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Viewpoints on the 2023 CMS Advance Notice

On February 2, 2022, the Centers for Medicare & Medicaid Services (CMS) released the 2023 Advance Notice for Medicare Advantage (MA) and Part D plan sponsors ("health plans"). As always, these changes contain a mix of both opportunities and challenges that plans will need to assess and develop strategies to help. Most importantly, commentary about general impact can vary greatly based on specific plan circumstances. Comments on the 2023 MA and Part D Advance Notice issued on February 2 are due by Friday, March 4, 2022.

Please keep in mind that rates and other information contained in this guide are preliminary and subject to change. Final rates are expected by April 4, 2022.

On January 12, 2022, CMS released the 2023 Medicare Advantage and Part D Proposed Rule (CMS-4192-P). The proposed rule serves as a context for many of the changes noted for the Star Ratings program in the Advance Notice as well as reinforces the health equity concepts outlined in the proposed rule. Comments on the policy and technical changes published January 12 are due by March 7, 2022.

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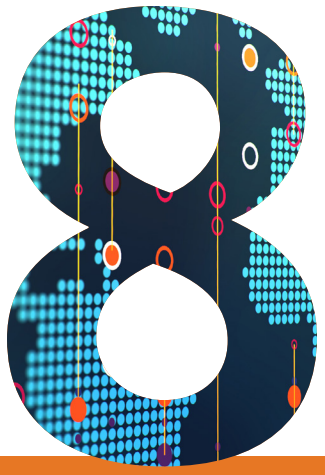

key proposed changes for 2023

1 **Accelerate shift toward driving "whole-person model of care,"** from seamless care coordination that closely aligns Medicaid and Medicare Advantage benefits and care delivery, to focused efforts on achieving health equity for complex populations such as D-SNPs and socially disadvantaged.

2 **Estimated MA and fee-for-service (FFS) effective growth rate of 4.75%.** This results in an estimated 3.94% change in national average plan payments after considering changes in risk score normalization factor. Actual results will vary significantly by county and plan.

See Part C plan payment

3 **Anticipate larger swings in county benchmarks** as a result of FFS rebasing, including 2020 data and calculation change for kidney acquisition cost (KAC) and graduate medical expense (GME) adjustments.

See Part C plan payment

4 **The key themes for the 2023 Star Ratings update are promoting health equity and eliminating health disparities in health care** as noted in "proposed new measure concepts" section. CMS is requesting stakeholder input on the proposed concepts to further engage in the rulemaking process. The rulemaking will formally introduce these concepts in Star Ratings program.

See Star Ratings program

5 CMS is proposing **updates to the RxHCC and end-stage renal disease (ESRD) risk adjustment models**.

See risk adjustment

6 **FFS normalization factors are expected to increase 0.8% for the CMS-HCC (hierarchical condition categories) model and 1% for the RxHCC model.** Normalization factors and risk adjustment models for CMS-HCC and RxHCC are not being adjusted to reflect the impact of COVID-19.

See risk adjustment

7 CMS is proposing to **decrease the Medicare Secondary Payer (MSP) revenue adjustment 21%**.

See Part C plan payment

8 Bid-to-benchmark ratios applied in the Employer Group Waiver Plans (EGWPs) payment rates proposed to **decrease from 83% to 80%**.

See Part C plan payment

Part C plan payment

Highlights of proposed changes

The 3.94% plan payment increase is a national average and does not account for all variables that affect plan payments. It reflects a 4.75% increase due to growth rate and a 0.81% decrease due to normalization factor updates. The national average plan payment increase does not reflect a CMS FFS rebasing, which will be provided with the Final Rate Announcement or impact of Star Rating changes. CMS did provide an estimate of 3.5% for plan coding trend, which would be in addition the 3.94% plan payment increase.

Plans should consider how the following may vary from the national averages:

- Potential impact of FFS rate rebasing, including county-level impacts of adding 2020 FFS data and removing 2015 data from AGA calculation; FFS repricing for the most current geographic price cost indices; Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) competitive bidding program changes; and Center for Medicare & Medicaid Innovation (CMMI) program impact:
  - Variances from average 0.54% Star Ratings change impact
  - Plan-specific coding trend
- 2022 applicable (“quartile”) percentages have been updated based on 2022 FFS per-capita rates.
- CMS United States Per Capita Costs (USPCC) projected cost estimates reflect the expected impact of COVID-19. This is an estimate of the average across all state and county codes in the country. The 4.75% effective growth rate is an expected blend of the total USPCC growth rate of 4.25% and the FFS growth rate of 4.84%. The FFS growth rate is a component of the total USPCC growth rate.

3.94% plan payment increase is a national average and does not account for all variables that affect plan payments.

Part C plan payment

- 2023 USPCC estimates relative to 2022 Final Rate Announcement estimates:
  - 2020 USPCC costs are higher than CMS original estimated. Specifically, the 2020 total USPCC is 0.2% higher and the 2020 FFS USPCC is 2%.
  - The 2021 and 2022 USPCC costs are projected to increase at a lower rate, while 2023 projections are expected to increase by more than 5%, which is double what CMS projected for 2023 in 2022.
  - GME/DGME methodology updates impact specific counties with a range of –$26.11 (or –2.4%) to +$47.39 (or +4.2%) PMPM.
  - Kidney acquisition cost methodology updates impact specific counties with a range of –$5.43 (or –0.47%) to +$14.34 (or +1.4%) PMPM.
  - AGA will be updated to incorporate 2020 actual FFS costs.
- The 2023 MSP adjustment to revenue for working aged/disabled, ESRD functioning graft beneficiaries is proposed to decrease from 0.173 to 0.136.
- The 2023 MSP adjustment to revenue for ESRD dialysis/transplant beneficiaries is proposed to decrease from 0.215 to 0.135.
- The national average for 2022 ESRD growth rate is estimated to be 5.58%, an increase from the 2022 5% ESRD growth rate.

CMS considered developing ESRD rates based on core-based statistical areas (CBSAs) to better align differences in rates between rural and urban areas. When comparing the CBSA-developed rates to the current methodology, CMS estimates MA ESRD rates in rural CBSAs would decrease 2.6% and increase 0.5% in urban CBSAs. CMS also found that rates for medically underserved areas may also decrease. Considering these findings, CMS will continue to explore possible changes to ESRD rates but is not proposing to make a change for 2023.

The basis of the EGWP payment rates is the average individual market bid-to-benchmark ratio by applicable percentage for the prior year bid submission. As a result of continued increase in competition in the individual market and expansion of supplemental benefits, the individual bid-to-benchmark has declined from 2021 to 2022 by roughly 3 percentage points from 83% to 80%, which is estimated to reduce EGWP revenue by roughly 1%.

Risk adjustment

Highlights of proposed changes

Risk scores will continue to be weighted 100% using Encounter Data System (EDS) submissions for non-PACE (Program of All-inclusive Care for the Elderly) MA plan risk score calculations.

- The MA coding pattern adjustment factor is to remain at 5.9%, consistent with 2021 (minimum statutory requirement).
- The 2020 CMS-HCC model normalization factor is to increase from 1.118 to 1.127.
- The 2017 CMS-HCC model normalization factor is to increase from 1.128 to 1.140 (applicable for PACE plans).

By all accounts, it appears CMS is proposing to ignore the impact COVID-19 has had on risk scores by excluding 2021 data in the normalization factor calculation. Employing CMS methodology to calculate the normalization factor using 2017 through 2021, the 2023 FFS normalization would be 1.059 instead of 1.127.

CMS is estimating FFS risk scores using the 2020 CMS-HCC model will **increase 7.2% from 2021 to 2023 from 1.051 to 1.127.**

Risk adjustment

Year	2020 CMS-HCC Model (Actual)	CMS projected using 2016–2020 linear slope	Projected using 2017–2021 linear slope
2015	1.000		
2016	1.019		
2017	1.030		
2018	1.048		
2019	1.063		
2020	1.078		
2021	1.051	1.094	1.044
2022		1.111	1.052
2023		1.127	1.059

Commentary on ESRD dialysis model change

- CMS is proposing updates to the ESRD risk adjustment model for MA plans and Medicare-Medicaid Plans (MMPs) to align with the Part C risk adjustment model.
  - Clinical version updated from V21 to V24
  - Model calibrated using 2018 diagnosis data to predict 2019 costs
  - Introduction of separate model segments for dual/non-dual and aged/non-aged cohorts
- The three-status structure of the ESRD model remains the same with separate model segments for dialysis, transplant and functioning graft beneficiaries.
  - Dialysis model and functioning graft model changes include LTI add-on factors, expanded dual segmentation and retention of certain V21 disease interaction variables
  - Transplant model changes are limited to data period updates
- PACE organizations will continue to use the 2019 ESRD risk adjustment model and the 2017 CMS-HCC model for non-ESRD risk scores.
- The 2020 ESRD dialysis model normalization factor is to decrease from 1.079 to 1.077.

Risk adjustment

Commentary on RxHCC model changes

In addition to calculating risk scores using 100% encounter and FFS data, CMS is proposing to recalibrate the RxHCC model.

- Clinical update so that RxHCCs are based on ICD-10-CM (Clinical Modification) diagnosis codes rather than ICD-9 codes used in the prior models.
  - Recalibrate RxHCC model, including a clinical update to the RxHCCs
  - The most recent clinical revision of the RxHCC model was implemented in calendar year (CY) 2015 and used ICD-9-CM diagnosis codes
- Update to the data years used to calibrate the model.
  - The underlying data would use 2018 FFS claims and Medicare Advantage prescription drug (MA-PD) EDS and expenditure data from 2019 Prescription Drug Event (PDE) records.
  - Reflects more current trends in utilization and spending
- The 2023 model has 84 payment RxHCCs.
  - The previous model has 76 payment RxHCCs.
  - Changes to some of the RxHCCs are due to changes in the transition from ICD-9 to ICD-10.
  - Finally, modifications were made to the assignments of underlying conditions within the RxHCCs to increase predictive accuracy.
- Renumbering RxHCCs
  - Some of the RxHCCs in the Part D risk adjustment model were renumbered.
  - CMS is to incorporate a series of gaps in the numbering of the RxHCCs between disease groups to help avoid a comprehensive renumbering due to any future model changes.
- The proposed 2023 RxHCC FFS normalization factor is to be 1.05. The 2022 RxHCC model FFS normalization factor was 1.043.
- The 2022 RxHCC model normalization factor is to increase from 1.063 to 1.073.
  - Applicable to PACE plans

Star Ratings program

Highlights of proposed changes

Key theme: Promoting health equity and eliminating health disparities in health care

2023 Star Ratings update

The following updates are from the CY 2023 Medicare Advantage and Part D Proposed Rule (CMS-4192-P), and the 2023 Advance Notice Announcement.

- Deadline is June 30, 2022, for the Complaints Tracking Module (CTM) and Independent Review Entity (IRE) data review by CMS.
- Weight of patient experience (i.e., CAHPS®), complaints and access measures are to increase from 2 to 4.
- Rheumatoid Arthritis Management (Part C) measure was retired.
- Statin Use in Persons with Diabetes measure (Part D) (SUPD) was updated as a process measure (from intermediate outcome measure) with a weight of 1.
- Controlling Blood Pressure (CBP) returns in Part C at a weight of 1.
- Cut points guardrails take effect to minimize threshold volatility.
- Three Healthcare Effectiveness Data and Information Set (HEDIS®) and Health Outcomes Survey (HOS) measures will be reported by removing:
  - 60% rule for Extreme and Uncontrollable Circumstances
  - 25% rule for affected contracts by 2020 COVID-19 public health emergency (PHE) can use higher of 2022 or 2023 Star Ratings for each measure

The key theme for the 2023 Star Ratings update is **promoting health equity and eliminating health disparities in health care**.

* CAHPS® — The acronym "CAHPS" is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

** HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Star Ratings program

2024 Star Ratings and beyond update

Non-substantive changes to Star Ratings measures

- Statin Use in Persons with Diabetes (SUPD) (Part D): Updated exclusions
- Removed Risk Adjustment Processing System (RAPS) RxHCC codes for exclusions for the following measures:
  - Medication Adherence for Diabetes Medication
  - Medication Adherence for Hypertension (RAS Antagonists)
  - Medication Adherence for Cholesterol (Statins)
  - Statin Use in Persons with Diabetes (SUPD) – Part D
- Medicare Plan Finder (MPF) Price Accuracy (Part D): Updated specifications
- Colorectal Cancer Screening and Breast Cancer Screening (Part C): Transition to electronic clinical data systems (ECDS) reporting only to align with measure steward, NCQA
- Statin Therapy for Patients with Cardiovascular Conditions (Part C): Updated specifications to include new exclusion
- Cross-Cutting: Frailty & Advanced Illness Exclusions in Various Measures (Part C): Updated specifications to align with measure steward, NCQA

Substantive changes to Star Rating measures

- Complaints about the Health/Drug Plan Parts C and D — Include category 1.30 (CMS Lead Marketing Misrepresentation: Allegation of inappropriate marketing by plan, plan representative, or agent/broker) in measure specifications
- Colorectal Cancer Screening (Part C): Include adults 45 to 49 to the measure specifications, if confirmed by the measure steward, NCQA
- Include sociodemographic status (SDS) adjustment and switch to continuous enrollment as defined by measure sponsor, Pharmacy Quality Alliance (PQA) for the following measures:
  - Medication Adherence for Diabetes Medication
  - Medication Adherence for Hypertension (RAS Antagonists)
  - Medication Adherence for Cholesterol (Statins)
  - Statin Use in Persons with Diabetes (SUPD) – Part D
- Controlling Blood Pressure (Part C): Consider replacing with new CBP measure when developed by NCQA
- Diabetes Care Measures (Part C): Consider introducing to Star Ratings when developed and released by NCQA
- Care for Older Adults (Part C): NCQA is assessing feasibility of collecting the information in digital format and consider updating Star Rating specifications per NCQA recommendation

Star Ratings program

- Adult Immunization Status (Part C): Consider using HEDIS results for influenza and pneumococcal immunizations instead of Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey

Display measures:

- Cardiac Rehabilitation (Part C)
- Physical Functioning Activities of Daily Living (PFADL) (Part C): HOS measure; increasing sample size and adjusting results to respondent characteristics such as age, education, gender, among others
- Persistence of Beta-Blocker Treatment After a Heart Attack (Part C): Update numerator specifications
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Part C): Update specifications to align with current clinical practice guidelines
- Update specifications to align PQA technical specifications for the following measures:
  - Concurrent Use of Opioids and Benzodiazepines (COB)
  - Initial Opioid Prescribing for Long Duration (IOP-LD)
  - Use of Opioids at High Dosage in Persons without Cancer (OHD)
  - Use of Opioids from Multiple Providers in Persons without Cancer (OMP) (Part D)
- Update specifications to align PQA technical specifications for the following measures:
  - Antipsychotic Use in Persons with Dementia Overall (APD)
  - Antipsychotic Use in Persons with Dementia, in Long-Term Nursing Home Residents (APD-LTNH) (Part D).

Potential new measure concepts and methodological enhancements

CMS is requesting stakeholder input on the proposed concepts to further engage in the rulemaking process. The rulemaking will formally introduce these concepts in Star Ratings program.

- Driving Health Equity (Part C and D): Potential replacement for categorical adjustment index (CAI) to drive health equity
- Stratified Reporting (Part C and D): New measures and variables to address within contract performance disparity
- Health Equity Index (Part C and D): Potential replacement for reward factor to drive health equity
- Measure of Contracts' Assessment of Beneficiary Needs (Part C): New measure to assess health-related social needs assessment completed by a contract for its beneficiaries

Star Ratings program

- Screening and Referral to Services for Social Needs (Part C): New measure under development by NCQA
- Value-based Care (Part C): New measure developed to drive care transformation through value-based contracts with providers
- Kidney Health (Part C): New measure concept from NCQA to be used for display measures
- Persistence to Basal Insulin (PST-INS) Measure (Part D): New PQA measure will be on Display page for 2024 and 2025
- Beneficiary Access and Performance Problems (Part C and D): Reintroduce as a Star Rating measure with updated specifications to include civil monetary penalties (CMPs) and sanctions
- CAHPS (Part C and D): Introduce web-based response mode based on current testing; test additional questions and new topics (e.g., language spoken at home, experience with video or phone visits and perceived discrimination)

Part D program changes

Highlights of proposed changes

- Part D benefit parameter increases consistent with changes in the annual percentage increase (API) in Part D expenditures are as follows:
  - 5.08% API for 2022 reflects a 5.81% for 2022 trend and –0.68% adjustment for prior periods
  - Deductible is increasing from $480 to $505
  - Initial coverage limit is increasing from $4,430 to $4,660
- 2023 Coordination of Benefits (COB) user fee remains at $1.05 per member per year (PMPY) and will be collected for the first nine months of the coverage year at $0.116 per member per month (PMPM) consistent with prior years.

5.08% API for 2022 reflects a 5.81% for 2022 trend and –0.68% adjustment for prior periods

Other announcements

Highlights of 2023 Medicare Advantage and Part D Proposed Rule

On January 12, 2022, CMS published the CY 2023 Medicare Advantage and Part D Proposed Rule. CMS is proposing several changes that could have a significant impact on health plan benefits, member premiums and health plan operations. The comment period for the proposed rule ends March 7, 2022. There is no indication when a Final Rule will be issued by CMS. There is no indication that the rule will be finalized to support health plans in their CY 2023 bid development. For example, the CY 2022 Final Rule for Medicare Advantage and Part D was issued on June 2, 2021. Stakeholders should work closely with CMS for guidance on how any potential impact on CY 2023 pricing should be included in the bid pricing process that is due on June 6, 2022.

Major proposal items discussed

1. Pharmacy DIR and redefining the negotiated price — CMS is proposing to redefine the negotiated price to be the lowest possible a pharmacy could receive inclusive of quality-based payments known as pharmacy direct and indirect renumeration.
2. Maximum out-of-pocket (MOOP) policy for dually eligible beneficiaries — Current guidance on the MOOP calculation allows plans to only count those amounts individual enrollees are responsible for paying, after state responsibility. The proposed rule would require health plans to attribute all member cost-sharing toward the MOOP, regardless of payer. This would result in reducing state Medicaid liability for Medicare cost-sharing and increase health plan liability for costs once the member hits the MOOP.

Other announcements

3. Marketing and communications oversight — CMS is proposing to strengthen oversight of the third-party marketing organizations to detect and prevent deceptive marketing and sales tactics.
4. Network adequacy at time of application submission — CMS is proposing health plans comply with network adequacy standards as part of the application process.
5. Star Rating calculation for three CY 2023 HEDIS measures collected through HOS data — CMS is proposing a technical change to allow them to calculate Star Ratings for HOS metrics. Without this change, CMS would be unable to calculate the 2023 Star Ratings since all contracts qualify for the extreme and uncontrollable circumstances adjustment for COVID-19.

Four things to consider for bid preparation

Financial impact may vary from plan to plan based on a combination of:

- Benchmark changes
- Risk adjustment changes
- Cost sharing and benefit design requirements
- Star Ratings
- Service-area mix

Continue to review COVID-19 impact on base period claims costs, trend and risk scores.

Review plan-specific impact of ESRD and RxHCC model changes.

Understand plan-specific impact of subpopulation changes (e.g., ESRD, MSP, etc.).

Begin to address health disparities of complex populations with a more holistic approach toward health equity and inclusivity.

Optum is here to help

Now more than ever, it's imperative that Medicare Advantage plans continue to execute effectively. They need to leverage quality, risk adjustment and cost of care if they are to produce achievable, competitive bids and provide products that reach stated goals for benefits, member premiums and margins. Integrating initiatives across each of these functions may improve results, improve the member and provider experience, and reduce program costs.

Optum is unique in its alignment and delivery of the critical combination of actuarial, care management and operational consulting expertise. In an environment where there are often more and more issues to address, we have helped our clients achieve the balanced approach they need to manage the challenges of the Medicare Advantage market.

Optum is unique in its combination of:

ACTUARIAL

CARE MANAGEMENT

OPERATIONS

TECHNOLOGY

Actuarial services and performance reporting: We have the experience and tools to assist in developing strategic bid pricing to help align with a plan sponsor's operational and strategic goals. We also offer both Parts C and D reporting tools to help plan sponsors monitor their performance during the plan year. This includes leveraging social determinants of health within analytics to understand gaps or barriers in care and help inform operational activities to advance health equity.

Risk score accuracy: We offer clinical and operational insight and delivery support to improve the accuracy and completeness of risk scores, combined with the analytics to illustrate the revenue impacts and critical path for such initiatives.

Star Ratings performance management: We offer projections, assessments, processes, dashboards and other critical components to improve Star Ratings outcomes. In addition, Optum offers consulting for member-reported measures, including CAHPS and Medicare Health Outcomes Survey (HOS).

Population health management: We have deep experience in care management and network management to minimize risk, including kidney programs aligned with these final rules.

Enabling risk-based reimbursement: We bring hands-on experience in creating transformational provider risk-sharing arrangements.

Meet our experts

Alex Balmes

Senior Director, Optum Government Programs Actuarial Services

Alex Balmes has 20 years of experience in health care, including 16 years providing actuarial services within Optum Advisory Service. His current focus is on Medicare Advantage, Medicaid and the ACA lines of business. His experience includes MA and Part D bid development, reserving, provider contracting, RA valuation, M&A management, actuarial recruiting and analytical systems development.

Rose A. Bernards, MBA

Practice Lead, Risk Adjustment, Optum Advisory Services

Rose Bernards brings over 25 years of health care experience to her role as part of Optum Advisory Services. Rose's career spans a combination of ambulatory clinic, hospital, insurance and vendor roles providing unique, integrated perspectives across the health care landscape. She currently helps support both payers and providers seeking to improve accurate and complete documentation and coding for their risk adjusted contracts across Medicare, Medicaid and commercial lines of business.

Randall Fitzpatrick, FSA, MAAA

Practice Lead, Optum Government Programs Actuarial Services

Randall Fitzpatrick provides consulting services to health insurers, Medicare Advantage organizations, MCOs and health care providers. His expertise includes pricing and filing of Medicare Advantage Part C and Part D bids, reserving, provider contract analytics and strategic market analyses for MA. He also provided actuarial services to CMS for the review and audit of its bid pricing tools.

Tejaswita Karve, PhD

Practice Lead, Star Ratings, Optum Advisory Services

Tejaswita Karve's expertise includes leveraging population health management strategies to maximize performance on quality ratings programs, specifically, on the Medicare Star Ratings program.

Tejaswita has over a decade of experience across several Fortune 100 organizations and renowned Integrated Delivery and Finance Systems. She has led the lifecycle of Star Ratings program from developing data-driven strategies, to building reporting and analytics capabilities as well as driving execution efforts. She is experienced in promoting advocacy positions with the state and federal agencies (CMS, Defense Health Agency) in support of whole-person care models and integrating social determinants of health in care delivery to help achieve better quality outcomes while delivering a seamless member experience.

Contact Optum to discuss how we can help you assess and address 2023 proposed regulatory changes.

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This document includes guidelines within our definition of the 2023 CMS Rate Announcement and other regulatory changes.

All information contained herein is provided solely as commentary and should not be misunderstood as constituting legal or compliance advice. Plans should consult their own legal and/or compliance advisors as to recommended next steps.

Sources

2023 Advance Notice: cms.gov/medicarehealth-plansmedicareadvtgspecratestatsannouncements-and-documents/2023-advance-notice

2023 Medicare Advantage and Part D Proposed Rule: federalregister.gov/documents/2022/01/12/2022-00117/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and

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