications*)
Transplant Disease Group: 1 HCC	**Transplant Disease Group: 1 HCC**

Table II-4. HCC Differences Between the Current and Proposed CMS-HCC Risk Adjustment Models, by Disease Group	
2020 model (V24)	**Proposed model (V28)**
• HCC 186 (*Major Organ Transplant or Replacement Status*)	• HCC 454 (*Stem Cell, Including Bone Marrow, Transplant Status/Complications*)
Openings Disease Group: 1 HCC • HCC 188 (*Artificial Openings for Feeding or Elimination*)	**Openings Disease Group: 1 HCC** • HCC 463 (*Artificial Openings for Feeding or Elimination*)

Renumbering of HCCs

As part of our revision, some of the HCCs in the CMS-HCC risk adjustment model were renumbered. In part, this reflects how there is an increase in the number of HCCs in the proposed model relative to the current model due to newly-created HCCs and the splitting of existing HCCs. In addition, renumbering the HCCs provides cohesiveness among related HCCs by grouping them into disease groups (see Table II-4 for examples of HCC disease groups). As we have done previously (for example, for the clinical revision of the RxHCC model for CY 2023[27]), we incorporated a series of gaps in the numbering of the HCCs between disease groups in order to avoid having to undertake a comprehensive renumbering as the result of potential changes to HCCs in the future. These gaps will allow future changes in the classifications without requiring the renumbering of the entire set of HCCs. For a complete list of HCCs in the proposed model, please see Table VI-4 in Attachment VI.

ICD-10-to-HCC mappings for the revised model proposed for CY 2024 are posted on the CMS Risk Adjustment Webpage, https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/RiskOtherModel-Related.

In addition, the risk adjustment model relative factors under the proposed model are available in Attachment VI Tables VI-1, VI-2, and VI-3. Model relative factors are driven by a number of factors, including the costs and clinical profile of the beneficiaries in the model sample, as well as the diagnoses and HCCs included in the model. The technical adjustments to risk scores described in Section J (Medicare Advantage Coding Pattern Difference Adjustment) and Section K (Normalization Factors) were calculated using the proposed model.

[27] CY 2023 Advance Notice, Attachment III, Section A.4.

For CY 2024 payments to PACE organizations, we will continue to use the 2017 CMS-HCC model to calculate risk scores, which we began using for CY 2020 payments to PACE organizations as described in the CY 2020 Advance Notice Part II and the CY 2021 Advance Notice Part I.[28]

Refer to Section L for information on encounter data as a source of diagnoses for CY 2024 risk score calculation.

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

CMS uses separate models to calculate the risk scores applied in payment for the Part A and Part B benefits provided to beneficiaries in ESRD status when enrolled in MA plans or PACE organizations.

For CY 2024, for MA plans, CMS will continue to use the 2023 ESRD risk adjustment models, which are described in the CY 2023 Advance Notice,[29] to calculate risk scores for beneficiaries in dialysis, transplant, and post-graft status.

For CY 2024, for PACE organizations, CMS will continue to use the 2019 ESRD risk adjustment models, which are described in the CY 2019 Advance Notice,[30] to calculate ESRD risk scores for PACE participants.

Refer to Section L for information on encounter data as a source of diagnoses for CY 2024 ESRD risk score calculation.

Section I. Frailty Adjustment for PACE Organizations and FIDE SNPs

While the CMS-HCC model predicts future Medicare expenditures of individuals based on their demographic and clinical characteristics, the model may not explain all of the variation in expenditures for frail community populations. The purpose of the frailty adjustment is to predict the Medicare expenditures of community populations with functional impairments that are unexplained by the diagnoses in the CMS-HCC model.

Section 1894(d)(2) of the Act requires CMS to take into account the frailty of the PACE population when establishing the capitated payment amounts for PACE organizations. In addition, section 1853(a)(1)(B)(iv) of the Act allows CMS to make an additional payment adjustment that takes into account the frailty of beneficiaries enrolled in Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs), if the average level of frailty in the FIDE SNP is

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[28] The CY 2020 and 2021 Advance Notices are available on the CMS website at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.

[29] CY 2023 Advance Notice (Section H): https://www.cms.gov/files/document/2023-advance-notice.pdf.

[30] The CY 2019 Advance Notice is available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2019Part2.pdf.

similar to that in the PACE program. For PACE organizations and eligible FIDE SNPs, we make this adjustment by adding a frailty score to a beneficiary's risk score.

CMS calibrates the frailty factors by regressing the residual, or unexplained, costs from the CMS-HCC risk adjustment model onto counts of activities of daily living (ADLs). Residual costs are unique to each version of the CMS-HCC model, and consequently, so are the frailty factors. For this reason, CMS must update the frailty factors whenever the CMS-HCC model changes.[31] CMS obtains ADLs from surveys of the general Medicare population. There are six ADLs: 1) bathing and showering, 2) dressing, 3) eating, 4) getting in or out of bed or chairs, 5) walking, and 6) using the toilet. To calculate frailty scores for payment, CMS uses the number of functional limitations represented by the ADL scale to determine the relative frailty of those in the community that are 55 years of age and older.

For CY 2024, CMS is proposing to update the frailty factors used to calculate frailty scores for beneficiaries enrolled in FIDE SNPs, consistent with the revision of the CMS-HCC model (see Section G). The preliminary frailty factors are calibrated to align with the proposed 2024 CMS-HCC model (calibrated on FFS claims for the years 2018 and 2019, specifically 2018 diagnoses and 2019 expenditures), using ADL data from the 2018 Medicare FFS Consumer Assessment of Health Providers & Systems (CAHPS) survey, an update from the previous frailty model which used ADL data from the 2014 CAHPS survey.

By using the FFS CAHPS results to calibrate the frailty factors, CMS uses methodologically-similar surveys to estimate the frailty factors, and for calculating annual frailty scores (which uses ADLs from the Health Outcomes Survey (HOS) and the Health Outcomes Survey – Modified (HOS-M)). The preliminary frailty factors associated with the proposed 2024 CMS-HCC model are in Table II-5.

Table II-5. Frailty Factors Associated with the 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

[31] Chapter 7 of the Medicare Managed Care Manual, Section 80: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf.

To calibrate the frailty factors, CMS applied a weight to the frailty regression, which is defined as the product of the following two weights:[32] 1) Medicare eligibility fraction weight to adjust for the potential impact of partial member months (equals the number of Medicare FFS, aged/disabled, continuing enrollee, community months in the payment year divided by 12), and 2) the CAHPS survey weight to adjust for the potential impact of non-response bias in the CAHPS survey.

MA organizations that are planning to sponsor a FIDE SNP and wish to be considered for frailty payments in 2024 must contract with a CMS-approved survey vendor to field the 2023 HOS or HOS-M at the PBP level so that the necessary information to calculate a frailty adjustment for the FIDE SNP's risk scores is available. For FIDE SNPs, CMS uses plan-level ADL information obtained from the HOS or HOS-M in one year to calculate frailty scores for the following year by applying the frailty factors that correspond to the ADL information gathered from the HOS or HOS-M data.

For CY 2024, CMS will continue calculating risk scores for beneficiaries enrolled in PACE organizations using the 2017 CMS-HCC model, and will use the frailty factors associated with the 2017 CMS-HCC model (Table II-6) to calculate frailty scores for PACE organizations in CY 2024.

Table II-6. Frailty Factors Associated with the 2017 CMS-HCC Model – PACE Organizations (Previously published in the 2017 Advance Notice & finalized in the 2017 Announcement)[33]

ADL	Non-Medicaid	Medicaid
0	-0.083	-0.093
1-2	0.124	0.105
3-4	0.248	0.243
5-6	0.248	0.420

Section J. Medicare Advantage Coding Pattern Difference Adjustment

For CY 2024, CMS proposes to apply the statutory minimum MA coding pattern difference adjustment factor of 5.90 percent.

[32] This weight (i.e., the product of the Medicare eligibility fraction weight and the CAHPS survey weight) was also used in a preliminary step to the frailty regression where the residuals (dependent variable of the frailty regression) are adjusted so that the weighted mean of residuals across the overall FFS CAHPS frailty sample equals 0.

[33] CY 2017 Advance Notice, Section K.

Section K. Normalization Factors

Background: The CMS-HCC risk adjustment models are calibrated with diagnostic and cost information for beneficiaries enrolled in Medicare FFS. The CMS-HCC risk adjustment model is prospective in that it uses health status in a base year (i.e., data collection year) to estimate incremental costs for a variety of beneficiary characteristics (e.g., age and gender) and health conditions in the following year (i.e., the payment year). Each model variable's incremental cost estimate, referred to as a dollar coefficient, is divided by the predicted average per capita expenditure for beneficiaries in the Medicare FFS program in a given year (i.e., the denominator year) to create relative factors. Risk scores are the sum of relative factors assigned to each beneficiary based on their demographic characteristics and health status from the prior year. For FFS beneficiaries, the average risk score is 1.0 in the denominator year.

When a risk adjustment model predicts expenditures in years other than the denominator year (prior or future years), the average risk score for FFS beneficiaries may no longer be 1.0 due to an underlying trend that reflects changes, such as those in coding and population characteristics, between the denominator year and other years. CMS applies a normalization factor to risk scores in the payment year to account for this trend in the average FFS risk score between the denominator year risk score (1.0) and the payment year. The normalization factor is a projection of this trend, and applying the factor is designed to effectively keep the average risk score at 1.0 in the payment year for beneficiaries in FFS.[34]

In determining the CMS-HCC models' normalization factors, we use the observed historical trend to predict the average risk score of FFS beneficiaries in the payment year, calculated using the model for the applicable population that will be used in the payment year. In determining the RxHCC model normalization factor, we use the observed historical trend to predict the average risk score of beneficiaries enrolled in Part D plans, including Medicare Advantage-Prescription Drug Plans (MA-PDs) and standalone prescription drug plans (PDPs), in the payment year. As with the CMS-HCC model normalization factors, the RxHCC model normalization factor is calculated using the model that will be used in the payment year.

CMS calculates each normalization factor annually using historical risk score data and the payment year risk adjustment model. This annual update serves two purposes. First, when paying plans for Part A and B benefits, it is important to keep the average risk score at 1.0 for beneficiaries in FFS so that risk scores in the payment year align with the rates, which are standardized to an average risk score of 1.0. A risk score accounts for the degree to which a beneficiary's risk status results in expected costs that are more or less than the expected cost of the average beneficiary in FFS. The rates, which are the benchmarks for Part C bidding,

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[34] See section 1853(a)(1)(C)(ii)(I) of the Act, which requires that the risk adjustment used in MA payment reflects changes in treatment and coding practices in the fee-for-service sector.

represent the expected cost of an average beneficiary in FFS in the payment year. Normalization helps to ensure that risk adjusted payments account for the underlying trend in the FFS risk score.

Second, updating the normalization factor annually stabilizes payments between model calibrations. Periodically, CMS updates the risk adjustment model with more current data and resets the year that the average risk score is 1.0 (i.e., the denominator year). Because there is a trend between the denominator year and the payment year, applying a normalization factor to risk scores provides year-over-year stability and avoids the volatility that would otherwise occur when the model is updated with a more recent denominator.

Since 2007, CMS has largely used the same methodology for calculating normalization factors, which is to project the slope calculated using five years of FFS risk scores calculated using the payment year model, from the denominator year to the payment year. After calculating the slope, we apply the equation (1+X)^n – where X is the slope calculated from the five-year trend of historical FFS risk scores, and the exponent, n, is the number of years between the denominator year and the payment year – to calculate the normalization factor. The normalization factor is thus a projection of the average FFS risk score in the payment year.

Prior to CY 2023, we typically updated the data points used to calculate the slope by dropping the earliest year's FFS risk score and adding the most recent year's FFS risk score so that the slope used for projection is based on the most recent risk scores available. For CY 2023, instead of updating the data points used to calculate the slope as we typically do, CMS calculated the CY 2023 normalization factors for the CMS-HCC risk adjustment models using the same five years of historical risk scores used to calculate the slope for developing the CY 2022 normalization factor (2016-2020).[35]

As we did for the CY 2023 normalization factors, CMS has again carefully considered the use of the 2021 FFS risk score in the calculation of the slope used to project the normalization factors for the CMS-HCC risk adjustment models for CY 2024. The 2021 risk score, which is based on diagnoses from 2020 dates of service, is significantly lower than the 2020 risk score, which was based on diagnoses from 2019 dates of service. Prior to 2021, risk scores progressively increased in the years used to identify the trend in risk scores. We believe that the decrease in the 2021 risk score is driven primarily by reduced utilization in 2020 due to the pandemic. Using the 2021 risk score and applying our typical methodology for the current CMS-HCC models yields a CY 2024 normalization factor that is lower than the actual 2022 FFS risk score. While there is inherent uncertainty with any prediction of future values, risk scores progressively increased in all the years used to identify the trend in risk scores prior to 2021, and the decreases in utilization in 2020 due to the pandemic were irregular. Therefore, CMS believes that the inclusion of the 2021

[35] See the CY 2023 Advance Notice and Rate Announcement.

risk score in the slope calculation, whether the risk score is based on the current or proposed CMS-HCC model, will result in a projected risk score (i.e., normalization factor) that is significantly below what the actual average FFS risk score is likely to be for future years. As such, CMS is proposing to exclude the 2021 FFS risk score from the historical risk scores used to identify the trend to project the normalization factor for all risk adjustment models for CY 2024.

For CY 2024 risk adjustment, CMS assessed the impact of updating the data years in the risk score trend to include the 2022 FFS risk score and dropping earlier years. The 2022 FFS risk score increased relative to the 2021 FFS risk score under all of the risk adjustment models, but is lower than the 2020 FFS risk score. While we think it is important to incorporate more recent years of data in the trend to reflect current risk, updating the data must be balanced with projecting a risk score that is reflective of what the average 2024 FFS risk score is likely to be in order to establish the appropriate normalization factor.

Proposal: For CY 2024, for the CMS-HCC risk adjustment models with a 2019 or 2020 denominator, CMS is proposing to calculate the normalization factors using a five-year linear slope methodology and updated average FFS risk scores for 2018 through 2022, but continuing to exclude the 2021 risk score as was done for the CY 2023 normalization factor. This methodology is similar to CMS's longstanding five-year linear slope methodology, except that one of the scores (2021) is excluded from the slope calculation due to it being anomalous. For the CMS-HCC risk adjustment models with a 2015 denominator and the RxHCC models, CMS is proposing to calculate the normalization factors using a five-year linear slope methodology and historical FFS risk scores (2016 through 2020), without including the 2021 and 2022 risk scores.

CMS carefully scrutinized the best way to calculate the 2024 normalization factors, considering the impact of the most recent years of average FFS risk scores in the trend. We again note that our normalization factors are projections of the payment year FFS risk scores, and any projection can be imprecise; however, the approaches CMS is proposing maintain the stability produced by using our five-year linear slope methodology and balance the impact of the pandemic on the normalization factor projection and the progressive increase in FFS risk scores evident in the historical trend. These proposals are discussed in more detail below.

CMS-HCC Risk Adjustment Models with 2019 or 2020 Denominators (the proposed 2024 Part C CMS-HCC model and the 2023 ESRD CMS-HCC models): For the risk adjustment models that have denominators based on more recent years – such as the ESRD models that have a 2019 denominator or the proposed CMS-HCC model that has a 2020 denominator – CMS is proposing to calculate the normalization factors using a five-year linear slope methodology and updated FFS risk scores (2018 through 2022, but continuing to exclude 2021). This is a modification of our typical calculation of the normalization factor because we propose not to include the 2021 risk score (that is based on 2020 diagnosis data) given CMS's concerns that the

lower than expected 2021 risk score will result in a projection that significantly underestimates what the 2024 risk score is likely to be.

CMS carefully considered whether or not to also exclude the 2022 FFS risk score for models with a more recent denominator. However, we believe that incorporating the 2022 FFS risk score in the trend, dropping the 2016 and 2017 risk scores, and continuing to exclude the 2021 FFS risk score, results in normalization factors that are better projections of the applicable 2024 average FFS risk score because the normalization factors are higher than the last actual FFS risk score in the trend and are consistent with the growth seen in risk scores year-over-year prior to the pandemic. Because CMS believes the normalization factor calculated using this modified approach is reasonable and incorporates more recent data years in the trend to reflect current risk, in line with our longstanding methodology, we propose to calculate normalization factors by taking the slope across the 2018-2022 risk scores, with 2021 being left blank, and projecting the slope to the payment year by applying the same equation used in the current methodology (which has typically been used since 2007) – (1+X)^n, where X is the historical slope calculated from the five-year trend of historical FFS risk scores, and the exponent, n, is the number of years between the denominator year and the payment year.

CMS-HCC Risk Adjustment Models with a 2015 Denominator (the 2017 Part C CMS-HCC model used for PACE organizations, the 2019 CMS-HCC ESRD models used for PACE organizations, and the 2020 Part C CMS-HCC model (if it were to be used in any capacity)): We also assessed the impact of using updated FFS risk score data in the trend for risk adjustment models with a 2015 denominator year, including the current CMS-HCC model used for MA plans as a comparison. Unlike models with more recent denominators, in our analysis of the updated FFS risk scores for these models, we observed that when using the 2018 through the 2022 risk scores in the trend and excluding the 2021 risk score, the resulting normalization factor is lower than the actual 2022 FFS risk score. Such a factor would indicate a projection that the average 2024 FFS risk score will be lower than the current 2022 average FFS risk score. We believe one contributing factor is that a model with a 2015 denominator (i.e., 2015 is the 1.0 year) requires a nine-year projection; the lower slope, applied over more years, depresses the projected 2024 risk score more than we believe to be reasonable to accurately project what the 2024 FFS risk score will be. (On the other hand, the models with more recent denominators (2019 and 2020) are only projecting out 4 or 5 years so the lower slope has less of an overall impact on the projection.) Given the increase in the 2022 actual FFS risk score relative to 2021 and the continuous increase in the average FFS risk score prior to the pandemic, it is not reasonable to apply a normalization factor that is lower than the most recent risk score data point in the trend. Therefore, CMS is proposing to calculate the normalization factors using a five-year linear slope methodology and historical FFS risk scores (2016 through 2020). We propose to exclude both the 2021 FFS risk score (based on 2020 diagnosis data) and the 2022 FFS risk score (based on 2021 diagnosis data) from the historical risk scores used to identify the trend to project the 2024 normalization factors for CMS-HCC models with a 2015 denominator.

As with the CMS-HCC risk adjustment models with 2019 or 2020 denominators, CMS will apply the same equation used in the current methodology (which has typically been used since 2007) to project the slope to the payment year, (1+X)^n, where X is the historical slope calculated from the five-year trend of historical FFS risk scores, and the exponent, n, is the number of years between the denominator year and the payment year.

RxHCC risk adjustment models (the 2020 RxHCC model used for PACE organizations and the 2023 RxHCC model): Distinct from the CMS-HCC risk adjustment models, which only use FFS risk scores to calculate the normalization factors, the normalization factors for the RxHCC risk adjustment models include both MA and FFS risk scores. For this reason, the availability of risk scores used to calculate RxHCC model normalization factors are lagged one year relative to CMS-HCC risk scores, meaning that the most recent final reconciled RxHCC risk score is for 2021 (using diagnoses from 2020 dates of service) and, therefore, the 2022 RxHCC risk score is not available for consideration in the calculation of the RxHCC normalization factor for CY 2024. For the same reasons we discussed for CY 2023,[36] and summarized above, we propose to use data for the risk score trend for the RxHCC normalization factors that do not include the 2021 risk score. For CY 2024, CMS is proposing to maintain the five-year linear slope methodology for estimating the RxHCC model normalization factors and use 2016 through 2020, which avoids the use of the 2021 risk score in the trend, consistent with the other risk adjustment models.

Risk adjustment models used for PACE: Risk adjustment models used for PACE have 2015 denominators. Per the discussion above, we propose to use 2016-2020 risk scores to calculate the CY 2024 normalization factors for the 2017 CMS-HCC model, 2019 ESRD CMS-HCC models, and the 2020 RxHCC risk adjustment model used to calculate risks scores for PACE organizations.

The preliminary normalization factors for each of the risk adjustment models and the annual average FFS risk scores are in subsections K1 through K4.

K1. Normalization Factors for the Part C CMS-HCC Models

The normalization factors for the Part C CMS-HCC risk adjustment models are applied to the community non-dual aged, community non-dual disabled, community full benefit dual aged, community full benefit dual disabled, community partial benefit dual aged, community partial benefit dual disabled, institutional, new enrollee, and C-SNP new enrollee risk scores.

Proposed Part C CMS-HCC Model for CY 2024: The proposed 2024 normalization factor calculated for the CMS-HCC risk adjustment model that we are proposing for CY 2024 is 1.015.

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[36] CY 2023 Advance Notice, Attachment II, Section L; CY 2023 Rate Announcement, Attachment III, Section M.

The proposed 2024 Part C CMS-HCC model has a 2020 denominator, meaning there are four years of trend between the denominator year and the payment year.

The risk scores in the trend used to calculate the CY 2024 normalization factor for the proposed 2024 Part C CMS-HCC model (years 2018-2022, excluding 2021) are included in Table II-7 Part C Normalization Factor Risk Scores. The 2021 risk score is provided for informational purposes only and was not used to calculate the proposed 2024 normalization factor.

2020 Part C CMS-HCC Model: If CMS were to continue using the 2020 CMS-HCC model in any capacity the normalization factor would be 1.146. The 2020 CMS-HCC model has a 2015 denominator, meaning there are nine years of trend between the denominator year and the payment year.

2017 Part C CMS-HCC Model: For PACE organizations, the proposed 2024 normalization factor calculated for the 2017 CMS-HCC risk adjustment model is 1.159. The 2017 CMS-HCC model has a 2015 denominator, meaning there are nine years of trend between the denominator year and the payment year.

The risk scores in the trend used to calculate the CY 2024 normalization factors for the 2020 Part C CMS-HCC model and the 2017 Part C CMS-HCC model (years 2016-2020) are included in Table II-7 Part C Normalization Factor Risk Scores. The 2021 and 2022 risk scores are provided for informational purposes only and were not used to calculate the normalization factors.

Table II-7. Part C Normalization Factor Risk Scores

Year	Proposed 2024 CMS-HCC Model	2020 CMS-HCC Model	2017 CMS-HCC Model
2016	-[37]	1.020	1.021
2017	0.969	1.031	1.035
2018	0.980	1.049	1.054
2019	0.990	1.064	1.070
2020	1.000	1.080	1.086
2021	0.968	1.048	1.054
2022	0.996	1.084	1.090

[37] The 2016 FFS risk score is not available for the proposed model because CMS does not have ICD-9 codes mapped to the proposed model's ICD-10 based HCCs. The diagnoses used to calculate 2016 risk scores are from 2015, when the ICD-9 classification system was in use.

K2. Normalization Factors for the ESRD CMS-HCC Dialysis Models

The normalization factors for the ESRD CMS-HCC dialysis models are applied to the risk scores for enrollees in the dialysis, dialysis new enrollee, and transplant segments.

2023 CMS-HCC ESRD Dialysis Model: For MA organizations, CMS will continue using the ESRD dialysis model implemented for CY 2023. The proposed 2024 normalization factor for the 2023 ESRD dialysis model is 1.022. The 2023 ESRD dialysis model has a 2019 denominator and there are five years of trend between the denominator year and the payment year.

The risk scores in the trend used to calculate the proposed normalization factor for the 2023 ESRD dialysis model (years 2018-2022, excluding 2021) are included in Table II-8 ESRD Dialysis Normalization Factor Risk Scores. The 2021 risk score is provided for informational purposes only and was not used to calculate the proposed 2024 normalization factor.

2019 ESRD CMS-HCC Dialysis Model: For PACE organizations, the proposed 2024 normalization factor for the 2019 ESRD dialysis model is 1.100. The 2019 ESRD dialysis model has a 2015 denominator, and there are nine years of trend between the denominator year and the payment year.

The risk scores in the trend used to calculate the proposed normalization factor for the 2019 ESRD dialysis model (years 2016-2020) are included in Table II-8 ESRD Dialysis Normalization Factor Risk Scores. The 2021 and 2022 risk score are provided for informational purposes only and were not used to calculate the proposed 2024 normalization factor.

Table II-8. ESRD Dialysis Normalization Factor Risk Scores

Year	2023 ESRD Dialysis Model	2019 ESRD Dialysis Model
2016	0.974	1.016
2017	0.983	1.029
2018	0.992	1.042
2019	1.000	1.053
2020	1.006	1.057
2021	0.997	1.047
2022	1.010	1.062

K3. Normalization Factors for the ESRD CMS-HCC Functioning Graft Models

The trends for the ESRD functioning graft models are calculated using FFS beneficiaries who are entitled to Part A, enrolled in Part B, who do not have ESRD, and are not in hospice status. The normalization factors for the ESRD functioning graft models are applied to the risk scores for

enrollees in the functioning graft community, functioning graft institutional, and functioning graft new enrollee segments.

2023 ESRD Functioning Graft Model: For MA organizations, CMS will continue using the ESRD functioning graft risk adjustment model that was implemented in CY 2023. The proposed 2024 normalization factor for the 2023 ESRD functioning graft model is 1.028. The 2023 ESRD functioning graft model has a 2019 denominator and there are five years of trend between the denominator year and the payment year.

The risk scores in the trend used to calculate the proposed normalization factor for the 2023 ESRD functioning graft model (years 2018 – 2022, excluding 2021) are included in Table II-9 ESRD Functioning Graft Normalization Factor Risk Scores. The 2021 risk score is provided for informational purposes only and was not used to calculate the proposed 2024 normalization factor.

2019 ESRD Functioning Graft Model: For PACE organizations, the proposed 2024 normalization factor for the 2019 ESRD functioning graft model is 1.159. The 2019 ESRD functioning graft model has a 2015 denominator, and there are nine years of trend between the denominator year and the payment year.

The risk scores in the trend used to calculate the proposed normalization factor for the 2019 ESRD functioning graft model (years 2016 - 2020) are included in Table II-9 ESRD Functioning Graft Normalization Factor Risk Scores. The 2021 and 2022 risk scores are provided for informational purposes only and were not used to calculate the proposed 2024 normalization factors.

Table II-9. ESRD Functioning Graft Normalization Factor Risk Scores

Year	2023 ESRD Functioning Graft Model	2019 ESRD Functioning Graft Model
2016	0.966	1.023
2017	0.973	1.039
2018	0.987	1.059
2019	1.000	1.074
2020	1.012	1.088
2021	0.976	1.054
2022	1.010	1.090

K4. Normalization Factors for the RxHCC Models

The normalization factors for the RxHCC models are applied to all Part D risk scores for beneficiaries enrolled in an MA-PD or PDP plan.

2023 RxHCC Model. For organizations other than PACE, CMS will continue using the RxHCC risk adjustment model implemented in CY 2023. The proposed 2024 normalization factor for the 2023 RxHCC model is 1.063. The 2023 RxHCC model has a 2019 denominator and there are five years of trend between the denominator year and the payment year.

2020 RxHCC Model. For PACE organizations, the proposed 2024 normalization factor for the 2020 RxHCC model is 1.084. The 2020 RxHCC model has a 2015 denominator, and there are nine years of trend between the denominator year and the payment year.

The risk scores in the trends used to calculate the proposed normalization factors for the 2023 and 2020 RxHCC models (years 2016 - 2020) are calculated using beneficiaries enrolled in MA-PDs and standalone PDPs, and are included in Table II-10 RxHCC Normalization Factor Risk Scores. The 2021 RxHCC risk score is provided for informational purposes only and was not used to calculate the normalization factors.

Table II-10. RxHCC Normalization Factor Risk Scores

Year	2023 RxHCC Model	2020 RxHCC Model
2016	0.962	1.014
2017	0.972	1.023
2018	0.986	1.034
2019	1.000	1.043
2020	1.009	1.049
2021	0.972	1.020

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

For non-PACE organizations, for CY 2024, CMS will continue the policy adopted in the CY 2023 Rate Announcement to calculate 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, for CY 2024, we will continue using the same method of calculating risk scores under the CMS-HCC and ESRD models that we have been using since CY 2015, which is to pool risk adjustment-eligible diagnoses from the following sources to calculate a single risk score (with no weighting): (1) encounter data, (2) Risk Adjustment Processing System (RAPS) data, and (3) FFS claims.

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

Section A. RxHCC Risk Adjustment Model

For CY 2024, we will continue using the 2023 RxHCC risk adjustment model to adjust direct subsidy payments for Part D benefits offered by stand-alone Prescription Drug Plans (PDPs) and Medicare Advantage-Prescription Drug Plans (MA-PDs), which was discussed in the 2023 Advance Notice and Rate Announcement.[38] Due to the timing of the passage of the IRA, the model will not reflect changes in the Part D benefit parameters for CY 2024. The IRA was enacted well into the timeline needed to conduct a revision to the RxHCC risk adjustment model to reflect these recent changes for CY 2024. It requires extensive time to prepare the data to calibrate, review, and finalize an updated model. For example, for the RxHCC model, this work includes re-mapping all the PDEs to reflect the new plan liability, and re-estimating the RxHCC coefficients based on the updated plan liability. We will recalibrate the RxHCC model based on the updated benefit structure and propose any changes for CY 2025.

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

For non-PACE organizations, for CY 2024, we will continue to calculate Part D risk scores using only risk adjustment-eligible diagnoses from encounter data and FFS claims.

For PACE organizations, for CY 2024, we will continue using the 2020 RxHCC model to calculate Part D risk scores using the same method we have been using since CY 2015, which is to pool risk adjustment-eligible diagnoses from the following sources to calculate a single risk score (with no weighting): (1) encounter data, (2) RAPS data, and (3) FFS claims.

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

The IRA made several amendments and additions to the Act that affect the structure of the defined standard Part D drug benefit for CY 2023 and subsequent years. Changes specific to CY 2023 are described in separate guidance specific to 2023.[39] Changes in place for CY 2024 are summarized below. Changes for 2025 and beyond will be covered in the CY 2025 Advance Notice and Rate Announcement.

IRA policies in place for CY 2024 include:

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[38] The 2023 Advance Notice and Rate Announcement can be found at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.

[39] Centers for Medicare & Medicaid Services, Contract Year 2023 Program Guidance Related to Inflation Reduction Act Changes to Part D Coverage of Vaccines and Insulin (Sept. 26, 2022). https://www.cms.gov/httpseditcmsgovresearch-statistics-data-and-systemscomputer-data-and-systemshpmshpms-memos-archive/hpms-memos-wk-5-september-26-30.

- Cost sharing for covered Part D drugs will be eliminated for beneficiaries in the catastrophic phase of coverage beginning in CY 2024.
- Beginning in CY 2024, the low-income subsidy program (LIS) under Part D will increase the income limits for the full LIS benefit from 135 percent of the federal poverty limit (FPL) to 150 percent of the FPL. Medicare beneficiaries earning between 135 percent and 150 percent of the FPL in CY 2024, who meet the resources requirements under either of sections 1860D-14(a)(3)(D) or (E) of the Act, and who would have been eligible for the partial low-income premium and cost-sharing subsidies and a reduced deductible under section 1860D-14(a)(2) of the Act had the IRA not been enacted, will be eligible for full low-income premium and cost-sharing subsidies, and a $0 deductible.
- For CY 2024, the deductible will continue not to apply to any Part D covered insulin product. Also, in the initial coverage phase and the coverage gap phase, cost sharing may not exceed the applicable copayment amount, which for CY 2024 is $35 for a month's supply of each covered insulin product.[40]
- For CY 2024, the deductible will continue not to apply 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.[41]
- Beginning in CY 2024, the base beneficiary premium (BBP) growth will be held to no more than 6 percent by statute. The BBP for Part D is the lesser of a 6 percent annual increase or the amount that would otherwise apply under the prior methodology if the IRA were not enacted.

Each of these provisions is discussed in more detail below.

C1. Elimination of beneficiary out-of-pocket costs in the catastrophic phase in CY 2024

Under section 1860D-2(b)(4)(A)(i) of the Act, as amended by section 11201(a) of the IRA, there is no cost sharing for covered Part D drugs above the annual out-of-pocket (OOP) threshold, as defined at section 1860D-2(b)(4)(B) of the Act, for any Part D beneficiaries, including LIS-eligible beneficiaries, beginning in CY 2024. Therefore, beginning in CY 2024, it is not necessary to update the parameters for maximum or minimum beneficiary cost sharing above the OOP threshold.

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[40] The elimination of the deductible for each Part D covered insulin product and implementation of cost-sharing capped at $35 for a month's supply of each Part D covered insulin product has been effective as of January 1, 2023.

[41] The elimination of the deductible and cost sharing for any adult vaccine recommended by ACIP has been effective as of January 1, 2023.

Also, under section 1860D-15(b)(1)(A) of the Act, as amended by section 11201(b) of the IRA, the reinsurance payment amount for CY 2024 for a Part D beneficiary remains 80 percent of the allowable reinsurance costs incurred after the beneficiary exceeds the annual OOP threshold. The annual OOP threshold is specified in Section D3 on annual adjustments for the Part D benefit parameters in CY 2024 below. As a result, Part D sponsors will be responsible for the additional coverage provided to Part D beneficiaries necessary to eliminate cost sharing in the catastrophic phase. In other words, Part D sponsors will be liable for 20 percent of costs incurred after a Part D beneficiary has incurred costs that exceed the annual OOP threshold for CY 2024, as compared to approximately 15 percent in prior coverage years.

C2. Expansion of full LIS and sunset of partial LIS as of January 1, 2024

Under section 1860D-14(a)(1) of the Act, as amended by section 11404 of the IRA, beginning in CY 2024, beneficiaries with incomes up to 150 percent of the FPL and who meet the resource standard in the statute at either of sections 1860D-14(a)(3)(D) or (E) of the Act will be eligible for the full LIS benefit. In other words, beneficiaries with incomes between 135 and 150 percent of the FPL, who meet the resource standard described at either of sections 1860D-14(a)(3)(D) or (E) of the Act, and who would have been eligible for the partial LIS benefit absent the enactment of the IRA will be eligible for the full LIS benefit. These category 4 beneficiaries will now have the same Part D benefit parameters as beneficiaries in category 1 of the LIS; category 2 and 3 of the LIS benefit remain unchanged. See Section D below for a discussion of these categories.

C3. Insulin copay cap

Under section 1860D-2(b)(9) of the Act, as added by section 11406 of the IRA, the deductible will not apply to any covered insulin product in CY 2024.[42] Also, in the initial coverage phase and the coverage gap phase, covered insulin products must be provided with cost sharing that does not exceed the applicable copayment amount, which is $35 for a one-month supply of each covered insulin product in CY 2024. For low-income subsidy-eligible beneficiaries in the coverage gap in 2024, the low-income cost-sharing subsidy will continue to cover the cost of a covered insulin product up to the nominal copayment amount for said product in accordance with section 1860D-14(a)(1)(C). There is no cost sharing for covered Part D drugs for any beneficiaries in the catastrophic coverage phase beginning in CY 2024, including for covered insulin products. Part D sponsors will be responsible for providing this coverage as a basic benefit, the cost of which should be reflected in plan bids beginning in CY 2024.

[42] Under section 1860D-2(b)(9) of the Act, as added by section 11406 of the IRA, a covered insulin product is defined as "an insulin product that is a covered Part D drug covered under the prescription drug plan or MA-PD plan that is approved under section 505 of the Federal Food, Drug, and Cosmetic Act or licensed under section 351 of the Public Health Service Act and marketed pursuant to such approval or licensure, including any covered insulin product that has been deemed to be licensed under section 351of the Public Health Service Act pursuant to section 7002(e)(4) of the Biologics Price Competition and Innovation Act of 2009 and marketed pursuant to such section."

In effect, for non-LIS beneficiaries, only the costs incurred by the beneficiary to pay for covered insulin products during the initial coverage phase and the coverage gap phase – including costs treated as incurred under section 1860D-2(b)(4)(C)(iii) and 1860D-2(b)(4)(E), such as manufacturer discounts provided as required under the Coverage Gap Discount Program – will count as true out-of-pocket (TrOOP) costs towards the OOP threshold that must be met to enter the catastrophic coverage phase. For LIS beneficiaries, both the costs incurred by the beneficiary to pay for covered insulin products during the initial coverage phase and the coverage gap phase and the low-income cost-sharing subsidy paid for covered insulin products will count as TrOOP towards the OOP threshold.

C4. ACIP-recommended Vaccine $0 cost sharing

Under section 1860D-2(b)(8) of the Act, as added by section 11401 of the IRA, for CY 2024, the deductible will not apply to any adult vaccine recommended by ACIP.[43] Also, the statute requires these vaccines be exempt from any co-insurance or other cost sharing for beneficiaries in the initial coverage, coverage gap, and catastrophic coverage phases. Note that, consistent with section 1860D-2(b) of the Act, as amended by the IRA, there is no cost sharing for covered Part D drugs for any Part D beneficiaries above the OOP threshold, i.e., the catastrophic coverage phase in CY 2024, including for ACIP-recommended vaccines. Part D sponsors will be responsible for providing this additional coverage as a basic benefit, the cost of which should be reflected in plan bids beginning in CY 2024. No cost will be incurred by LIS and non-LIS beneficiaries for ACIP-recommended adult vaccines and, therefore, no costs will count as TrOOP toward the OOP threshold for beneficiary progression into the catastrophic coverage phase.

Note that beneficiaries will not pay any portion of the dispensing fee or vaccine administration fee, if any, for CY 2024, for ACIP-recommended vaccines. Part D sponsors will be responsible for those fees during all phases of the benefit including the coverage gap, the cost of which should be reflected in plan bids beginning in CY 2024.

C5. Part D premium stabilization

Under section 1860D-13(a)(8) of the Act, as added by section 11102 of the IRA, an additional step is required as part of the determination of the BBP beginning in CY 2024. The BBP for CY 2024 will be the lesser of the BBP as it would have been calculated if the IRA had not been enacted or 106 percent of the CY 2023 BBP as released in the July 29, 2022 HPMS

[43] Section 1860D-2(b)(8)(B), as amended by section 11401 of the IRA, defines an adult vaccine recommended by ACIP as "a covered part D drug that is a vaccine licensed under section 351 of the Public Health Service Act for use by adult populations and administered in accordance with recommendations of the ACIP of the Centers for Disease Control and Prevention."

memorandum, titled "Annual Release of Part D National Average Bid Amount and Other Part C & D Bid Information," which was $32.74.[44] Therefore, if the BBP as calculated prior to the application of section 1860D-13(a)(8) for CY 2024 is less than or equal to 106 percent of the BBP for CY 2023, that amount will be used as the BBP for CY 2024. If it is higher than 106 percent of the BBP for CY 2023, then the CY 2024 BBP will be equal to 106 percent of the CY 2023 BBP. The HPMS Memorandum titled "Annual Release of Part D National Average Bid Amount and Other Part C & D Bid Information" will provide more information on the BBP calculation for CY 2024. We expect to release the memorandum during the usual timeframe after CY 2024 bids have been submitted.

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

D1. Updating the Medicare Part D Benefit Parameters

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) directs CMS to update the statutory parameters for the defined standard Part D drug benefit each year. These annual adjustments ensure that the actuarial value of the drug benefit remains consistent with changes in Part D drug expenses. These statutory parameters include the defined standard benefit deductible, initial coverage limit, and OOP threshold. In addition, CMS is required by statute to update the parameters for the LIS benefit. As described in Section C2 above, beneficiaries with incomes between 135 and 150 percent of the FPL, who meet the resource standard described at either of sections 1860D-14(a)(3)(D) or (E) of the Act, and who would have been eligible for the partial LIS benefit absent the enactment of the IRA, will be eligible for the full LIS beginning in CY 2024. For CY 2024, these category 4 beneficiaries will now have the same Part D benefit parameters as beneficiaries in category 1 of the LIS. Category 2 and 3 of the LIS remain unchanged. See the discussion of these categories in this section below. This Section D of Attachment III provides the methodologies used to update these statutory parameters for CY 2024. The relevant Part D benefit parameters are updated using one of two indexing methods, as specified by statute:

(1) the annual percentage increase in average expenditures for Part D drugs per eligible beneficiary (API); or
(2) the annual percentage increase in the Consumer Price Index (CPI) (all items, U.S. city average).

Under section 1860D-2(b) of the Act, as amended by section 11201(a) of the IRA, there is no cost sharing for covered Part D drugs above the OOP threshold for any beneficiaries, including those eligible for the LIS benefit, beginning in CY 2024. Therefore, it is not necessary to update

[44] https://www.cms.gov/files/document/july-29-2022-parts-c-d-announcement.pdf.

the parameters for maximum or minimum beneficiary cost sharing above the OOP threshold for CY 2024.

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

Section 1860D-2(b)(6) of the Act defines the API as "the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States for Part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the Secretary shall specify." The following defined standard Part D prescription drug benefit parameters are updated using the API: deductible; initial coverage limit; and OOP threshold. The following LIS cost-sharing parameter is also updated using the API: maximum copayments below the OOP threshold for certain low-income full subsidy eligible beneficiaries.

The CY 2023 annual percentage trend in the API can be found in Table III-1 below. The percent increase in the benefit parameters indexed to the API for CY 2024 is 8.01 percent. This increase reflects the CY 2023 annual percentage trend of 6.42 percent in the API as well as a multiplicative update of 1.50 percent for prior year revisions. See Section D2 for additional information on the calculation of the API.

Annual Percentage Increase in Consumer Price Index, September (CPI)

Section 1860D-14(a)(4) of the Act requires CMS to use the annual percentage increase in the CPI for the 12-month period ending in September 2023 to update the maximum copayments up to the OOP threshold for full-benefit dually eligible beneficiaries with incomes not exceeding 100 percent of the FPL for CY 2024. CMS uses an estimate of the September 2023 CPI based on projections from the President's FY2024 Budget for this purpose.

The CY 2023 annual percentage trend in the CPI can be found in Table III-1 below. The percent increase in the maximum copayments indexed to the CPI for CY 2024 is 7.83 percent. The CY 2024 increase reflects the CY 2023 annual percentage trend in the CPI of 3.81 percent as well as a multiplicative update of 3.87 percent for prior year revisions.

See Section D2 for additional information on the calculation of the annual percentage increase in the CPI.

Table III-1. Updated API and CPI for CY 2024

	Annual percentage trend for 2023	Prior year revisions	API for 2024
API	6.42%	1.50%	8.01%
September CPI (all items, U.S. city average)	3.81%	3.87%	7.83%

For ease of reference, we provide Table III-2 below which summarizes the Part D benefit parameters along with the cost threshold and cost limit of the Retiree Drug Subsidy program (discussed in more detail in Section H) that are required by statute to be updated with either the API or CPI each year. Table III-2 also includes estimates of the total gross covered prescription drug costs at the OOP threshold for both applicable and non-applicable beneficiaries (discussed further in subsection "Determining Total Gross Covered Drugs Costs at Out-of-Pocket Threshold" of Section D3). Table III-2 reflects the elimination of cost sharing above the OOP threshold for CY 2024 for all Part D beneficiaries regardless of their LIS status, consistent with the amendments to the Act made by section 11201(a) of the IRA. Table III-2 also reflects the CY 2023 values for the Part D benefit parameters that are required by statute to be updated each year. The CY 2024 values will be updated using either the CY 2024 API or CPI of 8.01 percent or 7.83 percent respectively. For completeness, we also provide in Table III-2 the Part D benefit parameters that remain constant from year-to-year.

Table III-2. Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy, and Retiree Drug Subsidy

	2023	2024[45]
Standard Benefit		
Deductible	$505	$545
Initial Coverage Limit	$4,660	$5,030
Out-of-Pocket Threshold	$7,400	$8,000
Total Covered Part D Spending at Out-of-Pocket Threshold for Non-Applicable Beneficiaries (1)	$10,516.25	$12,159.21
Estimated Total Covered Part D Spending for Applicable Beneficiaries (2)	$11,206.28	$13,172.18
Minimum Cost Sharing in Catastrophic Coverage Portion of the Benefit		
Generic/Preferred Multi-Source Drug	$4.15	Not Applicable
Other	$10.35	Not Applicable
Full Subsidy-Full Benefit Dual Eligible (FBDE) Beneficiaries (3)		
Deductible	$0.00	$0.00
Copayments for Institutionalized Beneficiaries [category code 3]	$0.00	$0.00
Copayments for Beneficiaries Receiving Home and Community-Based Services] [category code 3] (4)	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL [category code 2]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$1.45	$1.55

[45] These parameters reflect additional plan coverage required for covered insulin products under section 1860D-2(b)(9) of the Act, as added by section 11406 of the IRA, and ACIP-recommended vaccines under section 1860D-2(b)(8) of the Act, as added by section 11401 of the IRA. See Section C for additional information.

	2023	2024[45]
Other	$4.30	$4.60
Above Out-of-Pocket Threshold	$0.00	Not Applicable
Between 100% and 150% of FPL [category code 1]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$4.15	$4.50
Other	$10.35	$11.20
Above Out-of-Pocket Threshold	$0.00	Not Applicable
Full Subsidy-Non-FBDE Beneficiaries (3)		
Applied or eligible for QMB/SLMB/QI or SSI, income at or below 135% FPL in 2023 or at or below 150 % FPL for 2024 and beyond and resources ≤ $9,090 (individuals, 2023) or ≤ $13,630 (couples, 2023) [category code 1] (5)		
Deductible	$0.00	$0.00
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$4.15	$4.50
Other	$10.35	$11.20
Maximum Copayments above Out-of-Pocket Threshold	$0.00	Not Applicable
Partial Subsidy (3) (Partial Subsidy Category Sunsets Effective 1/1/24)		
Applied and income below 150% FPL and resources below $15,160 (individual, 2023) or $30,240 (couples, 2023) [category code 4] 5		
Deductible	$104	Not Applicable
Coinsurance up to Out-of-Pocket Threshold	15%	Not Applicable
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$4.15	Not Applicable
Other	$10.35	Not Applicable
Retiree Drug Subsidy Amounts		
Cost Threshold	$505	$545
Cost Limit	$10,350	$11,200

(1) For a beneficiary who is not considered an "applicable beneficiary," as defined at section 1860D-14A(g)(1) of the Act, and is not eligible for the Medicare Coverage Gap Discount Program, this is the amount of total drug spending required to reach the OOP threshold in the defined standard benefit. There is a 7 percent adjustment for the estimated total covered Part D spending at catastrophic for non-applicable beneficiaries, because beneficiaries take a longer time to reach the catastrophic phase threshold when they pay less cost sharing for insulins and vaccines (no more than $35 copay per month's supply of insulin and $0 copay on ACIP-recommended adult vaccines) under the 2024 defined standard benefit.

(2) For a beneficiary who is an "applicable beneficiary," as defined at section 1860D-14A(g)(1) of the Act, and is eligible for the Medicare Coverage Gap Discount Program, this is the estimated average amount of total drug spending required to reach the OOP threshold in the defined standard benefit. There is a 9 percent adjustment for the estimated total covered Part D spending at catastrophic for applicable beneficiaries, because beneficiaries take a longer time to

reach the catastrophic phase threshold when they pay less cost sharing for insulins and vaccines (no more than $35 copay per month's supply of insulin and $0 copay on ACIP-recommended adult vaccines) under the 2024 defined standard benefit.

(3) The LIS eligibility categories and corresponding cost-sharing benefits are sometimes referred to using category codes as follows:

- Category Code 1 – Non-institutionalized FBDE beneficiaries with incomes between 100% and 150% of FPL (beginning in CY 2024) and full-subsidy-non-FBDE beneficiaries. Note that LIS beneficiaries that would previously fall into category code 4 fall into category code 1 beginning in CY 2024 – see note for category code 4 below.
- Category Code 2 – Non-institutionalized FBDE beneficiaries with incomes up to 100% of the FPL.
- Category Code 3 – FBDE beneficiaries who are institutionalized or would be institutionalized if they were not receiving home and community-based services.
- Category Code 4 – Partial subsidy beneficiaries through CY 2023. As described in Section C2 above, beneficiaries with incomes between 135 percent and 150 percent of the FPL, who meet the resource standards under either of sections 1860D-14(a)(3)(D) or (E) of the Act, and who would have been eligible for the partial LIS benefit absent the enactment of the IRA, will be eligible for the full LIS benefit. These category 4 beneficiaries will now have the same Part D benefit parameters as beneficiaries in category 1 of the LIS. Category 2 and 3 of the LIS remain unchanged.

(4) Per section 1860D-14(a)(1)(D)(i) of the Act, full-benefit dually eligible beneficiaries who are receiving home and community-based services qualify for zero cost sharing if the individuals (or couple) would have been institutionalized otherwise.

(5) The resource limits for CY 2024 will be provided via the annual HPMS memo entitled "2024 Resource and Cost-Sharing Limits for Low-Income Subsidy (LIS)" that is expected to be released during the usual timeframe after the September 2023 CPI has been made available by the Bureau of Labor Statistics. Additionally, these amounts include $1,500 per person for burial expenses. Also, beneficiaries that would have been eligible for the partial LIS benefit had the IRA not been enacted will be eligible for the full LIS benefit if they meet either of the resource standard described at sections 1860D-14(a)(3)(D) or (E) of the Act.

D2. Calculation methodologies for the Annual Percentage Increase (API) and Consumer Price Index (CPI)

Annual Percentage Increase in Average Expenditures for Part D Drugs per Eligible Beneficiary (API) Calculation Methodology

For contract years 2006 and 2007, the APIs, as defined in section 1860D-2(b)(6) of the Act, were based on the National Health Expenditure (NHE) prescription drug per capita estimates because sufficient Part D program data was not available. Beginning with contract year 2008, the APIs

are based on Part D program data. For the CY 2024 benefit parameters, Part D program data will be used to calculate the annual percentage trend as follows:

$$\frac{August\ 2022–July\ 2023}{August\ 2021–July\ 2022} = \$4{,}916.80/\$4{,}620.25=1.064$$

In the formula, the average per capita cost for August 2021 – July 2022 is calculated from actual Part D PDE data, and the average per capita cost for August 2022 – July 2023 is calculated based on actual Part D PDE data for prescription drug claims with service dates from August 2022 – December 2022 and projected through July 2023.

The annual percentage trend in table III-3 is based on updated NHE prescription drug per capita costs and PDE data. The years in this table refer to the trend observed in the period of the August of the prior year to July of that year relative to the same interval in preceding years. For example, year 2021 represents the trend observed in August 2020 to July 2021 relative to August 2019 to July 2020.

Table III-3. Revised Prior Years' Annual Percentage Trends

Year	Prior Estimates of Annual Percentage Trend	Revised Annual Percentage Trend
2006	7.30%	7.30%
2007	5.92%	5.92%
2008	4.69%	4.69%
2009	3.14%	3.14%
2010	2.36%	2.36%
2011	2.15%	2.15%
2012	2.53%	2.53%
2013	-3.14%	-3.14%
2014	10.12%	10.12%
2015	9.89%	9.89%
2016	4.02%	4.02%
2017	1.87%	1.87%
2018	4.05%	4.05%
2019	4.92%	4.92%
2020	5.06%	5.06%
2021	4.69%	4.69%
2022	5.80%	7.37%

Accordingly, the CY 2024 benefit parameters will reflect the CY 2023 annual percentage trend and a multiplicative update for prior year revisions. The CY 2023 annual percentage trend can be found in Table III-4. The CY 2023 API are updated by 1.50 percent.

Table III-4. Annual Percentage Increase

Annual percentage trend for July 2023	6.42%
Prior year revisions	1.50 %
Annual percentage increase for 2024	8.01%

Note: Percentages are multiplicative, not additive. Values are carried to additional decimal places and may not agree to the rounded values presented above.

Annual Percentage Increase in Consumer Price Index, September (September CPI) Calculation Methodology

To ensure that plan sponsors and CMS have sufficient time to incorporate cost-sharing requirements into the development of the benefit, any marketing materials, and necessary systems, CMS includes in its methodology to calculate the annual percentage increase in the CPI for the 12-month period ending in September 2023, an estimate of the September 2023 CPI based on projections from the President's FY2024 Budget.

The September 2023 value is from the Bureau of Labor Statistics. The annual percentage trend in the September CPI for CY 2024 is calculated as follows:

$$\frac{\text{Projected September 2023 CPI}}{\text{Actual September 2022 CPI}} \text{ or } \$308.1/\$296.8=1.038$$

(Source: President's FY2024 Budget and Bureau of Labor Statistics, Department of Labor)

The CY 2024 benefit parameters reflect the CY 2023 annual percentage trend in the September CPI of 3.81 percent, as well as a 3.87 percent multiplicative correction for the revision to last year's estimate. The CY 2023 annual percentage trend in the CPI can be found in Table III-5 below.

Table III-5. Cumulative Annual Percentage Increase in September CPI

Annual percentage trend for September 2023	3.81%
Prior year revisions	3.87%
Annual percentage increase for 2024	7.83%

Note: Percentages are multiplicative, not additive. Values are carried to additional decimal places and may not agree to the rounded values presented above.

D3. Annual Adjustments for Part D Benefit Parameters in CY 2024

Defined Standard Part D Prescription Drug Benefit Parameters

In accordance with section 1860D-2(b) of the Act, CMS updates the statutory parameters for the defined standard Part D prescription drug benefit each year. As mentioned previously, these annual adjustments ensure that the actuarial value of the drug benefit remains consistent with changes in Part D drug expenses.

As described in section 1860D-2(b) of the Act and § 423.104(d), for CY 2024, the defined standard Part D prescription drug benefit is composed of four sequential coverage phases: deductible, initial coverage, coverage gap, and catastrophic coverage phases. Progression through the first two coverage phases is based on total gross covered prescription drug costs, as defined in § 423.308, which refers to spending on covered Part D drugs by beneficiaries or on their behalf by any third party as well as the Part D sponsor. Therefore, once total gross covered prescription drug costs for a beneficiary reach the deductible amount under the defined standard benefit, the beneficiary transitions into the initial coverage phase. Similarly, when total gross covered prescription drug costs for a beneficiary reach the initial coverage limit, the beneficiary transitions into the coverage gap.

By contrast, progression through the coverage gap is determined by accumulated TrOOP spending. TrOOP is spending on covered Part D drugs by the beneficiary or on his/her behalf by certain third parties (*see* sections 1860D-2(b)(4)(C)(iii) and (E) of the Act and the definition of incurred costs in § 423.100). Once accumulated TrOOP for a beneficiary reaches the OOP threshold, the beneficiary enters the catastrophic coverage phase.

Cost sharing for beneficiaries varies by coverage phase, by LIS status, whether the drug is applicable or non-applicable, and whether the drug is a covered insulin product or ACIP-recommended adult vaccine.[46] See Table III-6 below for non-LIS beneficiary cost sharing, the next section for discussion of cost-sharing requirements for LIS beneficiaries, and Section E for additional information on cost sharing in the coverage gap for applicable and non-applicable drugs.

We note that the term applicable beneficiary, as defined in 1860D-14A(g)(1) and § 423.100, refers to a non-LIS beneficiary enrolled in a stand-alone prescription drug plan or Medicare Advantage prescription drug plan and who is not enrolled in a retiree prescription drug plan. Therefore, an LIS beneficiary is a non-applicable beneficiary. We use the phrases “non-LIS beneficiary” and “applicable beneficiary” interchangeably throughout the rest of Attachment III.

[46] An applicable drug is defined in section 1860D-14A(g)(2) of the Act and § 423.100 as a covered Part D drug that is either approved under a new drug application (NDA) under section 505(c) of the Federal Food, Drug, and Cosmetic Act or licensed under section 351 of the Public Health Service Act (PHSA), including biosimilar or interchangeable biosimilar biological products licensed under section 351(k) of the PHSA. Non-applicable drugs are covered Part D drugs that do not meet the definition of an applicable drug, such as generic drugs. See Section C for definitions of covered insulin products and ACIP-recommended adult vaccines.

For CY 2024, the defined standard benefit deductible amount, initial coverage limit, and OOP threshold are updated by multiplying the CY 2023 amounts by the CY 2024 API and rounding as specified by the statute:

Deductible: From $505 in CY 2023 and rounded to the nearest multiple of $5.

Initial Coverage Limit: From $4,660 in CY 2023 and rounded to the nearest multiple of $10.

Out-of-Pocket Threshold: From $7,400 in CY 2023 and rounded to the nearest multiple of $50.

Table III-6 below summarizes the defined standard benefit parameters and provides the CY 2023 parameter values. The updated parameter values for CY 2024 are obtained by applying the 2024 API and rounding to a specified amount and are summarized in Table III-6. Table III-6 also reflects the elimination of cost sharing above the OOP threshold for CY 2024 for all Part D beneficiaries regardless of their LIS status, consistent with the amendments to the Act made by section 11201(a) of the IRA.

Table III-6. Part D Benefit Parameters for Defined Standard Benefit for CY 2023 and CY 2024 for Non-LIS Beneficiaries

	2023		2024[47]	
Deductible Phase	Cost sharing: 100%		Cost sharing: 100%	
	Deductible: $505		Deductible: $545	
Initial Coverage Phase	Cost sharing: 25%		Cost sharing: 25%	
	Initial Coverage Limit: $4,660		Initial Coverage Limit: $5,030	
Coverage Gap	Applicable Drugs: Cost sharing: 25% (1)	Non-applicable Drugs Cost sharing: 25%	Applicable Drugs Cost sharing: 25% (1)	Non-applicable Drugs Cost sharing: 25%
	Out-of-Pocket Threshold: $7,400		Out-of-Pocket Threshold: $8,000	
Catastrophic Coverage	Cost sharing: Greater of 5% or $4.15 (Generic/Preferred Multi-Source Drug) / $10.35 (Other)		Cost Sharing: 0%	

[47] These parameters reflect additional plan coverage required for covered insulin products under section 1860D-2(b)(9) of the Act, as added by section 11406 of the IRA, and ACIP-recommended vaccines under section 1860D-2(b)(8) of the Act, as added by section 11401 of the IRA. See Section C for additional information.

(1) The 25% coinsurance for applicable drugs for non-LIS beneficiaries during the coverage gap reflects the application of the 70% Medicare Coverage Gap Discount Program discount.

Annual Adjustments for Low-income Subsidy (LIS) Beneficiary Cost-sharing Parameters

The LIS benefit provides Part D cost-sharing assistance to certain low-income Medicare Part D beneficiaries across the same coverage phases described above. Medicare Part D beneficiaries who are eligible for full Medicaid benefits, recipients of Supplemental Security Income (SSI) benefits (*see* § 423.773(c)(1)(ii)), or eligible for a Medicare Savings Programs as a Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), or Qualifying Individual under a State's Medicaid plan (*see* § 423.773(c)(1)(iii)) are deemed automatically eligible for the full subsidy and do not have to separately apply for the LIS benefit. Other Medicare Part D beneficiaries must apply for the LIS benefit and may receive the full subsidy if they meet certain income and asset requirements, as described in section 1860D-14(a)(3)(E) of the Act.

The cost-sharing benefits for LIS beneficiaries are described in section 1860D-14(a)(1) of the Act. Full subsidy FBDE individuals who are institutionalized or receiving certain home and community-based services, as defined in § 423.772, have a $0 deductible and $0 copayments for all covered Part D drugs, regardless of the defined standard benefit phase. Other full subsidy (both FBDE and non-FBDE) beneficiaries also have a $0 deductible but pay nominal copayments for all covered Part D drugs below the OOP threshold as described in sections 1860D-14(a)(1)(D)(ii) and (iii).

As described in Section C2 above, beneficiaries with incomes between 135 and 150 percent of the FPL, who meet the statutory resource standards at either of sections 1860D-14(a)(3)(D) or (E) and who would have been eligible for the partial LIS benefit absent the enactment of the IRA, will be eligible for the full LIS benefit. Additionally, as described in Section C1 above, there is no cost sharing for covered Part D drugs above the OOP threshold for any Part D beneficiaries, including LIS-eligible beneficiaries.

The following LIS cost-sharing parameters are updated each year by multiplying the prior year's value by the API and rounding as specified by the statute:

Maximum Copayments up to the Out-of-Pocket Threshold for Certain Low-Income Full Subsidy Eligible Beneficiaries: From $4.15 per generic, preferred drug that is a multi-source drug, or biosimilar and $10.35 for all other drugs in CY 2023, rounded to the nearest multiple of $0.05.

Maximum Copayment Amounts up to the Out-of-Pocket Threshold for Full Benefit Dual Eligible Beneficiaries with Incomes Not Exceeding 100 Percent of the Federal Poverty Level: These copayments are increased from $4.15 per generic, preferred drug that is a multi-source drug, or biosimilar, and from $10.35 for all other drugs in CY 2023 and rounded to the nearest multiple of $0.05 and $0.10 respectively.[48]

Please see Table III-7 below for complete information on the different LIS benefit categories and cost-sharing parameters for CY 2023, as well as the LIS cost-sharing parameters updated for CY 2024 by either using the 2024 API or CPI. Table III-7 also reflects the elimination of cost sharing above the OOP threshold during CY 2024 for all Part D beneficiaries regardless of their LIS status, consistent with the amendments to the Act made by section 11201(a) of the IRA.

Table III-7. Updated Part D Low-income Cost-Sharing Parameters for CY 2024

	2023	2024[49]
Full Subsidy-Full Benefit Dual Eligible (FBDE) Beneficiaries (1)		
Deductible	$0.00	$0.00
Copayments for Institutionalized Beneficiaries [category code 3]	$0.00	$0.00
Copayments for Beneficiaries Receiving Home and Community-Based Services] [category code 3] (2)	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL [category code 2]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug (3)	$1.45	$1.55
Other (3)	$4.30	$4.60
Above Out-of-Pocket Threshold	$0.00	$0.00
Between 100% and 150% of FPL		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$4.15	$4.50
Other	$10.35	$11.20
Above Out-of-Pocket Threshold	$0.00	Not Applicable

[48] Per section 1860D-14(a)(4)(A) of the Act, the copayments are increased from the unrounded 2023 values of $4.1508 for multi-source generic or preferred drugs, and $10.3507 for all other drugs.

[49] These parameters reflect additional plan coverage required for covered insulin products under section 1860D-2(b)(9) of the Act, as added by section 11406 of the IRA, and ACIP-recommended vaccines under section 1860D-2(b)(8) of the Act, as added by section 11401 of the IRA. See Section C for additional information.

	2023	2024[49]
Full Subsidy-Non-FBDE Beneficiaries (1)		
Applied or eligible for QMB/SLMB/QI or SSI, income at or below 135% FPL in 2023 or at or below 150% FPL for 2024 and beyond and resources $9,090 (individuals,2023) or ≤ $13,630 (couple, 2023) [category code 1] (4)		
Deductible	$0.00	
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$4.15	$4.50
Other	$10.35	$11.20
Maximum Copayments above Out-of-Pocket Threshold	$0.00	Not Applicable
Partial Subsidy (1) (Partial Subsidy Category Sunset Beginning 1/1/2024)		
Applied and income below 150% FPL and resources below $15,160 (individual, 2023) or $30,240 (couples, 2023) [category code 4] (4)		
Deductible	$104	Not Applicable
Coinsurance up to Out-of-Pocket Threshold	15%	Not Applicable
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$4.15	Not Applicable
Other	$10.35	Not Applicable

(1) The LIS eligibility categories and corresponding cost-sharing benefits are sometimes referred to using category codes as follows:

- Category Code 1 – Non-institutionalized FBDE beneficiaries who meet the statutory resource requirements with incomes between 100% and 150% of FPL (beginning in CY 2024) and full-subsidy-non-FBDE beneficiaries. Note that LIS beneficiaries that would previously fall into category code 4 fall into category code 1 beginning in CY 2024 – see note for category code 4 below.
- Category Code 2 – Non-institutionalized FBDE beneficiaries with incomes up to 100% of the FPL and who meet the statutory resource requirements.
- Category Code 3 – FBDE beneficiaries who are institutionalized or would be institutionalized if they were not receiving home and community-based services.
- Category Code 4 – As described in Section C2 above, beneficiaries with incomes between 135 and 150 percent of the FPL who meet the resource standards under either of sections 1860D-14(a)(3)(D) or (E) of the Act, and who would have been eligible for the partial LIS benefit absent the enactment of the IRA, will be eligible for the full LIS premium and a $0 deductible. These category 4 beneficiaries will now have the same Part D benefit parameters as beneficiaries in category 1 of the LIS; category 2 and 3 of the LIS remain unchanged.

(1) Per section 1860D-14(a)(1)(D)(i) of the Act, full-benefit dually eligible beneficiaries who are receiving home and community-based services qualify for zero cost sharing if the individual (or couple) would have been institutionalized.
(2) Increases to the maximum copayments for non-institutionalized FBDE beneficiaries with incomes not greater than 100% of the FPL are applied to the unrounded CY 2023 values of $1.44 for generic/preferred multi-source drugs and $4.31 for all other drugs.
(3) The resource limits for CY 2024 will be provided via the annual HPMS memo entitled "2024 Resource and Cost-Sharing Limits for Low-Income Subsidy (LIS)" that is expected to be released during the usual timeframe after September 2023 CPI has been made available by the Bureau of Labor Statistics. Additionally, these amounts include $1,500 per person for burial expenses. In addition, beneficiaries that would have been eligible for the partial LIS benefit had the IRA not been enacted will be eligible for the full LIS benefit if they meet the resource standard described at either of sections 1860D-14(a)(3)(D) or (E) of the Act.

Determining Total Gross Covered Drugs Costs at Out-of-Pocket Threshold

As noted above, while the deductible and ICL thresholds are determined based on total gross covered prescription drug costs, as defined at 42 CFR § 423.308, the OOP threshold is determined based on TrOOP. Each year, for informational purposes, CMS calculates an estimate of the total gross covered prescription drug costs (also referred to as total covered Part D spending elsewhere) at the OOP threshold. This amount reflects the estimated total drug spending, regardless of payer, that is projected to occur when a beneficiary reaches the OOP threshold under the defined standard benefit.

Total gross covered prescription drug costs at the OOP threshold differs for LIS and non-LIS beneficiaries due to differences in beneficiary cost sharing for drugs in the coverage gap phase for the two types of beneficiaries (*see* section 1860D-2(b)(2)(C) and (D) of the Act and § 423.104(d)(4)). For LIS beneficiaries, the calculation of total gross covered prescription drug costs reflects 100 percent cost sharing in the coverage gap for all covered Part D drugs.[50] For non-LIS beneficiaries, the calculation of total gross covered prescription drug costs reflects 25 percent cost sharing, after the application of the 70 percent discount from the Medicare Coverage Gap Discount Program on ingredient costs, for applicable drugs, and reflects 25 percent cost sharing for non-applicable drugs. [51] This difference in cost sharing between LIS beneficiaries and non-LIS beneficiaries in the coverage gap generally leads to TrOOP accumulating more quickly

[50] Note that, for low-income subsidy-eligible beneficiaries in the coverage gap in 2024, the low-income cost-sharing subsidy will continue to cover the cost of a covered insulin product up to the nominal copayment amount for said product in accordance with section 1860D-14(a)(1)(C).

[51] For covered insulin products for non-LIS beneficiaries, the copayment amount up to the applicable copayment amount of $35 will apply toward the total gross prescription drug costs rather than 25 percent cost sharing (after the application of the 70 percent discount from the Medicare Coverage Gap Discount Program on ingredient costs for applicable drugs). In addition, ACIP-recommended vaccines will be exempt from any coinsurance or other cost sharing for all beneficiaries in the coverage gap phase, including cost sharing for vaccine administration and dispensing fees, if any. These changes may affect the calculation of total gross covered prescription drug costs for non-LIS beneficiaries in CY 2024. See Section C for additional information.

for LIS beneficiaries compared to non-LIS beneficiaries. Therefore, non-LIS beneficiaries can be generally expected to have higher total gross covered drug costs at the OOP threshold than LIS beneficiaries.

D4. Insulin copay cap

Under section 1860D-2(b)(9) of the Act, as added by section 11406 of the IRA, the deductible will not apply to any covered insulin product in CY 2024. Also, in the initial coverage phase and the coverage gap phase, covered insulin products must be provided with cost sharing that does not exceed the applicable copayment amount, which is $35 for a one-month supply of each covered insulin product in CY 2024. As noted in section D1 on updated Medicare Part D benefit parameters above, there is no cost sharing for covered Part D drugs for any beneficiaries in the catastrophic coverage phase beginning in CY 2024, including for covered insulin products. Part D sponsors will be responsible for providing this additional coverage as a basic benefit, the cost of which should be reflected in plan bids beginning in CY 2024.

In effect, for non-LIS beneficiaries, only the costs incurred by the beneficiary to pay for covered insulin products during the initial coverage phase and the coverage gap – including costs treated as incurred under section 1860D-2(b)(4)(C)(iii) and 1860D-2(b)(4)(E), such as manufacturer discounts provided as required under the Coverage Gap Discount Program – will count as true TrOOP costs towards the OOP threshold that must be met to enter the catastrophic coverage phase. For LIS beneficiaries, both the costs incurred by the beneficiary to pay for covered insulin products during the initial coverage phase and the coverage gap phase and the low-income cost-sharing subsidy paid for covered insulin products will count as TrOOP towards the OOP threshold. Note that, for low-income subsidy-eligible beneficiaries in the coverage gap in 2024, the low-income cost-sharing subsidy will continue to cover the cost of a covered insulin product up to the nominal copayment amount for said product in accordance with section 1860D-14(a)(1)(C).

D5. ACIP-recommended Vaccine $0 cost sharing

Under section 1860D-2(b)(8) of the Act, as added by section 11401 of the IRA, for CY 2024, the deductible will not apply to any adult vaccine recommended by ACIP. Also, these vaccines will be exempt from any co-insurance or other cost sharing for beneficiaries in the initial coverage, coverage gap, and catastrophic coverage phases, including for any dispensing fee or vaccine administration fee. Note that, consistent with section 1860D-2(b) of the Act, as amended by the IRA, there is no cost sharing for covered Part D drugs for any Part D beneficiaries above the out of pocket threshold, i.e., the catastrophic coverage phase in CY 2024, including for ACIP-recommended vaccines. Part D sponsors will be responsible for providing this additional coverage as a basic benefit, the cost of which should be reflected in plan bids beginning in CY 2024.

In addition, we note that the total gross covered prescription drug cost estimate at the OOP threshold will vary across both LIS and non-LIS beneficiaries because of other types of additional drug coverage that beneficiaries may have through third party arrangements. The following third-party arrangements contribute to both TrOOP and the total gross covered prescription drug cost estimate (*see* sections 1860D-2(b)(4)(C)(iii) and (E) of the Act and the definition of incurred costs in § 423.100): LIS cost-sharing support, State Pharmacy Assistance Programs, Indian Health Service and certain other Native American organizations, AIDS Drug Assistance Program, or by a manufacturer as payment under the Medicare Coverage Gap Discount Program. Any spending on covered Part D drugs under any other third-party arrangement does not count toward TrOOP but is captured in the total gross covered prescription drug cost estimate. Therefore, if the beneficiary has additional prescription drug coverage through third party arrangements that do not count toward TrOOP, the total gross covered prescription drug cost estimate at the OOP threshold would generally be higher.

CMS is providing the two CY 2023 values of total gross covered prescription drug costs at the OOP threshold for applicable and non-applicable beneficiaries that take into account additional drug coverage in Table III-8 below. The updated CY 2024 total gross covered prescription drug cost estimates at the OOP threshold for applicable and non-applicable beneficiaries are summarized in Table III-8.

Table III-8. Updated Total Gross Covered Drug Costs at the Out-of-Pocket Threshold for Applicable and Non-Applicable Beneficiaries in CY 2024

	2023	2024
Total Gross Covered Drug Costs at Out-of-Pocket Threshold for Non-Applicable Beneficiaries (1)	$10,516.25	$12,159.21
Estimated Total Gross Covered Drug Costs for Applicable Beneficiaries (2)	$11,206.28	$13,172.18

(1) For a beneficiary who is not considered an "applicable beneficiary," as defined at section 1860D-14A(g)(1) of the Act, and is not eligible for the Medicare Coverage Gap Discount Program, this is the amount of total drug spending required to reach the OOP threshold in the defined standard benefit.

(2) For a beneficiary who is an "applicable beneficiary," as defined at section 1860D-14A(g)(1) of the Act, and is eligible for the Medicare Coverage Gap Discount Program, this is the estimated average amount of total drug spending required to reach the OOP threshold in the defined standard benefit.

Calculation Methodology for Estimated Total Gross Covered Drug Costs at Out-of-Pocket Threshold for Applicable Beneficiaries

For CY 2024, the estimated total gross covered prescription drug costs at the OOP threshold for applicable beneficiaries will be calculated given the following basic assumptions:

- 100 percent beneficiary cost sharing in the deductible phase.
- 25 percent beneficiary cost sharing in the initial coverage phase.
- 25 percent beneficiary cost sharing for non-applicable drugs purchased in the coverage gap phase of the benefit.
- 95 percent cost sharing for the ingredient cost and sales tax for applicable drugs purchased in the coverage gap phase of the benefit—consisting of 25 percent beneficiary coinsurance and 70 percent Medicare Coverage Gap Discount Program discount.
- 25 percent cost sharing for the dispensing of applicable drugs and vaccine administration fees not associated with ACIP-recommended vaccines purchased in the coverage gap phase of the benefit.

In this estimate, it is assumed that the dispensing and vaccine administration fees account for 0.042 percent of the gross covered brand drug costs for non-LIS beneficiaries in the coverage gap. Therefore, a 75 percent reduction in cost sharing for dispensing and vaccine administration fees results in an overall reduction of 0.030 percent to 94.970 percent in cost sharing for applicable (brand) drugs in the coverage gap.

The CY 2024 calculation of the estimated total gross covered prescription drug costs at OOP threshold for applicable beneficiaries is as follows:

$$\left(\text{ICL}+\frac{\text{100\% beneficiary cost sharing in the gap}}{\text{weighted gap coinsurance factor}}\right) * \textit{Insulin and Vaccine Adjustment or}$$

$$\left(\$5{,}030 + \frac{\$6{,}333.75}{89.782\%}\right) * 1.09 = \$13{,}172.18$$

- *ICL* is the Initial Coverage Limit equal to $5,030.
- Insulin and Vaccine Adjustment=1.09.
- *100 percent beneficiary cost sharing in the gap* is the estimated total drug spending in the gap assuming 100 percent coinsurance and is equivalent to:

  *(*OOP threshold) – (OOP costs up to the ICL) *or* $8,000 − $1,666.25 = $6,333.75

  Weighted gap coinsurance factor is calculated as follows:

  (Brand Gross Drug Cost Below Catastrophic [GDCB] % for non-LIS × gap cost sharing for applicable drugs) + (Generic GDCB % for non-LIS × 25% gap cost sharing for non-applicable drugs)

or

(92.59% × 94.970%) + (7.41% × 25.00%) = 89.782%

- *Brand GDCB % for non-LIS* is the percentage of gross covered drug costs below the OOP threshold for applicable beneficiaries (i.e., non-LIS) attributable to applicable drugs, as reported on the 2022 PDEs.
- *Gap cost sharing for applicable drugs* is the coinsurance incurred by applicable beneficiaries (i.e., non-LIS) for applicable drugs in the coverage gap, where:
  - *Coinsurance for applicable drugs* = is calculated as follows:
    - [(percentage of gross covered brand drug costs attributable to ingredient cost and sales tax) × (cost-sharing percentage)] + [(percentage of gross covered brand drug costs attributable to dispensing and vaccine administration fees not associated with ACIP-recommended vaccines) × (cost-sharing coinsurance percentage)]

      or

      94.970% = [(99.958% × 95%) + (0.042% × 25%)]
- *Generic GDCB % for non-LIS* is the percentage of gross covered drug costs below the OOP threshold for applicable beneficiaries (i.e., non-LIS) attributable to non-applicable drugs as reported on the 2022 PDEs.

  Gap cost sharing for non-applicable drugs is the coinsurance incurred by applicable beneficiaries (i.e., non-LIS) for non-applicable drugs in the coverage gap.

Section E. Reduced Coinsurance for Applicable Beneficiaries in the Coverage Gap[52]

Section 1860D-2(b)(2)(C) and (D) requires a phased reduction in applicable beneficiary cost sharing for drugs in the coverage gap phase of the Medicare Part D benefit which, prior to CY 2011, was set at 100 percent. This gradual reduction in cost sharing began in 2011 and continued through CY 2019 for applicable drugs and through CY 2020 for non-applicable drugs, ultimately resulting in 25 percent cost sharing for applicable drugs, after the application of the 70 percent manufacturer discount required by statute, and 25 percent cost sharing for other, non-applicable Part D covered drugs. As a result, from CY 2020 onward, after applying the 70 percent manufacturer discount, the beneficiary coinsurance for non-LIS beneficiaries under basic

[52] These parameters reflect additional plan coverage required for covered insulin products under section 1860D-2(b)(9) of the Act, as added by section 11406 of the IRA, and ACIP-recommended vaccines under section 1860D-2(b)(8) of the Act, as added by section 11401 of the IRA. See Section C for additional information.

prescription drug coverage is 25 percent for applicable covered Part D drugs purchased during the coverage gap phase of the Part D benefit.

The reductions in cost sharing, in conjunction with the Medicare Coverage Gap Discount Program, effectively served to close the Medicare Part D coverage gap for applicable (i.e., non-LIS) beneficiaries by extending the 25 percent coinsurance for non-LIS beneficiaries from the initial coverage phase into the coverage gap phase for both applicable and non-applicable drugs. For a detailed description of how cost sharing was gradually reduced year-by-year during the CY 2011 to CY 2020 time period, see Tables III-2 and III-3 of the Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies – Part II.[53]

Section F. Part D Calendar Year EGWP Prospective Reinsurance Amount

CMS makes prospective reinsurance payments to all Part D Calendar Year EGWP sponsors based on the average per member-per month (PMPM) actual (final) reinsurance amounts paid to Part D Calendar Year EGWP sponsors for the most recently reconciled payment year, which for CY 2024 is CY 2021. The average PMPM actual reinsurance amount paid to Part D Calendar Year EGWPs for CY 2021 was $71.09.

Section G. Part D Risk Sharing

The risk sharing payments provided by CMS limit Part D sponsors' exposure to unexpected drug expenses. Pursuant to section 1860D-15(e)(3)(C) of the Act and § 423.336(a)(2)(ii), CMS may establish a risk corridor with higher threshold risk percentages for Part D risk sharing beginning in CY 2012. Widening the risk corridor would increase the risk associated with providing the Part D benefit and reduce the risk sharing amounts provided (or recouped) by CMS. While CMS may widen the risk corridors, the statute does not permit CMS to narrow the corridors relative to the CY 2011 thresholds.

CMS has evaluated the risk sharing amounts for CYs 2008–2021 to assess whether they have decreased or stabilized. A steady decline or stabilization in the Part D risk sharing amounts would suggest that Part D sponsors have significantly improved their ability to predict Part D expenditures. However, CMS has found that risk sharing amounts continue to vary significantly in aggregate from year to year and among Part D sponsors in any given year. Therefore, we do not believe it is appropriate to adjust the parameters at this time, and we will apply no changes to the current threshold risk percentages for CY 2024. We will continue to evaluate the risk sharing amounts each year to determine if wider corridors should be applied for Part D risk sharing.

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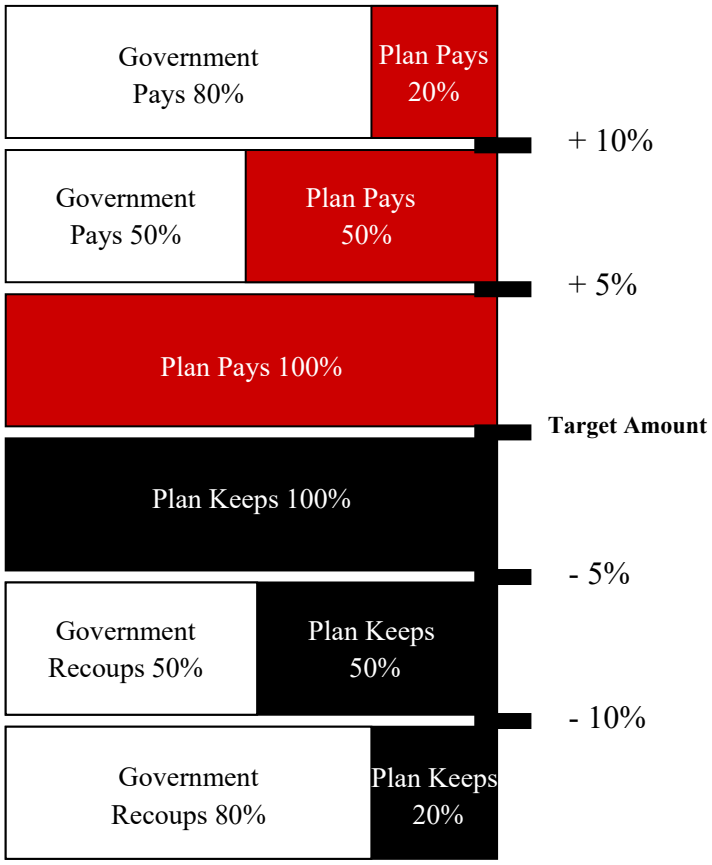
[53] See 2021 Advance Notice Part II at page 50 of https://www.cms.gov/files/document/2021-advance-notice-part-ii.pdf.

Thus, the risk percentages and payment adjustments for Part D risk sharing are unchanged from CY 2023. The risk percentages for the first and second thresholds remain at +/- 5 percent and +/- 10 percent of the target amount, respectively, for CY 2024. The payment adjustments for the first and second corridors are 50 percent and 80 percent, respectively. Figure III-1 below illustrates the risk corridors for CY 2024.

Figure III-1. Part D Risk Corridors for CY 2024



G1. Risk sharing when a plan's adjusted allowable risk corridor costs (AARCC) exceed the target amount

For the portion of a plan's adjusted allowable risk corridor costs (AARCC[54]) that is between the target amount and the first threshold upper limit (105 percent of the target amount), the Part D sponsor pays 100 percent of this amount. For the portion of the plan's AARCC that is between the first threshold upper limit and the second threshold upper limit (110 percent of the target amount), the government pays 50 percent and the plan pays 50 percent. For the portion of the

[54] Per § 423.336(a), the "adjusted allowable risk corridor costs" for a Part D plan are the allowable risk corridor costs for a Part D plan for the coverage year, reduced by the sum of the total reinsurance payments and total low-income cost-sharing subsidies paid to the sponsor of the Part D plan for the coverage year.

plan's AARCC that exceeds the second threshold upper limit, the government pays 80 percent and the plan pays 20 percent.

Example: If a plan's AARCC is $120 and its target amount is $100, the Part D sponsor and the government cover $9.50 and $10.50, respectively, of the $20 in unanticipated costs. The sponsor's responsibility is calculated as follows:

100% of ($105 − $100) + 50% of ($110 − $105) + 20% of ($120 − $110).

G2. Risk sharing when a plan's adjusted allowable risk corridor costs (AARCC) are below the target amount

If a plan's AARCC is between the target amount and the first threshold lower limit (95 percent of the target amount), the plan keeps 100 percent of the difference between the target amount and the plan's AARCC. If a plan's AARCC is between the first threshold lower limit and the second threshold lower limit (90 percent of the target amount), the government recoups 50 percent of the difference between the first threshold lower limit and the plan's AARCC. The plan would keep 50 percent of the difference between the first threshold lower limit and the plan's AARCC, as well as 100 percent of the difference between the target amount and first threshold lower limit. If a plan's AARCC is less than the second threshold lower limit, the government recoups 80 percent of the difference between the plan's AARCC and the second threshold lower limit, as well as 50 percent of the difference between the first and second threshold lower limits. In this case, the plan would keep 20 percent of the difference between the plan's AARCC and the second threshold lower limit, 50 percent of the difference between the first and second threshold lower limits, and 100 percent of the difference between the target amount and the first threshold lower limit.

Example: If a plan's AARCC is $80 and its target amount is $100, of the $20 in unexpected savings generated, the Part D sponsor keeps $9.50, and the government recoups $10.50. The sponsor's share is calculated as follows:

100% of ($100 − $95) + 50% of ($95 − $90) + 20% of ($90 − $80).

Section H. Retiree Drug Subsidy Amounts

Per § 423.886(b)(3), the cost threshold and cost limit for qualified retiree prescription drug plans are updated using the API, as defined previously in this document.[55] The updated cost threshold is rounded to the nearest multiple of $5 and the updated cost limit is rounded to the nearest multiple of $50. The cost threshold and cost limit are defined as $505 and $10,350, respectively,

[55] The cost threshold is the amount of gross retiree costs that a retiree must incur before the retiree drug subsidy applies. The cost limit is the maximum amount of gross retiree costs that the retiree drug subsidy will cover after a retiree hits the cost threshold.

for plans that end in CY 2023, and as $545 and $11,200 for plans that end in CY 2024, as noted in Table III-9.

Table III-9 Updated Retiree Drug Subsidy Amounts in CY 2024

	2023	2024
Retiree Drug Subsidy Amounts		
Cost Threshold	$505	$545
Cost Limit	$10,350	$11,200

Attachment IV. Updates for Part C and D Star Ratings

Part C and D Star Ratings and Future Measurement Concepts

The Part C and D Star Ratings measure the quality of and reflect the experiences of beneficiaries in Medicare Advantage (MA) and Prescription Drug Plans (PDPs or Part D plans), assist beneficiaries in finding the best plan for their needs, and determine eligibility for MA Quality Bonus Payments. The Star Ratings support CMS's efforts to make the patient the focus in all of our programs and to create incentives to eliminate health disparities.

The methodology for the Star Ratings system for the Part C and D programs is codified at §§ 422.160 - 422.166 and 423.180 - 423.186. In this Advance Notice, we are providing information and updates as required by §§ 422.164(c)(2), (d), (e)(2) and (f)(1); 422.166(f)(2); 423.184(c)(2), (d), (e)(2), and (f)(1); and 423.186(f)(2).

Reminders for 2024 Star Ratings

CMS finalized the application of Tukey outlier deletion for non-CAHPS measures beginning with the 2024 Star Ratings in the CY 2021 final rule (85 FR 33832-36).[56] We also finalized the addition of the Transitions of Care and Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions measures to be added to the 2024 Star Ratings in the CY 2022 final rule (86 FR 5921-26). Additionally, the Plan All-Cause Readmissions measure will be returned to the 2024 Star Ratings after being delayed due to the suspended collection of CAHPS and HEDIS data in 2020.[57]

We provide various datasets and reports to plan sponsors throughout the year. Part C and D sponsors should regularly review their underlying measure data that are the basis for the Star Ratings and immediately alert CMS if errors or anomalies are identified so any issues can be resolved prior to the first plan preview period.

As described at §§ 422.164(h) and 423.184(h), CMS annually sets and announces a deadline for MA and Part D organizations to request that CMS or the Independent Review Entity (IRE)

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[56] In the CY 2021 final rule, we finalized use of Tukey outlier deletion effective for the Star Ratings issued in October 2023 and subsequent years. (85 FR 33833-36) In the rulemakings since that time, we have not proposed to eliminate the Tukey outlier deletion aspect of the Star Ratings methodology. As we stated in May 2022 final rule (87 FR 27766), we will implement Tukey outlier deletion beginning with the 2024 Star Ratings to help improve stability of cut points and prevent cut points from being influenced by outliers. However, it appears that the sentence in §§ 422.166(a)(2)(i) and 423.186(a)(2)(i) ("Effective for the Star Ratings issued in October 2023 and subsequent years, prior to applying mean resampling with hierarchal clustering, Tukey outer fence outliers are removed.") was inadvertently removed from the codified regulation text. In the Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications proposed rule which appeared in the Federal Register on December 27, 2022 (87 FR 79452), we are proposing a technical amendment to fix this codification error from the May 2022 final rule. The comment period for the proposed rule closes on February 13, 2023. To be assured consideration, comments must be received through the means described in the proposed rule.

[57] See the Announcement of Calendar Year (CY) 2022 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, page 97.

review its Part C appeals data or CMS review its Complaints Tracking Module (CTM) data. CMS is announcing a deadline of June 30, 2023 for all contracts to make their requests for review of the 2022 appeals and CTM measure data for the 2024 Star Ratings. Sponsoring organizations can view and monitor their Part C appeals timeliness and effectuation compliance data on the Medical Appeal Search website. Sponsoring organizations should refer to the May 10, 2019 HPMS memorandum, "Complaints Tracking Module (CTM) File Layout Change and Updated Standard Operating Procedures," for instructions on how to request a review of CTM data.

Measure Updates for 2024 Star Ratings

The measures that will be used to calculate the 2024 Star Ratings are listed in Table IV-1 with information about the measure type, weight, and measurement year.

Table IV-1: 2024 Star Ratings Measures

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2024 CAI Values
C	Breast Cancer Screening	Process Measure	1	1/1/2022 – 12/31/2022	**Yes**	**Yes**
C	Colorectal Cancer Screening	Process Measure	1	1/1/2022 – 12/31/2022	**Yes**	**Yes**
C	Annual Flu Vaccine	Process Measure	1	3/2023 – 6/2023	**Yes**	**Yes**
C	Controlling Blood Pressure	Intermediate Outcome Measure	3	1/1/2022 – 12/31/2022	**Yes**	**Yes**
C	Monitoring Physical Activity	Process Measure	1	7/2022 – 11/2022	**Yes**	**Yes**
C	Special Needs Plan (SNP) Care Management	Process Measure	1	1/1/2022 – 12/31/2022	**Yes**	**No**
C	Care for Older Adults – Medication Review	Process Measure	1	1/1/2022 – 12/31/2022	**Yes**	**No**
C	Care for Older Adults– Pain Assessment	Process Measure	1	1/1/2022 – 12/31/2022	**Yes**	**No**

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2024 CAI Values
C	Osteoporosis Management in Women who had a Fracture	Process Measure	1	1/1/2022 – 12/31/2022	**Yes**	**Yes**
C	Diabetes Care – Eye Exam	Process Measure	1	1/1/2022 – 12/31/2022	**Yes**	**Yes**
C	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3	1/1/2022 – 12/31/2022	**Yes**	**Yes**
C	Reducing the Risk of Falling	Process Measure	1	7/2022 – 11/2022	**Yes**	**Yes**
C	Improving Bladder Control	Process Measure	1	7/2022 – 11/2022	**Yes**	**Yes**
C	Medication Reconciliation Post-Discharge	Process Measure	1	1/1/2022 – 12/31/2022	**Yes**	**Yes**
C	Plan All-cause Readmissions	Outcome Measure	1	1/1/2022 – 12/31/2022	**No**	**No**
C	Transitions of Care	Process Measure	1	1/1/2022 – 12/31/2022	**No**	**No**
C	Follow-up after Emergency Room Visit	Process Measure	1	1/1/2022 – 12/31/2022	**No**	**No**
C	Getting Needed Care	Patients' Experience and Complaints Measure	4	3/2023 – 6/2023	**Yes**	**No**
C	Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	4	3/2023 – 6/2023	**Yes**	**No**

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2024 CAI Values
C	Customer Service	Patients' Experience and Complaints Measure	4	3/2023 – 6/2023	**Yes**	**No**
C	Rating of Health Care Quality	Patients' Experience and Complaints Measure	4	3/2023 – 6/2023	**Yes**	**No**
C	Rating of Health Plan	Patients' Experience and Complaints Measure	4	3/2023 – 6/2023	**Yes**	**No**
C	Care Coordination	Patients' Experience and Complaints Measure	4	3/2023 – 6/2023	**Yes**	**No**
C	Complaints about the Health Plan	Patients' Experience and Complaints Measure	4	1/1/2022 – 12/31/2022	**Yes**	**No**
C	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	4	1/1/2022 – 12/31/2022	**Yes**	**No**
C	Health Plan Quality Improvement	Improvement Measure	5	NA	**No**	**No**
C	Plan Makes Timely Decisions about Appeals	Measures Capturing Access	4	1/1/2022 – 12/31/2022	**Yes**	**No**
C	Reviewing Appeals Decisions	Measures Capturing Access	4	1/1/2022 – 12/31/2022	**Yes**	**No**

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2024 CAI Values
C	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	4	2/2023 – 5/2023	**Yes**	**No**
C	Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1	1/1/2022 – 12/31/2022	**Yes**	**Yes**
D	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	4	2/2023 – 5/2023	**Yes**	**No**
D	Complaints about the Drug Plan	Patients' Experience and Complaints Measure	4	1/1/2022 – 12/31/2022	**Yes**	**No**
D	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	4	1/1/2022 – 12/31/2022	**Yes**	**No**
D	Drug Plan Quality Improvement	Improvement Measure	5	NA	**No**	**No**
D	Rating of Drug Plan	Patients' Experience and Complaints Measure	4	3/2023 – 6/2023	**Yes**	**No**
D	Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	4	3/2023 – 6/2023	**Yes**	**No**
D	MPF Price Accuracy	Process Measure	1	1/1/2022 – 9/30/2022	**Yes**	**No**
D	Medication Adherence for Diabetes Medications	Intermediate Outcome Measure	3	1/1/2022 – 12/31/2022	**Yes**	**Yes**

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2024 CAI Values
D	Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measure	3	1/1/2022 – 12/31/2022	**Yes**	**Yes**
D	Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measure	3	1/1/2022 – 12/31/2022	**Yes**	**Yes**
D	MTM Program Completion Rate for CMR	Process Measure	1	1/1/2022 – 12/31/2022	**Yes**	**Yes**
D	Statin Use in Persons with Diabetes	Process Measure	1	1/1/2022 – 12/31/2022	**Yes**	**Yes**

Improvement Measures (Part C & D) for the 2024 Star Ratings. Under §§ 422.164(f) and 423.184(f), improvement measures are calculated using performance measures that meet specific conditions. Table IV-1 includes information about which measures will be used to calculate the improvement measures for the 2024 Star Ratings. As stated in §§ 422.164(f)(4)(i) and 423.184(f)(4)(i), CMS will only include measures in the improvement calculations at the contract level if numeric value scores are available for both the current and prior year.

2024 Star Ratings Program and the Categorical Adjustment Index

The methodology for the Categorical Adjustment Index (CAI) is described at §§ 422.166(f)(2) and 423.186(f)(2), as well as in the annual Medicare Part C & D Star Ratings Technical Notes available on CMS's Part C and D Star Ratings website. As finalized at §§ 422.166(f)(2) and 423.186(f)(2), all measures identified as candidate measures will be included in the determination of the 2024 CAI values. The measure set for the 2024 CAI (for both Part C and D) is identified in Table IV-1.

In keeping with our commitment to transparency, a summary of the analysis of the candidate measure set that includes the minimum, median, and maximum values for the within-contract variation for the low-income subsidy (LIS)/dual eligible (DE) differences are posted with the 2024 CAI values on CMS's Part C and D Star Ratings website.

Extreme and Uncontrollable Circumstances Policy for the 2024 Star Ratings

Extreme and uncontrollable circumstances such as natural disasters can directly affect Medicare beneficiaries and providers, as well as the Parts C and D organizations that provide beneficiaries with important medical care and prescription drug coverage. An affected contract is identified based on these criteria:

> (1) Its service area is within an "emergency area" during an "emergency period" as defined in section 1135(g)(1) of the Act;
>
> (2) Its service area is within a geographic area designated in a major disaster declaration under the Stafford Act and the Secretary exercised authority under section 1135 of the Act based on the same triggering event(s); and
>
> (3) A certain minimum percentage (25 percent or 60 percent) of the enrollees under the contract must reside in a Federal Emergency Management Agency (FEMA)-designated Individual Assistance area at the time of the extreme and uncontrollable circumstance. (See §§ 422.166(i) and 423.186(i))

We use the start date of the incident period to determine which year of Star Ratings could be affected, regardless of whether the incident period extends to another calendar year (§§ 422.166(i) and 423.186(i)).

Under the 25 percent rules at §§ 422.166(i)(2)–(6) and 423.186(i)(2)–(5), contracts with at least 25 percent of their service area in a FEMA-designated Individual Assistance area in 2022 will receive the higher of their measure-level rating from the current and prior Star Ratings years for purposes of calculating the 2024 Star Ratings (thus, for 2024 Star Ratings, affected contracts will receive the higher of their measure-level ratings from 2023 or 2024 for the applicable measures). See also 84 FR 15770–77. The numeric scores for contracts with 60 percent or more of their enrollees living in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance are excluded from: (1) the measure-level cut point calculations for non-CAHPS measures; and (2) the performance summary and variance thresholds for the reward factor as described at §§ 422.166(i)(9)(i) and (i)(10)(i), and 423.186(i)(7)(i) and (i)(8)(i). Table IV-2 lists the emergency areas affected by emergency declarations first issued in 2022, as defined in section 1135 of the Act, and the exercise of the Secretary's authority under section 1135 of the Act.

Table IV-2: List of Section 1135 Waivers Issued in Relation to the FEMA Major Disaster Declarations

Section 1135 Waiver Date Issued	Waiver or Modification of Requirements Under Section 1135 of the Social Security Act	FEMA Incident Type	Affected State	Incident Start Date
5/9/2022	New Mexico Wildfires and Straight-line Winds	Wildfires	New Mexico	4/5/2022
8/2/2022	Kentucky Severe Storms, Flooding, Landslides, and Mudslides	Severe Storms, Flooding, Landslides, and Mudslides	Kentucky	7/26/2022
9/20/2022	Tropical Storm/Hurricane Fiona	Hurricane	Puerto Rico	9/17/2022
9/26/2022	Hurricane Ian	Hurricane	Florida	9/23/2022
9/30/2022	Hurricane Ian	Hurricane	South Carolina	9/25/2022

Table IV-3 lists the states and territories with Individual Assistance designations from the FEMA major disaster declarations.

Table IV-3: Individual Assistance Counties and County-Equivalents in FEMA Major Disaster Declared States/Territories

FEMA Declaration	State	FEMA Individual Assistance Counties or County-Equivalents
DR-4652-NM	New Mexico	Colfax, Lincoln, Mora, San Miguel, Valencia
DR-4663-KY	Kentucky	Breathitt, Clay, Floyd, Knott, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley
DR-4671-PR	Puerto Rico	Adjuntas, Aguada, Aguadilla, Aguas Buenas, Aibonito, Anasco, Arecibo, Arroyo, Barceloneta, Barranquitas, Bayamon, Cabo Rojo, Caguas, Camuy, Canovanas, Carolina, Catano, Cayey, Ceiba, Ciales, Cidra, Coamo, Comerio, Corozal, Culebra, Dorado, Fajardo, Florida, Guanica, Guayama, Guayanilla, Guaynabo, Gurabo, Hatillo, Hormigueros, Humacao, Isabela, Jayuya, Juana Diaz, Juncos, Lajas, Lares, Las Marias, Las Piedras, Loiza, Luquillo, Manati, Maricao, Maunabo, Mayaguez, Moca, Morovis, Naguabo, Naranjito, Orocovis, Patillas, Penuelas, Ponce, Quebradillas, Rincon, Rio Grande, Sabana Grande, Salinas, San German, San Juan, San Lorenzo, San Sebastian, Santa Isabel, Toa Alta, Toa Baja, Trujillo Alto, Utuado, Vega Alta, Vega Baja, Vieques, Villalba, Yabucoa, Yauco
DR-4673-FL	Florida	Brevard, Charlotte, Collier, DeSoto, Flagler, Glades, Hardee, Hendry, Highlands, Hillsborough, Lake, Lee, Manatee, Monroe, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, Sarasota, Seminole, St. Johns, Volusia
DR-4677-SC	South Carolina	Charleston, Georgetown, Horry

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

CMS solicits feedback on new measure concepts as well as measure updates through the annual Advance Notice and Rate Announcement process. We also provide advance notice regarding measures considered for implementation as future Star Ratings measures. As codified at §§ 422.164(c)(2)–(4), 423.184(c)(2)–(4), 422.164(d)(2), and 423.184(d)(2), new measures and measures with substantive specification changes must be added or updated through rulemaking, and must remain on the display page for at least two years prior to becoming a Star Ratings measure. In addition, CMS uses the Advance Notice and Rate Announcement process to announce non-substantive specification changes as described at §§ 422.164(d)(1) and 423.184(d)(1) and to remove measures as described at §§ 422.164(e) and 423.184(e). We are describing a number of measure concepts and changes in this Advance Notice. We encourage

interested parties to provide comments directly to measure developers during their public comment periods. For example, the National Committee for Quality Assurance (NCQA) and the Pharmacy Quality Alliance (PQA) regularly solicit public comments on new measures, changes to existing measures, and measure retirements.

As part of the CMS National Quality Strategy and Medicare Value-Based Care Strategy, CMS is committed to aligning a core set of measures across all our programs and ensuring we measure quality across the entire care continuum in a way that promotes the best, safest, and most equitable care for all individuals. Improving alignment of measures across federal programs and with private payers will reduce provider burden while also improving the effectiveness of quality programs. Across our CMS quality rating and value-based care programs, where applicable, we are considering including what CMS is calling a "Universal Foundation" of quality measures which is a core set of measures that are aligned across programs. This "Universal Foundation" is a building block to which programs will add additional aligned or program-specific measures. As a start, each program is considering which measures included in the "Universal Foundation" are not currently in their programs and the steps to add them over time if appropriate.

Having this "Universal Foundation" will support efforts to ensure high quality care for the more than 150 million Americans covered by our programs and serve as an alignment standard for rest of the health care system. The "Universal Foundation" will 1) focus provider attention, 2) reduce provider burden, 3) allow for consistent stratification of measures to identify disparities in care, 4) accelerate the transition to interoperable, digital quality measures, and 5) allow for cross-comparisons across quality and value-based care programs, to better understand what drives quality and equity improvement and what does not. The preliminary set of measures included in the Adult "Universal Foundation" are listed in Table IV-4 with information about whether the measures are currently in the Star Ratings program.

Table IV-4: Preliminary Adult Universal Foundation Measures

Meaningful Measure 2.0 Domain	**Measure**	**Part C and D Star Ratings**
Wellness and Prevention	Colorectal Cancer Screening (HEDIS)	Currently in Star Ratings
	Breast Cancer Screening (HEDIS)	Currently in Star Ratings
	Adult Immunization Status (HEDIS)	Soliciting feedback on this measure in this Advance Notice
Chronic Conditions	Controlling High Blood Pressure (HEDIS)	Currently in Star Ratings
	Diabetes: Hemoglobin A1c Poor Control (>9%) (HEDIS)	Currently in Star Ratings (reversed score so higher scores are better)

Meaningful Measure 2.0 Domain	Measure	Part C and D Star Ratings
Behavioral Health	Screening for Depression and Follow-Up Plan (HEDIS)	Soliciting feedback on this measure in this Advance Notice
	Initiation and Engagement of Substance Use Disorder Treatment (HEDIS)	Currently on display page
Seamless care coordination	Plan all-cause readmissions or Hospital all-cause readmissions (HEDIS)	Currently in Star Ratings
Person-centered care	Consumer Assessment of Healthcare Providers and Systems (CAHPS): Overall Rating Measures (CAHPS)	Currently in Star Ratings
Equity	Screening for Social Drivers of Health/ Social Need Screening and Intervention (HEDIS)	Solicited feedback in the 2023 Advance Notice/Rate Announcement about the NCQA measure focused on Screening and Referral to Services for Social Needs

CMS welcomes feedback on this approach and the measures included.

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 HEDIS measures to make a determination whether the optional exclusions could be required. NCQA is making updates to the following Star Ratings and display measures for measurement year 2023 (2025 Star Ratings):

- 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.

For all HEDIS measures that are part of the Star Ratings and display page, the optional exclusion for enrollees who died during the measurement year became a required exclusion for measurement year 2023. These updates would be non-substantive under § 422.164(d)(1)(i) since they narrow the population covered under the measures.

Care for Older Adults (COA) – Pain Assessment (Part C). NCQA is considering retiring the COA Pain Assessment indicator from the HEDIS measurement set for the following reasons: 1) pain assessments should be multidimensional, and the current indicator cannot ensure this; 2) the current indicator does not differentiate between acute and chronic pain; and 3) it also does not assess follow up, and evidence suggests that pain assessment alone does not improve quality of care. Additionally, the current measure is only reported for Special Needs Plans; however, a wider population of MA enrollees would benefit from a pain assessment and follow-up measure. Therefore, NCQA is conceptualizing a new Chronic Pain Assessment and Follow-up measure described below in the section on Potential New Measure Concepts and Methodological Enhancements for Future Years. NCQA plans to obtain feedback from their Committee for Performance Measurement (CPM) in September 2022 and to solicit public comment on the proposed retirement of this measure as part of the HEDIS public comment period in February 2023. Pending results of public comment, NCQA would seek approval from the CPM in May 2023 for retirement in measurement year 2025. We welcome feedback on the potential future retirement of this measure.

COA – Functional Status Assessment and Medication Review (Part C). NCQA is also exploring the development of new measures for Functional Status Assessment and Medication Review that may eventually replace these indicators of the COA measure and be reported for a wider population than only enrollees of Special Needs Plans. Any potential new measures are currently planned for development for measurement year 2025. If new measures are developed and implemented, NCQA would propose retirement of the existing COA measures and CMS may propose through rulemaking to retire the existing Star Ratings measures and replace them with these new measures.

Diabetes Care – Eye Exam and Diabetes Care – Blood Sugar Controlled (Part C). NCQA is reviewing these two measures for potential updates to the existing specifications and updates that leverage standardized electronic clinical data. NCQA is re-evaluating the approach to identify whether an enrollee has diabetes and would be included in the denominator to reflect the evolution of claims data coding practices, pharmacy practices, and the use of electronic clinical data. The current method identifies enrollees if they have at least two outpatient encounters with a diagnosis of diabetes on different dates of service *or* at least one inpatient encounter with a diagnosis of diabetes *or* a prescription for a diabetes medication. Potential updates include 1) simplifying the current claims-based denominator approach to identify enrollees if they have at least two encounters (in any setting except lab) on different dates of service with a diagnosis of diabetes; 2) revising the current pharmacy-based denominator approach to require a diabetes diagnosis for those enrollees identified through a dispensed diabetes medication alone (this would obviate the need for the existing exclusions of polycystic ovary syndrome, gestational diabetes, or steroid-induced diabetes); and 3) developing a new method that provides instruction for how to identify diabetes using clinical data, such as requiring at least two encounters with a diagnosis of diabetes. These potential clarifications for measurement year 2024 would be non-

substantive under § 422.164(d)(iv) by adding clarifications for the documentation requirements to identify enrollees with diabetes. As such, if NCQA proceeds, CMS will apply the update to the measures beginning with the 2024 measurement year (2026 Star Ratings). These changes would also apply to the Kidney Health Evaluation for Patients with Diabetes (Part C) measure currently on the display page and being proposed for the 2026 Star Ratings in the Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act (ACA) and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications proposed rule which appeared in the Federal Register on December 27, 2022 (87 FR 79452, 2024 Part C and D proposed rule). We welcome comment on these potential clarifications to determining which enrollees have diabetes.

NCQA is also evaluating the potential removal of the hybrid reporting method for the Diabetes Care - Eye Exam and Diabetes Care - Blood Sugar Controlled measures for measurement year 2024 and beyond. The measures would then be specified for the Administrative or ECDS (electronic clinical data systems) reporting methods. NCQA is also considering excluding enrollees with bilateral eye enucleation from the Diabetes Care – Eye Exam measure starting with measurement year 2024. This change would be non-substantive as described at §422.164(d)(1)(i) since it narrows the population covered by the measure. Another potential update that NCQA is considering is the incorporation of a Glucose Management Indicator (GMI) as another method to assess numerator compliance in the existing Diabetes Care – Blood Sugar Controlled measure for measurement year 2024 or beyond. GMI is a calculation derived from continuous glucose monitoring devices that assesses average blood sugar values and can provide information directly to patients and physicians at more frequent intervals. Based on guidelines from the American Diabetes Association, GMI can serve as an alternative method for A1C for use in clinical management.[58] NCQA is evaluating the inclusion of GMI alongside HbA1c as two methods to assess the numerator. In cases where enrollees have results available for both methods in the measurement year, the most recent result should be used (regardless of whether it is a GMI or HbA1c result). In cases where enrollees have results available for both methods on the same day, the HbA1c result should be used. If NCQA decides to add additional tests that meet the numerator requirements, it would be a non-substantive update as described at § 422.164(d)(1)(iv)(A). If this update is made, NCQA is considering renaming the measure *Glycemic Status Assessment for Patients With Diabetes*.

Breast Cancer Screening (Part C). For measurement year 2024, NCQA is considering revising the eligible population for this measure to be more inclusive of individuals at risk of breast cancer. The revised eligible population would include members 52-74 years of age who meet the

[58] American Diabetes Association Professional Practice Committee. 6. Glycemic targets: Standards of Medical Care in Diabetes—2022. Diabetes Care 2022; 45 (Suppl. 1); S83–S96.

screening criteria for breast cancer, including transgender and gender-diverse members who have breasts and are at risk of breast cancer. For example, this would include transgender men with sex assigned at birth as female, and transgender women with sex assigned at birth as male but have undergone estrogen hormone therapy. The intent of this change is to ensure that all members in need of breast cancer screening are included in the eligible population, meaningfully improving quality of care for a population that currently experiences disparities as it relates to preventive screenings. However, given the relatively small size of the additional population, this change will not meaningfully impact either the numerator or denominator of the measure. If NCQA decides to expand the population included in the denominator, it would be a non-substantive update as described at § 422.164(d)(1)(ii) given less than 0.3% of adults 50 years old and older identify as transgender or nonbinary.[59]

Statin Use in Persons with Diabetes (SUPD) (Part D). CMS will make the following non-substantive updates to the SUPD measure beginning with the 2024 measurement year and 2026 Star Ratings: 1) to use continuous enrollment (CE) to fully align with the PQA specifications and to no longer adjust for member-years (MYs), and 2) to align with the PQA age criteria specifications. CMS solicited feedback on using the CE specifications instead of MYs in the 2023 Advance Notice. These changes are non-substantive updates under § 423.184(d)(1) because they are updates with no change to the intent of the measure or the target population.

The SUPD measure analyzes the percent of Part D beneficiaries, ages 40 to 75 years, who were dispensed at least two diabetes medication fills that received a statin medication fill during the measurement period. CMS adapted the SUPD measure from the PQA specifications, and CMS currently adjusts Part D enrollment based on MYs to account for beneficiaries who are enrolled for only part of the contract year. For example, if a beneficiary is enrolled for 6 out of 12 months of the year, they will count as only 0.5 MYs in the rate calculation. However, the current PQA specifications use CE instead of MYs. As stated in the 2022 PQA Measure Manual, the beneficiary's index prescription start date (IPSD) begins on the earliest date of service for a diabetes medication during the measurement year. Beneficiaries are continuously enrolled during the measurement year with one allowable gap in enrollment which may be up to 31 days during the measurement year.

Beginning with measurement year 2024, CMS will use CE to fully align with the PQA specifications and to no longer adjust for MYs; this update would be non-substantive. This update is consistent with the update to use CE for the Part D medication adherence measures as described immediately below. In applying CE, CMS will also align with the PQA age criteria specifications for the SUPD measure; a beneficiary will be eligible for the measure based on their age at the start of the measurement year regardless of whether the beneficiary ages in or out

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[59] https://www.pewresearch.org/fact-tank/2022/06/07/about-5-of-young-adults-in-the-u-s-say-their-gender-is-different-from-their-sex-assigned-at-birth/.

during the measurement year. This will be a non-substantive change from CMS' current specifications with the MY adjustment in which a beneficiary is eligible for inclusion in the SUPD measure from the month the beneficiary meets the minimum age restriction and ending with the month before they exceed the maximum age restriction.

These changes are non-substantive updates under § 423.184(d)(1) because the updates do not modify the intent of the measure or the target population and may narrow the denominator population. We analyzed year of service (YOS) 2021 data as of January 2022 limited to contracts with a denominator greater than 30 members and compared rates using MYs and CE. We found that 88 percent of beneficiaries included in the measure using MYs were also in the denominator using CE. Overall, the mean SUPD rates using CE were slightly higher than rates using MYs by around 0.3 percentage points. For MA-PDs (non-MMPs), the mean rates increased from 85.08 percent to 85.51 percent with CE. About 45 percent of MA-PD contracts' rates stayed relatively the same, 43 percent increased, and 12 percent decreased. For PDPs, the mean rates increased from 82.00 percent to 82.38 percent. We found 55 percent of PDP contracts' rates stayed relatively the same, 43 percent increased, and 2 percent decreased. Finally, we found that there was a slight increase in SUPD rates across MA-PDs and PDPs for both female and male beneficiaries, as well as individuals with LIS, dual-eligibility, disability, and by race (Black, Hispanic, American Indian/Alaska Native, and Multiracial).

We will make this non-substantive measure update to the SUPD measure starting with the 2024 measurement year for the 2026 Star Ratings.

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

In the 2023 Rate Announcement, CMS solicited initial feedback on implementing risk adjustment of the medication adherence measures based on sociodemographic (SDS) characteristics (age, gender, dual eligibility/ LIS status, and disability status) according to the PQA specifications and endorsed by the National Quality Forum (NQF).

Implementing SDS risk adjustment is a substantive change according to § 423.184(d)(2). CMS proposed this change for the 2026 measurement year and 2028 Star Ratings in the 2024 Part C and D proposed rule published on December 27, 2022 (87 FR 79616-79617).[60]

We signaled that there may be a few non-substantive changes that are made to the adherence measures in the Announcement of Calendar Year (CY) 2023 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.[61] In addition, CMS will make the

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[60] Comments for the proposed rule are due by February 13, 2023 through the means described in the proposed rule.

[61] Please refer to the Announcement of Calendar Year (CY) 2023 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies at the following website: https://www.cms.gov/files/document/2023-announcement.pdf.

following non-substantive changes to the three adherence measures to fully align with the current PQA measure specifications which are endorsed by the NQF: 1) no longer adjust for MYs; instead apply the PQA's measure specifications to use CE as defined by the treatment period and exclude beneficiaries with more than 1-day gap in enrollment during the treatment period and 2) no longer adjust for inpatient (IP) or skilled nursing facility (SNF) stays as the PQA specifications do not include these adjustments. As a reminder, in accordance § 423.184(d)(1), non-substantive changes may be adopted during or in advance of the measurement period through the Advance Notice/Rate Announcement process. Because we intend to make these non-substantive changes along with the proposed substantive change to implement SDS risk adjustment, we include more information about the non-substantive changes, related timing, and data analysis in the 2024 Part C and D proposed rule (87 FR 79617-79618) to provide a more complete picture of the updates to the measures. We plan to implement CE starting with the 2024 measurement year for the 2026 Star Ratings. We plan to remove the IP/SNF stay adjustment from the adherence measures starting with the 2026 measurement year for the 2028 Star Ratings, which is the same time we propose to implement the SDS risk adjustment change, but is not dependent on finalizing the SDS risk adjustment proposal.

MTM Program Completion Rate MTM Program Completion Rate for Comprehensive Medication Review (CMR) (Part D). The data for this measure are reported by contracts to CMS in the Health Plan Management System (HPMS) per the Part D Reporting Requirements (OMB control number 0938-0992). Independent validation of these data are performed in accordance with § 423.514(j) (OMB control number 0938-1115), and the results are due in HPMS by June 30 of the year following the reporting period. Beneficiaries who are in hospice at any point during the reporting period are excluded from this measure. The Medicare Enrollment Database (EDB) is used to exclude beneficiaries in hospice. Starting with the 2023 reporting period for the 2025 Star Ratings, CMS will pull the EDB data to identify beneficiaries in hospice in June after the reporting period, which aligns with when the Part D Reporting Requirements data are pulled from HPMS. The data validation results are pulled in July of the year following the reporting period. This is a non-substantive change as described at § 423.184(d)(1) since this change does not meaningfully impact the numerator or denominator of the measure. In addition, the prevalence of beneficiaries in hospice is low (less than 4% of MTM program enrollees).

Display Measures

Display measures on CMS.gov are published separately from the Star Ratings and include measures that are transitioned from inclusion in the Star Ratings, new or updated measures before inclusion into the Star Ratings, and informational-only measures. Organizations and sponsors have the opportunity to preview the data for their display measures prior to release on CMS.gov. We anticipate all 2023 display measures will continue to be shown on CMS.gov in 2024 unless noted below.

Depression Screening and Follow-Up (Part C). We are considering whether to add the HEDIS Depression Screening and Follow-up for Adolescents and Adults measure to the 2026 Star Ratings display page. As CMS's Behavioral Health Strategy is working to support a person's whole emotional and mental well-being and promote person-centered behavioral health care (CMS Behavioral Health Strategy | CMS), we are considering behavioral health measures that could potentially be added to the Star Ratings program in the future through rulemaking. The HEDIS measure focused on Depression Screening and Follow-up measures the percentage of members who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. This aligns with the U.S. Preventive Services Task Force recommendations regarding screening and follow-up for depression (Depression in Adults: Screening - Healthy People 2030 | health.gov) and supports CMS's efforts to implement a core set of measures across quality programs. We welcome feedback on this measure.

Initiation and Engagement of Substance Use Disorder (SUD) Treatment (Part C). Prior to measurement year 2022, this measure was called Initiation and Engagement for Alcohol and Other Drug Abuse or Dependence Treatment. This HEDIS measure is currently on our display page. For measurement year 2022, NCQA updated the measure to change it from "member-based" to "episode-based"; lengthened the negative substance use disorder (SUD) history period from 60 days to 194 days to limit the number of members receiving ongoing treatment who inadvertently fall into the denominator; removed emergency department visits and medically managed withdrawal services from the negative SUD history period; removed the requirement that a psychosocial treatment encounter accompany pharmacotherapy; and split the adult age stratification between 18-64 years and 65+ years to better highlight any gaps in care between different age groups. Since many individuals with SUD attempt treatment multiple times before they are able to successfully engage, the revision of the measure to an "episode based" framework allows for each recovery attempt to count independently, which should result in a more valid representation of engagement with SUD treatment for health plan populations. Additionally, emergency department visits and withdrawal services alone are not suggestive of ongoing or planned treatment for individuals with SUD and thus do not signal that a member is already engaged in comprehensive care so these were removed from the measure's negative SUD history period. The requirement that psychosocial treatment accompany pharmacotherapy was also removed to align with the most current clinical practice guidelines (e.g., allowing for patients who may not accept concomitant psychosocial treatment).

We are considering potentially adding this measure to the Star Ratings in the future pending rulemaking. This would support CMS's efforts to implement a core set of measures across quality programs. We welcome feedback on this measure.

Timely Follow-up After Acute Exacerbations of Chronic Conditions (Part C). This clinical quality measure assesses the percentage of acute events requiring an emergency department visit or hospitalization for one of six chronic conditions, where outpatient, non-emergent follow-up is

received within a guideline-recommended timeframe after discharge to the community for each chronic condition:

1. Hypertension: Within 7 days
2. Asthma: Within 14 days
3. Congestive Heart Failure (CHF): Within 14 days
4. Coronary Artery Disease (CAD): Within 14 days
5. Chronic Obstructive Pulmonary Disease (COPD): Within 30 days
6. Diabetes: Within 30 days.

Follow-up care is a critical aspect of care coordination, ensuring patients understand and are adhering to their medication regimen, providers are monitoring patients for adverse events, and providers are educating patients to recognize warning signs. This measure was originally developed using MA encounter data submitted by MA contracts reflecting care received 2014-2016. The measure is constructed at the contract level. Details regarding measure specifications and validation are available from NQF (NQF 34455) and the measure steward, IMPAQ International.[62]

The measure calculation was subsequently replicated using encounter data from 2016 to 2020. Contract-level measure performance rates were found to be roughly stable over time with mean and median performance rates varying from 69-70% and 71-73%, respectively, between 2016 and 2019, before declining in 2020. CMS is planning to add this measure to the display page starting with the 2024 Star Ratings and is considering potential future inclusion of this measure in the Part C Star Ratings pending rulemaking. We welcome feedback on this measure.

Adult Immunization Status (Part C and D). We appreciate the feedback we received from last year's Advance Notice regarding replacing the current CAHPS influenza vaccination measure with the HEDIS influenza indicator from the Adult Immunization Status measure. Some commenters suggested that it would be more reliable than self-reported CAHPS data, while other commenters noted that the electronic data sources would have incomplete vaccination status data since patients can receive vaccines in community settings with or without an insurance claim. Many commenters cited discrepancies between HEDIS immunization data with self-reported CAHPS data. Some commenters suggested supplementing electronic data sources with other data sources to have more complete information. CMS will continue to take this feedback into consideration. Any changes to the current influenza measure in Star Ratings would need to be proposed through rulemaking.

CMS plans to add NCQA's Adult Immunization Status measure to the 2026 display page starting with data from the 2024 measurement year. This measure assesses the receipt of influenza, Td/Tdap, zoster, and pneumococcal vaccines. This measure is specified for the HEDIS ECDS Reporting Standard and captures receipt of vaccinations using data from a variety of electronic

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[62] See https://www.qualityforum.org/QPS/3455.

sources such as administrative claims, immunization registries, and EHRs, among others. For HEDIS measurement year 2023, NCQA has made a series of updates to the measure, including updating the pneumococcal indicator to assess adults 66 and older who received any of the following vaccines between age 19 and the end of the measurement period: pneumococcal conjugate vaccine (PCV) 20, PCV15, PCV13, or pneumococcal polysaccharide vaccine (PPSV) 23; removing the exclusions for chemotherapy, bone marrow transplant, and immunocompromising conditions; and expanding the age range for influenza and Td/Tdap vaccination status to Medicare enrollees age 19 and older and zoster for age 50 and older. We also continue to consider this measure as a potential future Star Ratings measure pending rulemaking. This measure is also part of the preliminary core set of measures that CMS is considering proposing across quality programs.

Concurrent Use of Opioids and Benzodiazepines (COB), Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH), and Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults (Poly-CNS) (Part D). We announced in the 2020 Rate Announcement that these measures would be on the display page for 2021 and 2022, and then CMS would consider adding them to the Star Ratings through the rulemaking process. In the 2024 Part C and D proposed rule (87 FR 79619-79620), CMS proposes to move the COB, Poly-ACH, and Poly-CNS measures from the display page to the 2026 Star Ratings (2024 measurement year). See the proposed rule for further information.[63] Additionally, CMS will make a non-substantive update for the 2024 measurement year to align with the PQA measure specifications to use CE and to no longer adjust for MYs.

Antipsychotic Use in Persons with Dementia, Overall (APD)/Antipsychotic Use in Persons with Dementia, in Long-Term Nursing Home Residents (APD-LTNH) (Part D). These measures currently reported on the display page are adapted from the APD measure developed by the PQA. The PQA recently made the following measure specification updates in their draft 2023 measure manual to the APD measure: 1) slight modification in the APD measure description; 2) updated definition to reflect appropriate indication for antipsychotic use; 3) added refractory depression as an exclusion to the numerator; and 3) removed the ">60 cumulative days supply" language from the denominator. In the draft 2023 measure manual, PQA slightly modified the APD description from "the percentage of individuals at least 65 years of age with dementia who received an antipsychotic medication without evidence of a psychotic disorder" to "the percentage of individuals at least 65 years of age with dementia who received an antipsychotic medication without evidence of an appropriate indication for an antipsychotic use." Additionally, the PQA updated the definition to reflect appropriate indication for antipsychotic use to align with FDA approved uses as individuals having one or more claims with schizophrenia, bipolar disorder, Huntington's disease, or Tourette's syndrome in the primary

[63] Comments for the proposed rule are due by February 13, 2023 through the means described in the proposed rule.

diagnosis or any other diagnosis fields during the measurement year. Furthermore, beneficiaries taking an antipsychotic with an FDA approved indication for treatment of refractory depression (i.e., depression resistant to treatment) is a new exclusion added to the numerator. However, the PQA developed the following process to exclude beneficiaries with refractory depression or treatment of refractory depression since there are no specific diagnosis codes available to identify refractory/treatment resistant depression. The update to remove beneficiaries with refractory depression was approved by the PQA's Quality Measure Expert Panel:

> 1) one or more prescription claim for an antipsychotic indicated for refractory depression during the measurement year. The antipsychotic medications would be based on the PQA's NDC lists; and
>
> 2) one or more prescription claim for an antidepressant during the measurement year. The antidepressant medications would be based on the PQA's NDC lists; and
>
> 3) major depression at any time during the measurement year based on the diagnosis codes provided by the PQA.

Currently, we identify beneficiaries for the denominator who have either a dementia diagnosis and/or two or more prescription claims with unique dates of service (DOS) and a total days' supply greater than 60 cumulative days for a cholinesterase inhibitor or N-methyl-D-aspartate (NMDA) receptor antagonist during the measurement year. However, in PQA's draft 2023 measure manual, PQA updates the APD measure specifications by removing the requirement for "greater than 60 cumulative days' supply" in the denominator since there is no known rationale for including this requirement in addition to the 2 or more prescription claims on different dates of service since beneficiaries can be eligible for the denominator with either prescription claims or diagnosis. Furthermore, the removal of > 60 days' cumulative supply would more accurately align the APD measure with the other PQA measures.

We tested the updated PQA measure specifications for both APD measures using 2021 PDE data with contracts with greater than 30 member-years. A total of 809 Part D contracts were included in the APD measure analysis and 418 Part D contracts for the APD-LTNH measure. With the added refractory depression exclusion, the numerator decreased for both APD measures. We found that 6.0% of beneficiaries in the APD denominator population were diagnosed with refractory depression and 10.1% of beneficiaries from the APD-LTNH denominator. For the APD measure, the mean rate for all contracts improved from 8.57% to 7.10% with the updated measure specifications. Similarly for the APD-LTNH measure, the mean rate overall improved from 7.99% to 5.96%. As a reminder, a lower rate indicates better performance for both APD measures. The tables below provide more information on the change in rates after applying the updated specifications.

Table IV-5. APD Rate Distribution for Contracts with > 30 Denominator Member-Years

	Contract Type	Percentile Distributions							
		Number of contracts	Mean	Min	p25	p50	p75	p90	Max
YOS 2021 PDE with Current Measure Specifications	All Contracts	809	8.57%	0.00%	6.09%	7.85%	10.09%	13.05%	30.75%
	MAPDs	749	8.52%	0.00%	5.93%	7.67%	10.10%	13.62%	30.75%
	MAPDs (non-MMP)	711	8.62%	0.00%	5.97%	7.72%	10.22%	13.76%	30.75%
	PDPs	60	9.19%	5.24%	8.46%	9.04%	9.93%	11.53%	12.44%
YOS 2021 PDE with Updated Measure Specifications	All Contracts	809	7.10%	0.00%	4.75%	6.22%	8.13%	11.66%	34.06%
	MAPDs	749	7.08%	0.00%	4.62%	6.05%	8.13%	11.95%	34.06%
	MAPDs (non-MMP)	711	7.15%	0.00%	4.64%	6.12%	8.17%	12.00%	34.06%
	PDPs	60	7.32%	2.33%	6.48%	7.30%	8.11%	9.15%	10.06%

Table IV-6: APD-LTNH Rate Distribution for Contracts with >30 Denominator Member-Years

	Contract Type	Percentile Distributions							
		Number of contracts	Mean	Min	p25	p50	p75	p90	Max
YOS 2021 PDE with Current Measure Specifications	All Contracts	418	7.99%	0.00%	4.95%	7.50%	10.37%	13.49%	20.67%
	MAPDs	373	7.92%	0.00%	4.69%	7.41%	10.37%	13.49%	20.67%
	MAPDs (non-MMP)	338	8.27%	0.00%	5.18%	7.87%	10.67%	14.15%	20.67%
	PDPs	45	8.57%	2.93%	6.66%	7.58%	9.70%	13.05%	17.51%

YOS 2021 PDE with Updated Measure Specifications	All Contracts	418	5.96%	0.00%	3.67%	5.44%	7.81%	10.46%	27.18%
	MAPDs	373	5.86%	0.00%	3.54%	5.30%	7.71%	10.27%	27.18%
	MAPDs (non-MMP)	338	6.09%	0.00%	3.74%	5.53%	7.95%	10.88%	27.18%
	PDPs	45	6.77%	3.03%	5.05%	5.99%	8.78%	10.65%	11.79%

Based on the results of the analysis, CMS plans to implement the updated measure specifications on the display page for the 2023 measurement year.

Initial Opioid Prescribing - Long Duration (IOP-LD) (Part D). We began reporting the IOP-LD measure in the 2023 display page (2021 measurement year). Currently, beneficiaries enrolled in hospice, with a cancer diagnosis, with a sickle cell disease diagnosis, or receiving palliative care during the measurement year or the 90 days prior to the measurement period are excluded from the measure. However, CMS will align with current PQA measure specifications, and therefore, these beneficiaries will be excluded from the measure during the measurement year or 90 days prior to the index prescription start date (IPSD), the earliest date of service for an opioid medication during the measurement year. CMS plans to update the IOP-LD measure on the display page for the 2023 measurement year.

Medication Adherence for HIV/AIDs (Antiretrovirals) (ADH-ARV)/ Antipsychotic Use in Persons with Dementia, Overall (APD)/Antipsychotic Use in Persons with Dementia, in Long-Term Nursing Home Residents (APD-LTNH)/ Use of Opioids at High Dosage in Persons without Cancer (OHD)/ Use of Opioids from Multiple Providers in Persons without Cancer (OMP)/ Initial Opioid Prescribing -Long Duration (IOP-LD) (Part D). Similar to the other Part D Patient Safety measures discussed above, CMS will align with the PQA measure specifications to use CE and no longer adjust for MYs. Currently, we do not have an exact timeline to update these display page and Patient Safety measures, but we will announce it in advance to sponsors.

Potential New Measure Concepts and Methodological Enhancements for Future Years

Health Equity (Part C and D). CMS continues to consider additional ways to advance health equity in the Part C and D programs. CMS released confidential stratified reports to Part C and D sponsors in HPMS in Spring 2022 to help contracts identify disparities in care by LIS/DE and disability status for most Part C and D Star Ratings measures. We are planning to submit the new HEDIS measure focused on Screening and Referral to Services for Social Needs to the Measures Under Consideration review process in early 2023. We are also interested in feedback on the stratified reports and additional measures or methodological enhancements to the Star Ratings that would continue to advance health equity. We proposed a health equity index reward in the 2024 Part C and D proposed rule and encourage readers to submit comments on the health equity index proposal through the process outlined in the proposed rule (87 FR 79626-79632).

Chronic Pain Assessment and Follow-up (Part C). NCQA is exploring a new measure for measurement year 2025 that would assess chronic pain and follow-up in Medicare enrollees age 65 and older. They are currently proposing two indicators for this measure. The first indicator would assess if enrollees with chronic pain received a multidimensional pain assessment, and the second indicator would assess if some type of follow-up was received among enrollees who tested positive for pain on the multidimensional assessment. We welcome feedback on this potential measure.

Cross-Cutting: Sexual Orientation and Gender Identity for HEDIS Measures (Part C). NCQA is evaluating approaches to update applicable HEDIS measure specifications where eligible populations are currently defined with gendered language to ensure inclusive and gender-affirming approaches aligned with measure intent. Any potential changes to HEDIS measures, such as Breast Cancer Screening, would be considered for measurement year 2024 or beyond. These potential updates for measurement year 2024 or beyond would be non-substantive under § 422.164(d)(1)(ii) because the changes are not expected to meaningfully impact the numerator or denominator of the affected measures.

Cross-Cutting: Identifying Chronic Conditions in HEDIS Measures (Part C). NCQA is reevaluating how to identify those with chronic conditions (e.g., diabetes, bipolar disorder, advanced illness) with the goal of updating the claims-based approach that is currently used across HEDIS measures to identify conditions by incorporating clinical data. The potential revised claims method would identify members with a condition if they have at least two encounters with the diagnosis (in any setting except lab) on different dates of service. This would be in place of the current method which has unneeded complexity by looking for at least two visits (e.g., outpatient, observation, telephone, emergency department, non-acute inpatient encounters) on different dates of service or at least one inpatient encounter or discharge with a diagnosis. These potential updates would simplify the way conditions are identified and would impact the following Star Ratings and display measures: Diabetes Care – Eye Exam, Diabetes Care - Blood Sugar Controlled, Follow-up After Emergency Department Visit for Patients with Multiple Chronic Conditions, and Kidney Health Evaluation for Patients with Diabetes. Potential updates would also apply to how advanced illness diagnoses are identified as part of the cross-cutting advanced illness and frailty exclusion. This exclusion is implemented in the following Star Ratings measures: Breast Cancer Screening, Colorectal Cancer Screening, Controlling High Blood Pressure, Diabetes Care - Eye Exam, Diabetes Care – Blood Sugar Controlled, Kidney Health Evaluation for Patients with Diabetes, Osteoporosis Management in Women Who Had a Fracture, Statin Therapy for Patients With Cardiovascular Disease. These potential updates for measurement year 2024 would be non-substantive under § 422.164(d)(1)(iv) by adding clarifications for the documentation requirements to identify enrollees with chronic conditions.

Blood Pressure Control Measures (Part C). NCQA is exploring the development of new blood pressure control measures that utilize the capabilities of digital quality measures and leverage standardized electronic clinical data. The current Controlling Blood Pressure measure included in

Part C Star Ratings assesses the percentage of members 18-85 years of age with hypertension whose blood pressure was adequately controlled (<140/90 mmHg). The numerator currently assesses if control was reached by using only the most recent blood pressure reading available. NCQA is planning to test a new approach which takes an average of blood pressure readings over time and will also explore alternative evidence-based blood pressure control thresholds (<130/80 mmHg). Their testing efforts will also inform the development of an accompanying HEDIS blood pressure control measure for patients with diabetes. The new measures are being explored for measurement year 2025 and beyond, and if implemented, would eventually replace the current HEDIS measures related to blood pressure. If new measures are introduced, NCQA would propose retirement of the existing blood pressure measures. CMS welcomes feedback on these potential new measures and possible future use as display or Star Ratings measures pending rulemaking.

Kidney Health (Part C). NCQA is exploring potential measure concepts for kidney health management related to person-centered outcomes, shared decision making, and preparedness for kidney failure for measurement year 2025 and beyond. CMS welcomes feedback on these concepts for potential use as display or Star Ratings measures in the future pending rulemaking.

Social Connection Screening and Intervention (Part C). NCQA is developing a potential new measure for measurement year 2024 that assesses the percentage of members age 65 and older who were screened using pre-specified instruments at least once during the measurement period for social isolation, loneliness, or inadequate social support and received a corresponding intervention if they screened positive. The proposed measure will have two indicators, one for social connection screening and one for social connection intervention. This measure would be reported using electronic clinical data, including data from electronic health records, registries, case management systems, and administrative claims. NCQA is considering stratifying the measure by age (65-74, 75-84, and 85+) and race/ethnicity. The potential new measure may be posted for the HEDIS public comment period in February 2023. CMS welcomes feedback on these concepts for potential use as display or Star Ratings measures in the future pending rulemaking.

Broadening the Mental Health Conditions Assessed by Health Outcomes Survey (HOS) (Part C). CMS continues to explore ways to enhance the HOS to provide MA contracts with useful and actionable feedback about their enrollee populations. For example, we are exploring whether to broaden the mental health items in the survey to ensure we have the data to assess whether enrollees with social risk factors such as low-income status are experiencing more issues with poor mental health. This effort supports CMS's focus on health equity.

The existing HOS mental health measures focus broadly on emotional problems with an emphasis on depression. While depression is a significant health problem in the Medicare population that has been linked to poor health outcomes, many older adults live with mental health conditions beyond depression. For example, 1.2% to 15% of community samples of

persons over 60 years of age show anxiety symptoms.[64] We are exploring ways to measure a broader array of mental health conditions and provide more actionable feedback and data to health plans for quality improvement. The 2-item measure of Generalized Anxiety Disorder (GAD-2) is used clinically as a way to screen anxiety disorders generally and Generalized Anxiety Disorder more specifically.[65] In combination with the Patient Health Questionnaire-2 (PHQ-2) that is currently on the HOS and is used as a screening tool for depression, the combined questions (GAD-2 and PHQ-2) make up the PHQ-4, which functions well as a general mental health screening tool. Adding the GAD-2, therefore, could widen the scope of measurement of HOS to anxiety disorders and enhance the survey's ability to screen for mental health needs.

CMS welcomes feedback on the value of adding the GAD-2 to HOS for these purposes, any unintended consequences that might come from such an addition, and alternate approaches to broadening the scope of mental health conditions assessed. We welcome feedback on whether the GAD-2 is the best focus for efforts to fill in gaps in HOS mental health measurement and enhance the ability of plans to improve in the mental health area.

Measuring Access to Mental Health Care on HOS (Part C). Since 2006, the HOS has used seven items from the Veterans RAND 12-Item Health Survey (VR-12) to calculate mental health summary scores. In addition, one HOS question from the VR-12 assesses change in emotional health compared with one year ago but is not used in the calculation of the summary scores. Two additional mental health items measure mild, moderate, or severe depression. One item assesses memory problems.

These mental health-related questions do not address access to care, but access to mental health care could be useful to measure for quality improvement. There are existing surveys that include questions to assess need for and access to mental health services. [66, 67] These questions include whether an appointment was made (or attempted) during the last 6 or 12 months, how difficult it was to make appointments, whether psychiatric medications were prescribed or other treatment conducted as soon as needed, or whether there were challenges in filling psychiatric prescriptions. These types of measures could help plans assess variation in access to mental health care.

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[64] Bryant, C., Jackson, H., & Ames, D. (2008). The prevalence of anxiety in older adults: methodological issues and a review of the literature. *Journal of Affective Disorders, 109*(3): 233-250.

[65] Kroenke, K.; Spitzer, R.L.; Williams, J.B.; Monahan, P.O.; Löwe B. (2007). Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. *Ann Intern Med*, 146:317-325.

[66] Agency for Healthcare Research and Quality (AHRQ). (2021, May). *Supplemental items for CAHPS Clinician & Group Adult Survey 3.0/3.1: Access to Mental Health Services*. https://www.ahrq.gov/cahps/surveys-guidance/item-sets/cg/suppl-mentalhealth-cg30-adult.html.

[67] Kyanko KA, Curry LA, Keene DE, et al. Does primary care fill the gap in access to specialty mental health care? A mixed methods study. *J Gen Intern Med.* 2022:1-7.

CMS welcomes input about the range of care services that might be useful to include in a mental health care access measure, what barriers to care should be considered, and whether there might be unintended consequences from asking these types of questions on the HOS.

Addressing Unmet Health-Related Social Needs on HOS (Part C). In the 2023 Advance Notice and Rate Announcement we described a new HEDIS measure focused on screening and referral to services for social needs that NCQA refers to as the Social Need Screening and Intervention (SNS-E) measure. This measure focuses on whether members were screened at least once during the measurement year. Commenters to the Advance Notice generally supported its use, but some requested CMS eventually go beyond this measure to include not just screening and referrals but also access to appropriate services.

CMS is working on developing an additional measure that would complement the SNS-E measure as we expand our work related to health equity. This new measure would be a survey-based assessment of enrollee health-related social needs, specifically housing instability, food insecurity, and transportation availability. Each question set would begin with an initial screening item. The subsequent items would assess whether the respondent has received assistance and whether a need currently exists. While the SNS-E measure aims to capture screening and assessment by the plan and its providers, we are considering potential HOS questions that would focus on enrollees' perceptions of unmet needs and of the plans' assessment and intervention. The HOS questions would also provide additional information about ongoing unmet needs even if the plan intervened.

CMS welcomes comments on the value of collecting information about unmet health-related social needs, and whether plans provided screening and referral related to those needs using the HOS instrument.

CAHPS (Part C and D).

As noted in the 2023 Advance Notice and Rate Announcement, in an effort to increase response rates for the MA and PDP CAHPS surveys, CMS tested the effects on response rates and survey scores of a web-based mode, as an addition to the current mixed mode protocol. The testing also allowed for assessment of the impact of the web mode on the current MA and PDP CAHPS survey instruments with the Agency for Healthcare Research and Quality's (AHRQ) 5.1 Health Plan Survey wording clarifications for explicit references to care received via telehealth (phone or video). Commenters to the 2023 Advance Notice overwhelmingly supported the addition of a web mode for the MA and PDP CAHPS survey as part of the mixed mode data collection protocol.

In the CAHPS field test we found that for enrollees with email addresses, the web-mail-phone protocol increased MA response rates by 4 percentage points; we found little change to response rates for PDPs as the web responses in the field test substituted for a decline in the mail responses. We believe that the availability of better email addresses across all contracts will help

improve response rates overall and may help contribute to cost savings for plans in the long run, as web responses should be less costly.

The AHRQ's 5.1 clarifications explicitly added references to in-person, phone, or video appointments to a few of the CAHPS survey items asking about health care experiences. The survey instructions already ask the respondent to think about the times they got health care in person, by phone, or by video call when completing the survey, so the modified question wording just reminds the respondent of the instructions. In the field test we did not find evidence that the 5.1 changes affect scores on the CAHPS Star Ratings measures.

We are planning to implement the web-based mode (as an addition to the current mixed mode protocol) as well as the 5.1 wording clarifications (to explicitly include telehealth or use terms appropriate to both telehealth and in-person visits) in the 2024 CAHPS survey implementation used for the 2025 Star Ratings. These changes will also be included in an upcoming OMB Paperwork Reduction Act package for the MA and PDP CAHPS surveys. We note that while the 2024 Part C and D proposed rule did propose to amend §§ 422.164(d)(1) and 423.184(d)(1) described at 87 FR 79622 to add collection of survey data through another mode of survey administration to the non-exhaustive list of non-substantive measure updates that can be made without rulemaking, that proposal is only a clarification. The current regulations permit non-substantive changes like those described in this section to be done through the Advance Notice/Rate Announcement process. As we stated in the 2024 Part C and D proposed rule, the expansion of how data are collected is non-substantive because there is no change to the information that is being collected; the only change is the way in which it is collected. The CAHPS 5.1 wording changes are also non-substantive as specified at §§ 422.164(d)(1)(iv)(C) and 423.184(d)(1)(iv)(C) because they reiterate the existing instructions when answering the questions.

Also, as noted in the 2023 Advance Notice and Rate Announcement, we tested some additional questions for potential implementation as part of the MA and PDP CAHPS survey. The new survey items capture more detail or test new approaches to topics covered in the current MA and PDP CAHPS surveys (e.g., patient-provider communication, getting test results, communication between providers), and also new topics (e.g., perceived unfair or insensitive treatment). There was support from commenters to the 2023 Advance Notice for adding questions on unfair or insensitive treatment to the survey, as long as consideration is given to survey length.

The questions on unfair treatment asked whether in the last 6 months anyone from a clinic, emergency room, or doctor's office treated the enrollee in an unfair or insensitive way because of their disability, age, culture or religion, language or accent, race or ethnicity, sex (female or male), sexual orientation, gender or gender identity, or income. While few enrollees reported experiencing unfair treatment overall, unfair treatment by health condition was most common, followed by unfair treatment by disability and age. Across MA contracts in the field test, 9.4 percent of respondents endorsed one or more reasons for being treated in an unfair or insensitive

way. This item would be new to the survey and if it were to be considered as a potential display measure for the 2025 Star Ratings year, it would need to go through the OMB Paperwork Reduction Act process before being implemented. If it were to be considered as a future Star Ratings measure, CMS would also put the potential measure through the Measures Under Consideration process, with future rulemaking used to adopt the measure for the Star Ratings program. We are interested in additional feedback from stakeholders on the potential unfair treatment measure.

We also tested modifications to the Getting Appointments and Care Quickly measure. For example, we tested a question that would replace the current question "In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?" in the existing three-item composite measure. The replacement question that did not focus on the exact amount of time waiting did not test well. As an alternative, we are considering taking out the question related to waiting more than 15 minutes, since telehealth and type of provider may influence how enrollees respond to this item. We are therefore considering reducing the Getting Appointments and Care Quickly measure to the existing two items:

- In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
- In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?

Although this change would reduce the reliability of the measure slightly, a two-item Getting Appointments and Care Quickly measure would still have high reliability with a mean reliability of 0.75.[68] We are interested in stakeholder feedback on removing this question from the Getting Appointments and Care Quickly measure starting with the 2024 survey administered for the 2025 Star Ratings. This change would be considered non-substantive as described at § 422.164(d)(1) since it would not change the population covered by this measure, the two existing questions that would continue to be included in the measure, and the intent of the measure that focuses on getting care as soon as needed.

We also tested some potential alternative questions for the current questions included in the Care Coordination measure focused on how often doctors, nurses, or health care providers explain the results of tests, how often the explanations were easy to understand, and how often the information was as much as was needed. We are conducting ongoing analysis of these questions to see whether they would fit into an updated Care Coordination measure. More information will be shared in the future as we continue to consider any potential updates to this measure. We are interested in stakeholder feedback on the existing Care Coordination measure.

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[68] See https://www.rand.org/pubs/technical_reports/TR653.html for a description of reliability and what is considered sufficient reliability to discern differences among groups.

Attachment V. Economic Information for the CY 2024 Advance Notice

Below, we provide the economic information for significant provisions in the Advance Notice. Provisions not specifically addressed below are intended to represent a continuation of the policies established for CY 2023 and, as a result, do not have an impact associated with them. We note that the information provided below is likely to change as the rates and underlying assumptions are updated; we will provide revised impact estimates in the Rate Announcement that reflect the payment methodologies being finalized and the latest data available.

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

A1. Medicare Advantage and PACE non-ESRD Ratebook

The FFS growth percentage for the 2024 MA non-ESRD rates is estimated to be 2.15 percent, and the MA growth percentage for the 2024 MA non-ESRD rates is estimated to be 1.81 percent. As a result, the effective growth rate for 2024 MA non-ESRD rates is estimated to be 2.09 percent. The MA non-ESRD ratebook impact summarized here is calculated by comparing 2024 Part C expenditures reflecting these growth rate assumptions to the expected 2024 Part C expenditures assuming the MA non-ESRD ratebook remains unchanged from that finalized for 2023. The net impact on the Medicare Trust Funds for CY 2024 is expected to be $7.3 billion. This figure accounts for the impact of the benchmark rate cap, MA rebate, and MA EGWP policies, as well as the portion of the difference between benchmarks and bids that the government retains and the portion of the program costs covered by Part B premiums.

The MA growth percentage, used to calculate the 2024 PACE non-ESRD rates as well as in development of the applicable amount used in setting MA non-ESRD rates, is estimated to be 1.81 percent. The PACE non-ESRD ratebook impact is calculated by comparing the 2024 PACE expenditures reflecting this growth rate assumption to the expected 2024 PACE expenditures assuming that the PACE non-ESRD ratebook remains unchanged from the CY 2023 PACE non-ESRD ratebook. The net impact on the Medicare Trust Funds for CY 2024 for the PACE ratebook change is expected to be $30 million. This figure accounts for the portion of the program costs covered by Part B premiums.

If we continue the adjustment to the calculation of county benchmarks in Puerto Rico for the number of beneficiaries with zero claims, then the net impact on the Medicare Trust Funds for CY 2024 of implementing the zero-claims adjustment in Puerto Rico is expected to be $280 million.

A2. Indirect Medical Education (IME) Phase Out

Section 161 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275) amended section 1853(k)(4) of the Act to require CMS to phase out indirect

medical education (IME) amounts from pre-ACA MA capitation rates, which are used to set the cap on MA benchmarks and are used as the basis for PACE non-ESRD capitation rates. Note that section 1894(d)(3) of the Act provides that the IME payment phase-out does not apply to PACE capitation rates. Section 1853(n)(2)(A)(i) and (n)(2)(F) of the Act provides that the IME phase-out is applied in developing the post-ACA MA benchmarks. Per statute, the maximum incremental IME phase-out is 0.60 percent of the FFS rate per year. We estimated the impact of the IME phase-out change between 2023 and 2024. Since the maximum IME reduction is 8.4 percent in 2023 and 9.0 percent in 2024, we calculate the impact as the difference for those counties with IME percentages of at least 8.4 percent, with the maximum impact of 0.6 percent (i.e., the difference between 8.4 and 9.0 percent). Also, since the IME reduction to MA benchmarks is increasing, the impact is considered to be a net savings to the Medicare Trust Funds.

In payment year 2024, there are no counties that have IME amounts greater than 8.4 percent of the FFS rate. Since all counties have IME amounts less than 8.4 percent of their respective FFS rates, there is no impact by the change in the IME phase-out percentage in 2024. For the ESRD ratebook, all IME amounts used for MA ESRD rates are less than 8.4 percent of the FFS rate, so there is no impact from the IME phase-out change on the ESRD ratebook for 2024.

Note that the statutorily prescribed methodology for calculating the IME phase-out in 2024 is the same as that provided by statute for CY 2023; we are providing this impact assessment for informational purposes.

A3. Medicare Advantage and PACE ESRD Ratebooks

The FFS growth percentage for the 2024 MA ESRD rates is estimated to be 2.68 percent. The impact on the MA and PACE ESRD ratebooks is calculated by comparing projected 2024 Part C expenditures with this growth rate assumption to the expected 2024 Part C expenditures with the assumption that the MA and PACE ESRD ratebooks would have been unchanged from those finalized for 2023. The net impact on the Medicare Trust Funds for CY 2024 is expected to be $550 million. This figure accounts for the portion of the program costs covered by Part B premiums.

A4. CMS-HCC Risk Adjustment Model

For CY 2024 CMS is proposing an updated Part C CMS-HCC risk adjustment model for organizations other than PACE. The CY 2024 impact on MA risk scores of the proposed Part C CMS-HCC model, is projected to be -3.12%, which represents a $11.0 billion net savings to the Medicare Trust fund in 2024. The current 2020 CMS-HCC model (2015 denominator) and the proposed 2024 CMS-HCC model (2020 denominator) have different denominator years (i.e., number of years adjusted for risk score trend). Therefore, risk scores under the models are not comparable when determining impacts due to the different number of years of risk score trend. In order to isolate the impact of the model updates, the risk score impact has been adjusted to

remove the impact of risk score trend. When estimating the impact of the proposed model, the impact takes into account the portion of the difference between benchmarks and bids that the government retains and the portion of the program costs covered by Part B premiums.

A5. ESRD Risk Adjustment Model

For CY 2024, CMS is continuing the use of the ESRD risk adjustment models implemented in CY 2023. Therefore, no economic impact is applicable.

A6. Frailty Adjustment for FIDE SNPs

For CY 2024, CMS is proposing to calculate frailty scores for FIDE SNPs using updated frailty factors associated with the proposed 2024 CMS-HCC model. To calculate impacts, CMS utilized the survey results from the 2021 HOS / HOS-M to estimate the frailty scores based on the frailty factors used for CY 2023 (associated with the 2020 CMS-HCC model) and the proposed CY 2024 frailty factors (associated with the 2024 CMS-HCC model). The CY 2024 impact of transitioning to frailty scores calculated using the updated frailty factors, relative to CY 2023, is a change in frailty scores of -15.68%, which represents a net savings of $50 million dollars to the Medicare Trust Funds in 2024. This impact takes into account the portion of the difference between benchmarks and bids that the government retains and the portion of the program costs covered by Part B premiums.

A7. MA Coding Pattern Difference Adjustment

For CY 2024, we will continue to apply the statutory minimum coding pattern difference adjustment (5.90%). There is no change in policy from CY 2023, and we applied the same factor for CY 2023, therefore the year-over-year impact is zero.

A8. Normalization

The normalization factors serve to offset the trend in risk scores and maintain a 1.0 average FFS risk score. For CY 2024, for the CMS-HCC risk adjustment models with a 2019 or 2020 denominator, CMS is proposing to calculate the normalization factors using a five-year linear slope methodology and updated average FFS risk scores for 2018 through 2022, but continuing to exclude the 2021 risk score as was done for the CY 2023 normalization factor. For the CMS-HCC risk adjustment models with a 2015 denominator and the RxHCC models, CMS is proposing to calculate the normalization factors using a five-year linear slope methodology and historical FFS risk scores (2016 through 2020). Since normalization is applied to risk scores to maintain the same average risk scores in each program year-over-year, the impact of normalization is zero.

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

B1. Part D Risk Adjustment Model

For CY 2024, we are continuing the use of the RxHCC risk adjustment model that was implemented in CY 2023. Therefore, no economic impact is applicable.

B2. Annual Percentage Increase for Part D Parameters

The methodology for updating other Part D parameters for CY 2024 remains unchanged from that used for CY 2023. As a result, updating the other Part D parameters does not have an impact on the Medicare Trust Fund alone; the impact of such parameter updates is dependent on the behavior and bid assumptions of Part D plan sponsors.

Attachment VI. CMS-HCC Risk Adjustment Factors

Table VI-1. 2024 CMS-HCC Model Relative Factors for Continuing Enrollees

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
Female								
0-34 Years		-	0.238	-	0.346	-	0.454	0.948
35-44 Years		-	0.288	-	0.332	-	0.420	0.810
45-54 Years		-	0.340	-	0.384	-	0.404	1.031
55-59 Years		-	0.385	-	0.421	-	0.424	0.949
60-64 Years		-	0.436	-	0.502	-	0.414	0.881
65-69 Years		0.330	-	0.435	-	0.365	-	1.188
70-74 Years		0.395	-	0.506	-	0.423	-	1.119
75-79 Years		0.465	-	0.596	-	0.485	-	0.965
80-84 Years		0.524	-	0.665	-	0.544	-	0.862
85-89 Years		0.624	-	0.775	-	0.618	-	0.750
90-94 Years		0.737	-	0.869	-	0.738	-	0.627
95 Years or Over		0.742	-	0.877	-	0.835	-	0.481
Male								
0-34 Years		-	0.106	-	0.191	-	0.306	0.826
35-44 Years		-	0.154	-	0.204	-	0.261	0.719
45-54 Years		-	0.215	-	0.293	-	0.300	0.991
55-59 Years		-	0.283	-	0.410	-	0.353	0.989
60-64 Years		-	0.345	-	0.504	-	0.374	0.917
65-69 Years		0.332	-	0.531	-	0.375	-	1.275
70-74 Years		0.396	-	0.626	-	0.417	-	1.224
75-79 Years		0.502	-	0.714	-	0.498	-	1.319
80-84 Years		0.571	-	0.789	-	0.565	-	1.238
85-89 Years		0.664	-	0.907	-	0.615	-	1.135
90-94 Years		0.800	-	0.993	-	0.712	-	0.946
95 Years or Over		0.896	-	1.058	-	0.904	-	0.825
Medicaid and Originally Disabled Interactions								
Originally Disabled, Female		0.228	-	0.160	-	0.103	-	-
Originally Disabled, Male		0.135	-	0.158	-	0.075	-	-

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
Medicaid		-	-	-	-	-	-	0.130
Disease Coefficients								
HCC1	HIV/AIDS	0.301	0.213	0.397	0.237	0.196	0.109	1.322
HCC2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	0.500	0.598	0.649	0.780	0.447	0.591	0.605
HCC6	Opportunistic Infections	0.381	0.763	0.588	0.833	0.518	0.685	0.728
HCC17	Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic	4.209	3.995	3.896	4.235	3.946	4.103	1.952
HCC18	Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid	2.341	2.486	2.277	2.537	2.166	2.403	1.110
HCC19	Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers	1.798	1.989	1.563	1.661	1.520	1.554	0.957
HCC20	Lung and Other Severe Cancers	1.136	0.978	1.166	1.173	1.214	1.067	0.672
HCC21	Lymphoma and Other Cancers	0.671	0.540	0.654	0.739	0.627	0.618	0.493
HCC22	Bladder, Colorectal, and Other Cancers	0.363	0.366	0.382	0.409	0.410	0.351	0.314
HCC23	Prostate, Breast, and Other Cancers and Tumors	0.186	0.233	0.196	0.218	0.203	0.237	0.197
HCC35	Pancreas Transplant Status	0.949	1.393	1.117	0.573	1.117	2.740	1.106
HCC36	Diabetes with Severe Acute Complications	0.166	0.191	0.186	0.235	0.166	0.210	0.280
HCC37	Diabetes with Chronic Complications	0.166	0.191	0.186	0.235	0.166	0.210	0.280
HCC38	Diabetes with Glycemic, Unspecified, or No Complications	0.166	0.191	0.186	0.235	0.166	0.210	0.280
HCC48	Morbid Obesity	0.186	0.144	0.300	0.178	0.164	0.118	0.442

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
HCC49	Specified Lysosomal Storage Disorders	9.256	13.778	2.833	6.399	3.269	7.771	1.528
HCC50	Amyloidosis, Porphyria, and Other Specified Metabolic Disorders	0.648	0.883	0.555	0.789	0.435	0.529	0.362
HCC51	Addison's and Cushing's Diseases, Acromegaly, and Other Specified Endocrine Disorders	0.510	0.606	0.634	0.654	0.313	0.393	0.620
HCC62	Liver Transplant Status/Complications	0.376	0.184	0.261	0.409	0.571	0.271	0.593
HCC63	Chronic Liver Failure/End-Stage Liver Disorders	0.962	1.032	1.102	1.209	0.861	1.101	0.894
HCC64	Cirrhosis of Liver	0.447	0.383	0.475	0.414	0.391	0.270	0.378
HCC65	Chronic Hepatitis	0.185	0.248	0.101	0.220	0.156	0.189	0.378
HCC68	Cholangitis and Obstruction of Bile Duct Without Gallstones	0.388	0.383	0.085	0.354	0.391	0.270	0.090
HCC77	Intestine Transplant Status/Complications	1.172	6.301	5.039	6.161	5.039	5.039	5.089
HCC78	Intestinal Obstruction/Perforation	0.326	0.534	0.382	0.548	0.478	0.688	0.380
HCC79	Chronic Pancreatitis	0.357	0.574	0.525	0.799	0.444	0.709	0.218
HCC80	Crohn's Disease (Regional Enteritis)	0.550	0.635	0.490	0.651	0.479	0.603	0.374
HCC81	Ulcerative Colitis	0.244	0.285	0.201	0.286	0.205	0.237	0.258
HCC92	Bone/Joint/Muscle/Severe Soft Tissue Infections/Necrosis	0.479	0.529	0.611	0.632	0.471	0.539	0.556
HCC93	Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders	0.617	0.470	0.439	0.384	0.405	0.288	0.297
HCC94	Systemic Lupus Erythematosus and Other Specified Systemic Connective Tissue Disorders	0.268	0.239	0.237	0.250	0.224	0.196	0.297

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
HCC107	Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero	0.457	1.449	0.610	1.939	0.303	1.569	0.692
HCC108	Sickle Cell Disorders, Except Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero; Beta Thalassemia Major	0.146	0.386	0.103	0.408	0.303	0.416	0.098
HCC109	Acquired Hemolytic, Aplastic, and Sideroblastic Anemias	1.144	1.815	1.048	1.541	1.009	1.514	0.529
HCC111	Hemophilia, Male	4.639	30.706	15.539	31.424	11.201	32.199	6.310
HCC112	Immune Thrombocytopenia and Specified Coagulation Defects and Hemorrhagic Conditions	0.450	0.640	0.460	0.634	0.574	0.708	0.516
HCC114	Common Variable and Combined Immunodeficiencies	2.262	2.598	2.016	2.670	2.137	2.789	0.691
HCC115	Specified Immunodeficiencies and White Blood Cell Disorders	0.565	0.692	0.438	0.498	0.302	0.613	0.691
HCC125	Dementia, Severe	0.341	0.296	0.438	0.367	0.401	0.345	-
HCC126	Dementia, Moderate	0.341	0.296	0.438	0.367	0.401	0.345	-
HCC127	Dementia, Mild or Unspecified	0.341	0.296	0.438	0.367	0.401	0.345	-
HCC135	Drug Use with Psychotic Complications	0.424	0.637	0.702	1.181	0.522	0.922	0.297
HCC136	Alcohol Use with Psychotic Complications	0.424	0.637	0.502	1.181	0.522	0.922	0.297
HCC137	Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications	0.424	0.365	0.502	0.471	0.394	0.348	0.297
HCC138	Drug Use Disorder, Mild, Uncomplicated, Except Cannabis	0.423	0.264	0.502	0.384	0.355	0.348	0.297

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
HCC139	Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications	0.242	0.207	0.478	0.250	0.308	0.159	-
HCC151	Schizophrenia	0.511	0.380	0.591	0.414	0.501	0.304	0.449
HCC152	Psychosis, Except Schizophrenia	0.484	0.290	0.579	0.255	0.501	0.247	0.208
HCC153	Personality Disorders; Anorexia/Bulimia Nervosa	0.396	0.290	0.420	0.255	0.464	0.232	0.199
HCC154	Bipolar Disorders without Psychosis	0.351	0.166	0.349	0.126	0.314	0.108	0.199
HCC155	Major Depression, Moderate or Severe, without Psychosis	0.299	0.166	0.316	0.126	0.269	0.108	0.199
HCC180	Quadriplegia	1.125	0.986	1.068	1.095	1.311	1.399	0.735
HCC181	Paraplegia	0.942	0.648	0.859	0.832	0.883	0.852	0.563
HCC182	Spinal Cord Disorders/Injuries	0.478	0.368	0.402	0.308	0.401	0.316	0.270
HCC190	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease, Spinal Muscular Atrophy	1.175	1.792	1.427	3.642	0.640	1.243	0.628
HCC191	Quadriplegic Cerebral Palsy	0.855	0.743	0.393	0.466	0.840	0.104	-
HCC192	Cerebral Palsy, Except Quadriplegic	0.314	0.129	-	0.067	0.220	0.104	-
HCC193	Chronic Inflammatory Demyelinating Polyneuritis and Multifocal Motor Neuropathy	1.692	1.427	0.957	0.939	1.149	0.850	0.913
HCC195	Myasthenia Gravis with (Acute) Exacerbation	2.909	3.633	2.153	3.323	2.690	1.779	1.837
HCC196	Myasthenia Gravis without (Acute) Exacerbation and Other Myoneural Disorders	0.516	0.642	0.503	0.507	0.427	0.248	0.486
HCC197	Muscular Dystrophy	0.426	0.632	0.369	0.681	0.162	0.145	0.292
HCC198	Multiple Sclerosis	0.647	0.908	0.791	1.143	0.569	0.770	0.226

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
HCC199	Parkinson and Other Degenerative Disease of Basal Ganglia	0.615	0.517	0.634	0.504	0.474	0.354	0.219
HCC200	Friedreich and Other Hereditary Ataxias; Huntington Disease	0.279	0.208	0.165	0.281	0.050	0.428	-
HCC201	Seizure Disorders and Convulsions	0.245	0.196	0.233	0.170	0.245	0.202	0.131
HCC202	Coma, Brain Compression/Anoxic Damage	0.543	0.238	0.721	0.279	0.549	0.309	0.097
HCC211	Respirator Dependence/Tracheostomy Status/Complications	0.879	0.878	1.981	1.418	1.022	0.590	1.570
HCC212	Respiratory Arrest	0.370	0.510	0.573	0.662	0.409	0.493	0.258
HCC213	Cardio-Respiratory Failure and Shock	0.370	0.510	0.573	0.662	0.409	0.493	0.258
HCC221	Heart Transplant Status/Complications	1.053	0.999	1.412	1.781	0.880	1.371	0.840
HCC222	End-Stage Heart Failure	2.505	5.770	2.927	6.612	3.009	6.106	0.826
HCC223	Heart Failure with Heart Assist Device/Artificial Heart	2.505	5.770	2.927	6.612	3.009	6.106	0.826
HCC224	Acute on Chronic Heart Failure	0.360	0.442	0.406	0.537	0.311	0.411	0.217
HCC225	Acute Heart Failure (Excludes Acute on Chronic)	0.360	0.442	0.406	0.537	0.311	0.411	0.217
HCC226	Heart Failure, Except End-Stage and Acute	0.360	0.442	0.406	0.537	0.311	0.411	0.217
HCC227	Cardiomyopathy/Myocarditis	0.189	0.200	0.173	0.198	0.145	0.186	0.189
HCC228	Acute Myocardial Infarction	0.252	0.254	0.493	0.517	0.324	0.407	0.310
HCC229	Unstable Angina and Other Acute Ischemic Heart Disease	0.240	0.254	0.325	0.458	0.278	0.315	0.310
HCC238	Specified Heart Arrhythmias	0.299	0.296	0.407	0.304	0.293	0.261	0.245
HCC248	Intracranial Hemorrhage	0.239	0.180	0.377	0.332	0.313	0.183	0.081
HCC249	Ischemic or Unspecified Stroke	0.239	0.180	0.377	0.277	0.299	0.172	0.081

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
HCC253	Hemiplegia/Hemiparesis	0.387	0.320	0.437	0.390	0.437	0.403	-
HCC254	Monoplegia, Other Paralytic Syndromes	0.321	0.172	0.292	0.365	0.290	0.335	-
HCC263	Atherosclerosis of Arteries of the Extremities with Ulceration or Gangrene	1.118	1.066	1.432	1.276	1.007	1.056	0.696
HCC264	Vascular Disease with Complications	0.455	0.520	0.498	0.461	0.513	0.622	0.338
HCC267	Deep Vein Thrombosis and Pulmonary Embolism	0.294	0.431	0.445	0.568	0.338	0.498	0.245
HCC276	Lung Transplant Status/Complications	2.531	1.583	2.210	2.292	2.961	1.277	3.085
HCC277	Cystic Fibrosis	0.998	2.818	1.340	3.760	0.650	3.829	0.873
HCC278	Idiopathic Pulmonary Fibrosis and Lung Involvement in Systemic Sclerosis	0.818	1.209	0.791	1.640	0.650	0.937	0.873
HCC279	Severe Persistent Asthma	0.818	0.842	0.594	0.808	0.650	0.804	0.873
HCC280	Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders	0.319	0.209	0.390	0.281	0.321	0.234	0.312
HCC282	Aspiration and Specified Bacterial Pneumonias	0.440	0.362	0.538	0.269	0.409	0.173	0.353
HCC283	Empyema, Lung Abscess	0.204	-	0.131	0.074	-	-	-
HCC298	Severe Diabetic Eye Disease, Retinal Vein Occlusion, and Vitreous Hemorrhage	0.336	0.364	0.323	0.319	0.327	0.301	0.545
HCC300	Exudative Macular Degeneration	0.596	0.366	0.370	0.255	0.459	0.380	0.196
HCC326	Chronic Kidney Disease, Stage 5	0.815	0.927	0.985	0.946	0.965	1.050	0.958
HCC327	Chronic Kidney Disease, Severe (Stage 4)	0.514	0.523	0.565	0.661	0.484	0.447	0.462

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
HCC328	Chronic Kidney Disease, Moderate (Stage 3B)	0.127	0.179	0.116	0.181	0.140	0.178	0.145
HCC329	Chronic Kidney Disease, Moderate (Stage 3, Except 3B)	0.127	0.179	0.116	0.181	0.140	0.178	0.145
HCC379	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	1.965	2.140	2.580	2.570	2.349	2.349	1.420
HCC380	Chronic Ulcer of Skin, Except Pressure, Through to Bone or Muscle	1.078	1.091	1.422	1.285	1.268	1.378	0.839
HCC381	Pressure Ulcer of Skin with Full Thickness Skin Loss	1.075	1.091	1.379	1.192	1.136	1.089	0.423
HCC382	Pressure Ulcer of Skin with Partial Thickness Skin Loss	0.838	0.994	1.029	0.935	0.845	0.937	0.343
HCC383	Chronic Ulcer of Skin, Except Pressure, Not Specified as Through to Bone or Muscle	0.646	0.707	0.890	0.707	0.660	0.654	0.343
HCC385	Severe Skin Burn	1.291	0.234	2.362	0.857	-	0.204	-
HCC387	Pemphigus, Pemphigoid, and Other Specified Autoimmune Skin Disorders	0.406	0.302	0.658	0.622	0.477	0.498	0.125
HCC397	Major Head Injury with Loss of Consciousness > 1 Hour	0.199	0.150	0.349	0.190	0.128	0.052	0.085
HCC398	Major Head Injury with Loss of Consciousness < 1 Hour or Unspecified	0.199	0.150	0.349	0.190	0.128	0.052	0.085
HCC399	Major Head Injury without Loss of Consciousness	0.199	0.150	0.349	0.190	0.128	0.052	0.085
HCC401	Vertebral Fractures without Spinal Cord Injury	0.522	0.605	0.622	0.559	0.538	0.412	0.231
HCC402	Hip Fracture/Dislocation	0.467	0.561	0.561	0.570	0.499	0.527	0.089
HCC405	Traumatic Amputations and Complications	0.598	0.577	0.799	0.844	0.639	0.698	0.284

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
HCC409	Amputation Status, Lower Limb/Amputation Complications	0.598	0.562	0.799	0.844	0.604	0.623	0.284
HCC454	Stem Cell, Including Bone Marrow, Transplant Status/Complications	1.068	0.452	1.326	0.608	1.338	0.416	1.596
HCC463	Artificial Openings for Feeding or Elimination	0.673	0.914	0.891	0.947	0.526	0.853	0.634
Disease Interactions								
DIABETES_HF	Diabetes*Heart Failure	0.112	0.023	0.183	0.041	0.164	0.053	0.209
HF_CHR_ LUNG	Heart Failure*Chronic Lung Disorder	0.078	0.062	0.109	0.097	0.140	0.108	0.145
HF_KIDNEY	Heart Failure*Kidney	0.176	0.314	0.194	0.420	0.140	0.328	-
CHR_LUNG_CARD _RESP_FAIL	Chronic Lung Disorder*Cardiorespiratory Failure	0.254	0.242	0.340	0.275	0.329	0.270	0.331
HF_HCC238	Heart Failure*Specified Heart Arrhythmias	0.077	0.257	0.140	0.372	0.135	0.314	-
gSubUseDisorder_ gPsych_	Substance Use Disorder*Psychiatric	-	0.087	-	0.152	-	0.149	-
Disabled/Disease Interactions								
DISABLED_ HF	Disabled, Heart Failure	-	-	-	-	-	-	0.488
DISABLED_ ULCER_	Disabled, Skin Ulcer	-	-	-	-	-	-	0.537
DISABLED_ CANCER	Disabled, Cancer	-	-	-	-	-	-	0.367
DISABLED_ NEURO_	Disabled, Neurological	-	-	-	-	-	-	0.154
DISABLED_ CHR_LUNG	Disabled, Chronic Lung Disorder	-	-	-	-	-	-	0.278
Payment HCC Counts								
D1	1 payment HCCs	-	-	-	-	-	-	-

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
D2	2 payment HCCs	-	-	-	-	-	-	-
D3	3 payment HCCs	-	-	-	-	-	-	-
D4	4 payment HCCs	-	-	-	-	-	-	-
D5	5 payment HCCs	0.050	0.088	0.049	0.095	0.016	0.105	-
D6	6 payment HCCs	0.102	0.223	0.071	0.245	0.096	0.191	-
D7	7 payment HCCs	0.188	0.380	0.160	0.472	0.207	0.435	-
D8	8 payment HCCs	0.316	0.440	0.267	0.607	0.345	0.581	-
D9	9 payment HCCs	0.444	0.750	0.353	0.841	0.345	0.823	-
D10P	10 or more payment HCCs	0.728	1.431	0.746	1.471	0.901	1.268	0.373

NOTES:

1. The denominator used is $10,402.34.
2. In the "disease interactions" and "disabled interactions," the variables are defined as follows:
   Cancer = HCCs 17-23
   Cardiorespiratory Failure = HCCs 211-213
   Chronic Lung Disorder = HCCs 276-280
   Diabetes = HCCs 35-38
   Heart Failure = HCCs 221-226
   Kidney = HCCs 326-329
   Neurological = HCCs 108-192; HCCs 195-199
   Psychiatric = HCCs 151-155
   Skin Ulcer = HCCs 379-382
   Specified Heart Arrhythmias = HCC 238
   Substance Use = HCCs 135-139

SOURCE: 2018-2019 100% Medicare data.

Table VI-2. 2024 CMS-HCC Model Relative Factors for Aged and Disabled New Enrollees

	Non-Medicaid & Non-Originally Disabled	Medicaid & Non-Originally Disabled	Non-Medicaid & Originally Disabled	Medicaid & Originally Disabled
Female				
0-34 Years	0.711	1.025	-	-
35-44 Years	0.950	1.303	-	-
45-54 Years	1.155	1.415	-	-
55-59 Years	1.152	1.289	-	-
60-64 Years	1.212	1.396	-	-
65 Years	0.532	0.986	1.212	1.599
66 Years	0.532	0.990	1.276	1.599
67 Years	0.557	1.004	1.276	1.599
68 Years	0.584	1.004	1.276	2.021
69 Years	0.625	1.004	1.276	2.021
70-74 Years	0.694	1.043	1.276	2.021
75-79 Years	0.901	1.128	1.276	2.021
80-84 Years	0.988	1.342	1.276	2.021
85-89 Years	1.287	1.563	1.287	2.021
90-94 Years	1.287	1.712	1.287	2.021
95 Years or Over	1.287	1.712	1.287	2.021
Male				
0-34 Years	0.409	0.738	-	-
35-44 Years	0.669	1.264	-	-
45-54 Years	0.906	1.420	-	-
55-59 Years	0.984	1.477	-	-
60-64 Years	1.057	1.542	-	-
65 Years	0.567	1.182	1.057	1.727
66 Years	0.576	1.234	1.155	1.959
67 Years	0.617	1.319	1.155	1.959
68 Years	0.678	1.367	1.155	1.959
69 Years	0.684	1.455	1.297	1.959
70-74 Years	0.808	1.455	1.297	1.959
75-79 Years	1.049	1.455	1.297	2.813
80-84 Years	1.245	1.503	1.297	2.813
85-89 Years	1.516	1.682	1.516	2.813
90-94 Years	1.516	1.981	1.516	2.813
95 Years or Over	1.516	1.981	1.516	2.813

NOTES:

1. The denominator used is $10,402.34.
2. For payment purposes, a new enrollee is a beneficiary who did not have 12 months of Part B eligibility in the data collection year. CMS-HCC new enrollee models are not based on diagnoses, but include factors for different age and sex combinations by Medicaid and the original reason for Medicare entitlement.

SOURCE: 2018-2019 100% Medicare data.

Table VI-3. 2024 CMS-HCC Model Relative Factors for New Enrollees in Chronic Condition Special Needs Plans (C-SNPs)

	Non-Medicaid & Non-Originally Disabled	Medicaid & Non-Originally Disabled	Non-Medicaid & Originally Disabled	Medicaid & Originally Disabled
Female				
0-34 Years	1.332	1.655	-	-
35-44 Years	1.332	1.655	-	-
45-54 Years	1.536	1.965	-	-
55-59 Years	1.536	1.989	-	-
60-64 Years	1.628	2.030	-	-
65 Years	0.900	1.285	1.708	2.085
66 Years	0.900	1.285	1.708	2.085
67 Years	0.940	1.351	1.719	2.148
68 Years	1.004	1.351	1.745	2.148
69 Years	1.020	1.467	1.755	2.233
70-74 Years	1.195	1.634	1.929	2.295
75-79 Years	1.419	1.885	2.032	2.484
80-84 Years	1.612	2.061	2.239	2.735
85-89 Years	1.833	2.250	2.239	2.735
90-94 Years	2.016	2.400	2.239	2.735
95 Years or Over	2.016	2.400	2.239	2.735
Male				
0-34 Years	1.206	1.485	-	-
35-44 Years	1.206	1.485	-	-
45-54 Years	1.472	1.845	-	-
55-59 Years	1.552	1.994	-	-
60-64 Years	1.642	2.035	-	-
65 Years	0.944	1.422	1.642	2.035
66 Years	0.944	1.422	1.659	2.150
67 Years	0.985	1.477	1.659	2.195
68 Years	1.005	1.477	1.659	2.195
69 Years	1.065	1.477	1.677	2.246
70-74 Years	1.216	1.735	1.807	2.316
75-79 Years	1.496	1.952	2.039	2.487
80-84 Years	1.704	2.194	2.155	2.573
85-89 Years	1.924	2.403	2.346	2.573
90-94 Years	2.142	2.403	2.346	2.573
95 Years or Over	2.142	2.403	2.346	2.573

NOTES:

1. The denominator used is $10,402.34.
2. For payment purposes, a new enrollee is a beneficiary who did not have 12 months of Part B eligibility in the data collection year. CMS-HCC new enrollee models are not based on diagnoses, but include factors for different age and sex combinations by Medicaid and the original reason for Medicare entitlement.

SOURCE: 2018-2019 100% Medicare data.

Table VI-4. 2024 CMS-HCC Model with Disease Hierarchies

CMS-HCC	If the Disease Group is listed in this column…	…Then drop the CMS-HCC listed in this column
	CMS-HCC Hierarchical Condition Category Label	
17	Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic	18, 19, 20, 21, 22, 23
18	Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid	19, 20, 21, 22, 23
19	Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers	20, 21, 22, 23
20	Lung and Other Severe Cancers	21, 22, 23
21	Lymphoma and Other Cancers	22, 23
22	Bladder, Colorectal, and Other Cancers	23
35	Pancreas Transplant Status	36, 37, 38
36	Diabetes with Severe Acute Complications	37, 38
37	Diabetes with Chronic Complications	38
62	Liver Transplant Status/Complications	63, 64, 65, 68
63	Chronic Liver Failure/End-Stage Liver Disorders	64, 65, 68, 202
64	Cirrhosis of Liver	65, 68
77	Intestine Transplant Status/Complications	78, 80, 81
80	Crohn's Disease (Regional Enteritis)	81
93	Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders	94
107	Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero	108
111	Hemophilia, Male	112
114	Common Variable and Combined Immunodeficiencies	115
125	Dementia, Severe	126, 127
126	Dementia, Moderate	127
135	Drug Use with Psychotic Complications	136, 137, 138, 139
136	Alcohol Use with Psychotic Complications	137, 138, 139
137	Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications	138, 139
138	Drug Use Disorder, Mild, Uncomplicated, Except Cannabis	139
151	Schizophrenia	152, 153, 154, 155
152	Psychosis, Except Schizophrenia	153, 154, 155
153	Personality Disorders; Anorexia/Bulimia Nervosa	154, 155
154	Bipolar Disorders without Psychosis	155
180	Quadriplegia	181, 182, 253, 254
181	Paraplegia	182, 254
191	Quadriplegic Cerebral Palsy	180, 181, 182, 192, 253, 254
192	Cerebral Palsy, Except Quadriplegic	180, 181, 182, 253, 254
195	Myasthenia Gravis with (Acute) Exacerbation	196
211	Respirator Dependence/Tracheostomy Status/Complications	212, 213
212	Respiratory Arrest	213

CMS-HCC	If the Disease Group is listed in this column…	…Then drop the CMS-HCC listed in this column
	CMS-HCC Hierarchical Condition Category Label	
221	Heart Transplant Status/Complications	222, 223, 224, 225, 226, 227
222	End-Stage Heart Failure	223, 224, 225, 226, 227
223	Heart Failure with Heart Assist Device/Artificial Heart	224, 225, 226, 227
224	Acute on Chronic Heart Failure	225, 226, 227
225	Acute Heart Failure (Excludes Acute on Chronic)	226, 227
226	Heart Failure, Except End-Stage and Acute	227
228	Acute Myocardial Infarction	229
248	Intracranial Hemorrhage	249
253	Hemiplegia/Hemiparesis	254
263	Atherosclerosis of Arteries of the Extremities with Ulceration or Gangrene	264, 383, 409
276	Lung Transplant Status/Complications	277, 278, 279, 280
277	Cystic Fibrosis	278, 279, 280
278	Idiopathic Pulmonary Fibrosis and Lung Involvement in Systemic Sclerosis	279, 280
279	Severe Persistent Asthma	280
282	Aspiration and Specified Bacterial Pneumonias	283
326	Chronic Kidney Disease, Stage 5	327, 328, 329
327	Chronic Kidney Disease, Severe (Stage 4)	328, 329
328	Chronic Kidney Disease, Moderate (Stage 3B)	329
379	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	380, 381, 382, 383
380	Chronic Ulcer of Skin, Except Pressure, Through to Bone or Muscle	381, 382, 383
381	Pressure Ulcer of Skin with Full Thickness Skin Loss	382, 383
382	Pressure Ulcer of Skin with Partial Thickness Skin Loss	383
397	Major Head Injury with Loss of Consciousness > 1 Hour	202, 398, 399
398	Major Head Injury with Loss of Consciousness < 1 Hour or Unspecified	202, 399
405	Traumatic Amputations and Complications	409

How Payments are Made with a Disease Hierarchy

EXAMPLE: If a beneficiary triggers HCCs 195 (Myasthenia Gravis with (Acute) Exacerbation) and 196 (Myasthenia Gravis without (Acute) Exacerbation and Other Myoneural Disorders), then HCC 196 will be dropped. In other words, payment will always be associated with the HCC in column 1 if an HCC in column 3 also occurs during the same collection period. Therefore, the organization's payment will be based on HCC 195 rather than HCC 196.