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What Payers and Providers Should Know About Proposed Changes to Medicare Advantage

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On February 1st, CMS released the 2024 Medicare Advantage and Part D Advance Notice to inform Medicare Advantage organizations of proposed changes to the program. The changes that were proposed in that notice stretch far beyond just Medicare Advantage organizations (MAOs). Providers serving Medicare Advantage members in value-based arrangements will also be impacted and in many cases the impact to these providers would be significantly more impactful. Here's what MAOs and providers need to know about the proposed changes.

CMS intends to revise the risk adjustment model that is used to adjust capitation payments to reflect the burden of illness in the members that have selected their health plan. The proposal intends to remove nearly 23% of the diagnosis codes that are used in the current risk adjustment methodology and to constrain the coefficients across certain HCC categories so that the same coefficient is applied to risk adjustment factor regardless of the severity of the HCC category. CMS also proposes these changes be applied to the payments to MAOs starting in 2024, meaning the new model would be implemented retro-actively to apply for diagnoses identified starting this year. The reason given for these changes is predicated on a flawed assessment by CMS that analyzed the variation in coding between FFS Traditional Medicare and Medicare Advantage and the application of "Principle 10" of the risk adjustment model development. Principle 10 relates to the exclusion of codes that have discretionary coding variations and codes that are not credible cost predictors.

In the advance notice, CMS estimates that these changes will result in $11 billion in savings for the Medicare trust fund for 2024, or a -3.12% impact to the revenues of MAOs. The negative impact to MAO is diluted across their network of providers that have their own variations in coding specificity and overall outcomes for members. . The providers that assume risk with the health plans and provide more active management of their patients' care will likely be impacted the most. These are the providers driving preventive services to identify these conditions earlier while they are more easily treatable and documenting the conditions to allow for enhanced analytics and improved outcomes.

It is worth noting that CMS' interpretation of their assessment used to make these proposed changes mistakes correlation for causation. There are many explanations for the variation in coding between traditional Medicare and Medicare Advantage. One of those reasons lies in the higher prevalence of people disadvantaged by health inequities selecting Medicare Advantage plans and these individuals will be adversely impacted if this proposal were to go into effect. It is also worth noting that CMS relied heavily on Principle 10 of the risk adjustment model development, however their proposed changes are contradictory to other principles of the same document; specifically Principle 5, which relates to the encouragement of more specific coding.

The advance notice is intended to inform plans of the changes CMS intends to make to the Medicare Advantage program as it works through the bid process and to allow for public comments in response to the proposal. Plans, providers and Medicare recipients should take advantage of this opportunity to comment on this materially adverse impact this proposal would inevitably cause and to explain this issue to elected representatives.

Plans and providers in Medicare Advantage risk arrangements also need to develop a strategy in the event CMS moves forward with the proposed changes. . Other health plan mitigation strategies may include evaluating network configurations and designing narrow networks that drive efficiency and of course may leave more providers out and potentially reduce access for beneficiaries. An evaluation of contracts might be warranted as well and some plans may eliminate contracts that are lower performing.

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There are other changes listed in the advance notice that have a lesser effect on the program as a whole. Some of these proposed changes are beneficial and should be recognized when making public comments to CMS. These changes are inclusive of the expansion of the Part D Low Income Subsidy from 135% of the federal poverty line (FPL) to 150% and further integrating Health Equity metrics into the Star Rating methodology. CMS should take a holistic look at their proposal and assess how the potential outcomes are misaligned to their mission.

We strongly suggest that instead of completely recategorizing the CMS-HCC model, CMS should aim to expand upon the existing version with the addition of categories that are related to the SDoH ICD-10 codes. The ingestion of that data is an important quality aspect as reflected in the Stars methodology aimed at quality but the impact and variation of different SDoH factors should also be reflected in the risk adjustment methodology. That would serve to better predict future costs and create a greater incentive for providers and plans to capture that data and take steps to address the barriers their members and patients face in receiving equitable health outcomes. Changes to the model should allow 60 days for organizations to assess and publicly comment on such changes and those changes should follow the three-year phased-in implementation as per past model changes.

For more information regarding Medicare Advantage, please contact info@copehealthsolutions.com.

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