COPE HEALTH SOLUTIONS

Medicare Advantage Rule Changes for 2024

On March 31st U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), released the Calendar Year (CY) 2024 Medicare Advantage (MA) and Part D Rate Announcement that finalized payment policies for these programs. CMS will phase-in certain updates, and on average, CMS anticipates a payment increase for MA plans of 3.32% from 2023 to 2024, which is approximately a $13.8 billion increase in MA payments for next year.

CMS responded to public comments from the Advance Notice and adjusted their original proposal to have a three-year phased-in approach to the risk adjustment changes. This will reduce the initial impact of the changes and allow plans and providers more time to evaluate their positions and strategies going forward. CMS rejected other calls to scrap the changes all together or allow for a longer comment period time so that organizations could adequately evaluate the impact of these changes. Historically, CMS has allotted 60 days for comments on material changes to the risk adjustment model, as described in the SSA. Although, phasing these changes in over the next three years will allow stakeholders to see the impact of them before they are fully implemented, we believe that the changes in the final rule may create a headwind to obtaining CMS' overall goal of having 100% of Medicare beneficiaries in accountable or value-based care arrangements by 2030.

These changes to Medicare advantage will affect providers, payers, and beneficiaries in more ways than CMS has anticipated. Many providers that serve low income and high-risk beneficiaries will see significant impacts. Organizations such as ChenMed, Humana, and Centene have commented and have expressed their concerns about the truncated 30-day window to evaluate and comment on the changes to the risk adjustment model. "Humana is concerned that the proposed changes to the CMS-HCC risk adjustment model could result in unintended consequences that negatively impact the benefits available to beneficiaries enrolled in Medicare Advantage". It is projected that CMS cuts would have a disproportionate impact on seniors and individuals with disabilities living on a fixed income. A preliminary analysis from ChenMed showed that they believe revenue per beneficiaries would drop by 17% and that these changes would take away from the proactive, preventive care models that are required to serve low-income populations to provide the best quality of care.

Changes to the risk adjustment model will have serious consequences to provider groups engaged in value-based reimbursement arrangements, partciularly those serving socio-economically disadvantaged populations. The costs incurred to treat these disadvantaged populations extend beyond the scope of medical treatments to include transportation, meals, and engagement activities focused on reducing loneliness. Many of these additional benefits may become cost prohibitive when the new payment structure is implemented. Provider groups will need to weigh these decisions as they budget for the upcoming calendar year.

Pavan Patel
Manager

Andrew Smithson
Director

Dan Serrano
Principal & Senior Vice President

Allen Miller
Principal & CEO

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Providers should be mindful of how these changes will impact their organizations, and should plan ahead to develop mitigation strategies that would allow them to remain successful as these rules start to phase in. Those impacted by these changes should develop their mitigation strategies now in order to implement them prior to the rule taking effect. There are definitely mitigation options to explore, for instance a greater use of Advanced Practitioners to expand empanelment or robust clinical models to identify and treat chronic conditions, such as CHF, that are both costly and impact risk adjustment. Growth plans and expansion strategies will need to be re-evaluated.

Providers will need to work closely with their payer partners to understand the impacts to any additional benefits, such as transportation, the need for those benefits within their attributed panels, and how that will impact their patients care going forward. Although taking risk as a provider best aligns all stakeholder goals, the compressed revenues within this line of business may in some cases make that transition more challenging and providers should be well prepared to ensure success prior to engaging in value-based arrangements.

Contact info@copehealthsolutions.com for information on how we can help your organization navigate through these changes.

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If you have any questions, please contact us at info@copehealthsolutions.com or call (213) 259-0245.