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2021 Medicare Advantage

Summary of Advance Rate Notice Part II and Related Memos

February 12, 2020

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Executive Summary

On February 5, 2020, CMS released the 2021 Advance Notice Part II. Shortly thereafter, three memos were released through HPMS covering key information needed for bidding that traditionally had been addressed in the proposed Call Letter. The documents and comment deadlines are as follows:

- Advance Notice, Part II - March 6, 2020.
- Contract Year 2021 Part C Benefits Review and Evaluation – March 9, 2020
- Contract Year 2021 Final Part D Bidding Instructions – N/A (Final)
- CY 2021 Medicare Parts C and D Annual Calendar – N/A

It is important to note that the Department of Health and Human Services also released a proposed rule detailing changes to the Parts C and D programs on February 5, 2020. The comment deadline for this Proposed Rule is April 6, 2020. This Wakely summary does not address the Proposed Rule; although, we will address it in a separate summary.

The CY 2021 fee-for-service (FFS) growth rate, which is the major driver of Part C benchmark rates, is 2.57%. This is 189 basis points lower than the December 3, 2019 estimate in the CMS early preview of growth rates.

As noted in Part I of the Advance Notice, released January 6, 2020, CMS plans to continue using the same Parts C and D risk adjustment models used for CY 2020 for CY 2021. The weights on the RAPS and EDS models will be 25% and 75%, respectively for CY 2021 (compared with 50%/50% in CY 2020), which is consistent with CMS published schedules in prior years. CMS estimates that the impact of the change in the weighting of RAPS- and EDS-based scores on average Part C risk scores nationwide is small at +0.25%; however, the impact can vary substantially by plan. The comparable CMS nationwide estimate for Part D risk scores is 0%. Medicare Advantage Organizations (MAOs) can see their plan-specific impact by downloading risk scores in HPMS; although, this data has not been updated from 2016 diagnoses.

CMS is continuing to observe a significant increase in Part C FFS risk scores. The proposed CY 2021 FFS normalization factors are 1.106/1.097 for RAPS and the EDS models, respectively. The RAPS FFS normalization factor was 1.075 for CY 2020, which implies a reduction in RAPS risk scores of 2.8%, assuming no trend in MAO coding. Similarly, the EDS normalization factor for CY 2020 was 1.069, which implies a reduction in EDS risk scores of 2.6%, assuming no trend in MAO coding.

Following is a brief summary of the key changes and proposals in the 2021 Notice:

Part C Payment Methodology

- The non-ESRD FFS growth rate percentage for CY 2021 is 2.57%. The comparable MA growth rate is 4.52%, which is used to derive pre-ACA benchmark rates.

Risk Scores

- CMS is not changing the existing RAPS-based 2017 HCC model and 2020 EDS HCC Payment Condition model. The blend is 25%/75% 2017 HCC/2020 Payment Condition model.
- The FFS Normalization factors for CY 2021 are 1.106 and 1.097 for the 2017 HCC and 2020 Payment Condition models, respectively.
- CMS is proposing to maintain the 2020 RxHCC model for CY 2021. The RxHCC FFS normalization factor is proposed to be 1.063. The CY 2020 normalization factor was 1.043.
- The coding pattern adjustment is set at the statutory minimum of 5.90%, which represents no change compared with PY2019 and CY 2020.

EGWPs

- Plans will not need to file EGWP bid pricing tools (BPTs) for as was the case in CY.
- CMS proposes to continue calculating separate HMO and PPO bid-to-benchmark ratios based on individual plan data and then re-weighted with EGWP enrollment.

Part C Benefit Changes

- Cost sharing standards were updated for MA and PD benefits. Because ESRD beneficiaries will be allowed to proactively join MA plans beginning in 2021 (as required by the 21st Century Cures Act), CMS altered the calculations for determining the mandatory MOOP amount for 2021, as well as the maximum cost sharing requirements for inpatient acute and Skilled Nursing facility services. The mandatory MOOP for 2021 will be $7,550, which is a significant increase over the 2020 value of $6,700.
- Part D parameters were updated, including small increases to the deductible, initial coverage limit, and true out-of-pocket threshold.

TBC Thresholds

- The Total Beneficiary Cost (TBC) threshold is proposed to increase by $1.00 to $37.00 for 2021. The increase is due to changes in policy related to ESRD enrollment, and the related increased mandatory MOOP amount.
- Benefits and cost sharing reductions offered as part of Part C uniformity flexibility or the VBID model will be excluded from the TBC calculation.

Star Rating Changes

- CMS will continue its policy regarding extreme and uncontrollable events with regard to 2021 star ratings. Only one natural disaster in 2019 qualified for the Star Rating extreme and uncontrollable circumstances policy adjustments for the 2021 Star Rating Year, and this was the December 2019 earthquakes in Puerto Rico. This will impact 16 counties in Puerto Rico.
- Looking ahead to star ratings for 2022 and beyond, there are two substantive change proposed:
    1. CMS will no longer allow the consideration of cognitive status, ambulation status, hearing, vision and speech, or other functional independence as acceptable for a functional status assessment under the "Caring for Older Adults" measure.
    2. For the Medication Adherence Measures (Part D), CMS is proposing to adopt the Pharmacy Quality Alliance (PQA) recommendation to risk adjust Hypertension, Diabetes, and Cholesterol components of the medication adherence measures for age, gender, low-income status, and disability status.

Part D – Preferred Specialty Tier

- The Final Part D bidding guidance memo notes that the Parts C and D Proposed Rule proposes to allow a second, "preferred" formulary tier for specialty drugs. .

Overall MA Payment Impact

Wakely estimates that, on average, 2021 Part C standardized benchmarks will increase 3.13% over 2020 nationwide. This reflects the impact of the growth rate, change in star ratings, changes to applicable percentages (i.e. quartile rankings), and the removal of kidney acquisition costs by county, which is new for 2021. We also estimate that the change in CMS revenue for 2021 versus 2020 is expected to be +0.96%. This takes into account changes in Part C risk scores, including the FFS normalization factor, MA Coding Pattern adjustment, and estimated average rebate.

Plans should be aware that the changes in the benchmarks can be considerably different (and typically are greater in magnitude) than the change in CMS revenue to the plan. Plans are paid 100% of their Part C basic bid (assuming they bid below the benchmark), which is unaffected by the benchmark for most plans, plus a percentage of the remaining difference of the excess of the benchmark above the bid. Therefore, a reduction in the benchmark will impact plans differently based on the disparity of the plan's bid compared to the benchmark (i.e. the "savings") and the star-based percentage of the savings retained by the plan (i.e. Part C "rebate").

Our analysis of county specific benchmarks and plan revenue was aggregated using November 2019 CMS published MA enrollment and star ratings for payment year 2021.

Details regarding our calculations and assumptions are provided in Appendix A at the end of this summary.

The remainder of this summary includes many details discussed at length in the Notice.

Attachment I: Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for CY 2021

Section A. MA Growth Percentage

The preliminary estimate of the CY 2021 MA USPCC growth rates is +4.52% (last year the rate was +5.79%). This represents a reduction from the Early Preview (December 3, 2019) estimate of +5.28%.

Section B. FFS Growth Percentage

The non-ESRD fee-for-service growth rate is estimated at +2.57% (last year's growth rate was +5.58%), which is 189 basis points lower than the +4.46% estimate in the December 3, 2019 Early Preview of Growth Rates. In the February 7, 2020 CMS Stakeholder call, OACT indicated that the causes of this decrease were as follows:

- Re-classification of ESRD costs in Part A, and bad debt: -30 basis points (bps)
- Increase in 2018 FFS enrollment (but no change in expenditures): -70 bps
- Additional run-out: -89 bps (implied)

OACT stated that the FFS growth rate is not impacted by the fact that Medicare Advantage Organizations (MAOs) will no longer be responsible for organ acquisition costs for kidney transplants beginning in 2021 (discussed further in the summary of Attachment II).

Wakely estimates that the nationwide average change in blended standardized (non-risk adjusted) MA Benchmarks from 2020 to 2021 will be 3.13% and the nationwide average change in average plan revenue to be 0.96%. It is important to note that this does not assume any change in risk scores from 2020 to 2021. See Appendix A at the end of this summary for additional detail.

As has been the case in past years, the change in benchmarks can vary significantly depending on geographic area, plan star rating and applicable percentage. For 2021, a new source of variation by county is the removal of organ acquisition costs. The impact varies significantly by county, ranging from no change (several counties) to -4.3% (Trujillo Alto, Puerto Rico).

The table below shows the top five and bottom five growth rates by State (these changes include changes due to star rating, double bonus status, applicable percentage, benchmark cap, and kidney acquisition costs).

Table 1: States with Highest and Lowest Benchmark Change (Wakely estimates)

Rank	State	Change
1	AL	6.1%
2	NJ	5.4%
3	OH	5.1%
4	NE	5.0%
5	CT	4.7%
47	OR	1.8%
48	HI	1.7%
49	DC	1.6%
50	TX	1.6%
51	PR	1.1%

Attachment II: Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2021

Section A. MA Benchmark, Quality Bonus Payments and Rebate

CMS intends to rebase county FFS rates in 2021 (which is the basis of the "Specified Amount").

County benchmark rates are capped at the Applicable Amount (defined below). CMS interprets that the comparison occurs after the Quality Bonus Payment Percentage ("QBP") has been included. As in prior years' notices, CMS states that they share stakeholder concerns about a rate-setting mechanism (i.e. the benchmark cap) that diminishes incentives for MA plans to continuously improve the care provided to Medicare beneficiaries.

Below are the key components of the Part C benchmark calculation:

- **2021 "Applicable Amount" (pre-ACA amount)**: The greater of a county's 2020 FFS cost and the 2020 Applicable Amount increased by the 2021 National Per Capita MA Growth Percentage of 4.52%.
- **2021 "Specified Amount" (FFS benchmark)**: 2021 FFS Cost less IME phase-out less kidney acquisition costs multiplied by the "Applicable Percentage" plus the QBP

- **"Applicable Percentage"** varies by county and is based on the county's rank of 2020 per capita FFS rate, assigned by quartiles per below:

Table 2: FFS Quartile Assignment

Quartile	Applicable Percentage
4th (highest)	95.0%
3rd	100.0%
2nd	107.5%
1st (lowest)	115.0%

If a county's quartile changed from last year, the Applicable Percentage is the average of the current and prior year's applicable percentage. Note that applicable percentages for 2022 county rates will use 2021 rankings, which will include the new adjustment for kidney acquisition costs.

- **Quality Bonus Percentage (QBP), or "applicable % quality increase":** The QBP is 5% for 4, 4.5 and 5 star MAOs, and is 0% for plans with a star rating below 4. For new plans under a new parent and low enrollment plans, a 3.5% QBP applies. Plans that are new under an existing parent receive an enrollment weighted average of the existing contracts under that parent.

For consolidations of two or more contracts of the same plan type and legal entity approved on or after January 1, 2019, the QBP rating for the first year following consolidation is determined by the enrollment weighted average of what would have been the QBPs of both contracts using November enrollment from the year the Star Ratings were released. *Example:* for two contracts consolidating for January 2021, the 2021 QBP rating is based on 2020 Star Ratings released in 2019, using November 2019 enrollment of the two contracts.

Double QBP percentages are awarded to "qualifying plans" located in qualifying or "double bonus" counties. Double bonus counties must:

1. Have a population of over 250,000 (as of 2004).
2. Have at least 25% of MA-eligible beneficiaries enrolled in MA plans (as of December 2009).
3. Have 2021 per capita FFS spending lower than the national average.

The final 2021 rate notice will contain a list of all double bonus counties, as the third criterion above is not yet known.

- **Rebates**. Rebate levels are based on plan Star Ratings as follows:

Table 3: MA Rebate Percentages

Star Rating	2020
4.5+ Stars	70%
3.5 to < 4.5 Stars	65%
< 3.5 Stars	50%

The percentage is applied to the amount by which the risk-adjusted service area benchmark exceeds the risk-adjusted bid. New plans are treated as having 3.5 Stars; CMS intends to treat low enrollment plans the same way.

Section B. Calculation of Fee for Service Cost

2021 FFS County Cost = [FFS USPCC] x [County-level Geographic Index aka AGA]

- With the Advance Notice, CMS is releasing county-level 2018 FFS cost data used to develop 2021 rates:

  https://www.cms.gov/Medicare/Health-Plans/ MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html

AGA Development Overview:

- A five-year average of FFS costs from 2014 to 2018 is initially calculated (last year was 2013 to 2017), and is then adjusted.
- Costs for Hospice services and Cost plans are excluded.
- CMS will re-price 2014 to 2018 to the most current wage and geographic practice cost indices and adjust historical FFS claims for legislative changes.
- Adjustments are made for shared savings and losses from programs like the MSSP, Pioneer, and NextGen ACO programs
- GME and IME costs are removed.
- Counties with less than 1,000 members are blended with other counties in the market area for credibility.
- Adjustments are made for beneficiaries in Veteran Affairs and/or the Department of Defense health programs.

After the AGA has been applied, the following additional adjustments apply:

- CMS is considering whether to apply an adjustment to Puerto Rico FFS costs to reflect Puerto Rico's high proportion of zero-claimant members versus the national average. Such an adjustment has been applied in prior years. Puerto Rico data only includes beneficiaries with Part A & B for all five years of the base period. (Puerto Ricans are not auto-enrolled into Part B, they must opt in).

- VA and DoD adjustments for those dually enrolled in VA and/or the DoD health programs.

- Organ acquisition costs for kidney transplants. This adjustment is new for 2021 and was prompted by the 21st Century Cures Act. It does not apply to PACE organizations. A carve-out ratio is applied to FFS costs by taking estimated "pass-through" kidney acquisition costs divided by the five-year average Parts A and B FFS costs in the county (or state for ESRD rates).

Section C. IME Phase Out

IME is being phased out from MA capitation rates. For 2021, CMS will first calculate FFS rates including IME. The maximum reduction for any county in 2020 is 7.2% of the FFS rate. As in prior years, CMS will publish rates with and without the 2020 IME reduction.

Section D. ESRD Rates

ESRD Rates = [2014-2018 FFS ESRD dialysis USPCC] x [trend to 2021] x [State AGA] x [GME and IME removal factor] x [kidney acquisition cost removal factor].

- State AGA is the weighted average of state ESRD FFS dialysis costs for 2014 to 2018 divided by the national average for the same timeframe normalized for risk score.

- CMS proposes to reprice historical inpatient, outpatient and SNF claims for 2014 to 2018 to reflect the most recent wage indices (in this case FY2020), and reprice physician claims with the most recent Geographic Practice Cost Indices (CY 2020). This is a continuation of an enhancement introduced last year.

- CMS is also proposing to reprice ESRD PPS dialysis claims for 2014 to 2018 (2014 is the first year the dialysis PPS was fully phased in).

- ESRD state rates for PACE plans will include kidney acquisition costs.

Section E. Location of Network Areas for PFFS Plans in Plan Year 2022

Non-employer MA PFFS plans offered in a network area must meet certain access standards. Network area is defined as an area that the Secretary identifies as having at least two network-based plans. CMS will include the list of network areas for plan year 2022 in the Final Announcement. CMS will use January 1, 2020 enrollment data to identify the location of network areas for plan year 2022. The list of network areas for plan year 2021 was published in the April 1, 2019 Final Announcement for CY 2020.

Section F. MA Employer Group Waiver Plans

For 2021, CMS intends to continue to waive bid pricing tool requirements.

CMS is also proposing to continue the payment methodology implemented for MA EGWPs finalized in the 2020 Rate Announcement.

The steps of the EGWP payment rate calculations are outlined below:

- The bid to benchmark (B2B) ratio **within each quartile** is calculated as follows using February 2020 individual market MA enrollment for weighting:

$$\text{2020 individual market B2B ratio} = \frac{\text{Weighted avg of ISAR adjusted 2020}}{\text{Weighted avg of county standardized benchmarks}}$$

ISAR = Intra-Service Area Rate Adjustment

- The 2020 individual market B2B ratios will be calculated separately for HMO plan types and PPO plan types by quartile.
- B2Bs for PPOs and HMOs will be weighted by the total proportion of EGWP PPO and HMO plan type enrollment, respectively, to result in the final B2B ratios for 2021 by quartile.
- The EGWP Part C Base payment rate is calculated as follows, with the MA county benchmark reflecting the published 5.0%, 3.5%, and 0.0% bonus county rate book rates (vary based on star rating, including adjustments for qualifying double bonus counties):

*EGWP Base Rate = B2B Ratio for Applicable Quartile * MA County Benchmark*

EGWP Rebate Rate = Rebate % × (MA County Benchmark - EGWP Base Rate)

EGWP Total Payment = (EGWP Base Rate + EGWP Rebate Rate) × Risk Score

Regional PPO (RPPO) EGWP rates will be derived as follows:

RPPO EGWP Base Rate = B2B Ratio × 2021 Monthly Capitation Rate

RPPO EGWP Regional Rebate = (1-B2B Ratio) × 2021 Regional Rate × Rebate %

Regional PPO EGWP Total Payment = (RPPO Base Rate + Regional Rebate Rate) × Risk Score

- For 2021, CMS is proposing to continue to allow MA EGWPs to use a portion of Part C payment to buy down enrollee Part B premium.
- CMS is proposing to collect Part B premium buy-down amounts in the EGWP PBP submission.
- EGWPs that choose to use a portion of their payment to buy-down Part B premium will have that amount reduced from their capitated payment.
- Similarly, the Part B buy-down amount cannot vary among beneficiaries within a plan, and is subject to the same maximum Part B buy-down amount as non-EGWP plans.

Section G. CMS-HCC Risk Adjustment Model for CY 2021

CMS is proposing to continue using the 2020 CMS-HCC model to calculate encounter data-based risk scores and the 2017 CMS-HCC model to calculate RAPS-based risk scores, weighting the two models by 75%/25%, respectively. CMS published for public comment the proposed Part C risk adjustment model in Part I of the Advance Notice, released January 6, 2020. Comments will be accepted until March 6, 2020 and the comments will be addressed in the 2021 Rate Announcement.

Section H. ESRD Risk Adjustment Models for CY 2021

CMS is proposing continued use of the ESRD risk adjustment models applied in 2020. CMS is proposing that for CY 2021, 75% of the risk scores for beneficiaries in ESRD status will be calculated with the 2020 ESRD models (using diagnoses from encounter data, RAPS inpatient records, and FFS) and 25% of the risk scores will be calculated with the 2019 ESRD models (using diagnoses from RAPS and FFS).

Section I. Frailty Adjustment for PACE Organizations and FIDE SNPs

For FIDE SNPs in CY 2021, CMS will continue to use the CY 2020 frailty factors for the 2017 CMS-HCC model. CMS will also continue to use the CY 2020 frailty factors for the 2020 CMS-HCC model. CMS is proposing to blend the frailty scores calculated with the 2020 CMS-HCC

model at 75% with the frailty scores calculated with the 2017 CMS-HCC model at 25%. The blended frailty score will be compared with the PACE level of frailty in the same manner as CY 2020 to determine whether that FIDE SNP has a similar average level of frailty as PACE.

For PACE organizations, CMS is proposing to continue use of the 2017 CMS-HCC model to calculate risk scores used to pay for Part A and B services in CY 2021, as noted in Part I of the 2021 Advance Notice. CMS will use the frailty factors associated with the 2017 CMS-HCC model to calculate frailty scores for PACE organizations in CY 2021.

Table 4: Frailty Factors Associated with the 2017 CMS-HCC Model

Activities of Daily Living (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

Table 5: Frailty Factors Associated with the 2020 CMS-HCC Model

Activities of Daily Living (ADL)	Non-Medicaid	Medicaid
0	-0.078	-0.134
1-2	0.161	0.025
3-4	0.293	0.155
5-6	0.293	0.370

Section J. Medicare Advantage Coding Pattern Adjustment

CMS is proposing the coding pattern adjustment for CY 2021 is the statutory minimum of 5.90%. This is the same adjustment used for CY 2020.

Section K. Normalization Factors

CMS is proposing the following normalization factors for CY 2021:

Table 6: CY 2021 Normalization Factors

Model	2020 Payment Year	Proposed 2021 Payment Year	Year-to-Year Impact
2017 CMS-HCC Model	1.075	1.106	-2.80%
2020 CMS-HCC Model	1.069	1.097	-2.55%
Blended 25% 2017 Model /75% 2020 Model (illustration of approximate impact)	1.071	1.099	-2.62%
PACE	1.075	1.106	-2.80%
ESRD Dialysis	1.059	1.079	-1.85%
ESRD Functioning Graft	1.084	1.118	-3.04%
2020 RxHCC model	1.043	1.063	-1.88%

For CY 2021, CMS is proposing to maintain the same linear slope projection method as was used in CY 2020 to calculate the normalization factors. CMS acknowledges that the normalization factor has been increasing at a faster rate in recent years. They believe this is due to changes in demographics, the reported health status of the Original Medicare population, and the implementation of ICD-10. CMS expects the ICD-10 effects to stabilize going forward, but expects that demographic trends, an incentive to report diagnosis codes more completely in alternative payment models, and a changing case mix in Original Medicare may continue to put upward pressure on Original Medicare risk scores.

Section L. Medical Loss Ratio Credibility Adjustment

CMS proposes the credibility factors as published in the *Medicare Program; Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs Final Rule* (78 FR 31284, 31295-96). Comments on the proposed credibility factors are being accepted until April 6, 2020. The proposed credibility factors for use in the credibility adjustment to the Medical Loss Ratios of certain contracts with relatively low enrollment are as follows:

Table 7: Base Credibility Factors for MA Contracts

Member Months	Base Credibility Factor (additional percentage points)
<2,400	N/A (Non-credible)
2,400	8.4
6,000	5.3
12,000	3.7
24,000	2.6
60,000	1.7
120,000	1.2
180,000	1.0
>180,000	0.0 (fully credible)

Table 8: Base Credibility Factors for Part D Contracts

Member Months	Base Credibility Factor (additional percentage points)
<4,800	N/A (Non-credible)
4,800	8.4
12,000	5.3
24,000	3.7
48,000	2.6
120,000	1.7
240,000	1.2
360,000	1.0
>360,000	0.0 (fully credible)

These proposed factors are unchanged as compared with the current MLR rule.

In the CY 2021 proposed rule, CMS also proposed to include an additional adjustment factor for MA Medical Savings Account (MSA) contracts that receive an MLR credibility adjustment. The proposed deductible factor would serve as a multiplier on the applicable credibility adjustment and will recognize that the variability of claims experience is greater under health insurance

policies with higher deductibles than under policies with lower deductibles. The proposed deductible factors are the same factors that apply under the commercial MLR regulations.

Section M. Encounter Data as a Diagnosis Source for CY 2021

CMS is proposing the following EDS/RAPS mix:

- 75% EDS (supplemented with RAPS inpatient data) and FFS.
- 25% RAPS and FFS.
- EDS Part C risk scores will be calculated with the 2020 CMS-HCC model, while ESRD dialysis and functioning graft risk scores will be calculated using the 2020 ESRD models.
- RAPS Part C risk scores will be calculated with the 2017 CMS-HCC model, while ESRD dialysis and functioning graft risk scores will be calculated using the 2019 ESRD model.

For PACE organizations for CY 2021, CMS proposes to continue using the 2017 CMS-HCC model to calculate risk scores for non-ESRD aged/disabled participants and the 2019 ESRD models to calculate risk scores for participants with ESRD. CMS proposes to continue calculating risk scores by pooling risk adjustment-eligible diagnoses from encounter data, RAPS data, and FFS claims to calculate a single risk score (with no weighting).

Attachment III: Changes in the Payment Methodology for Medicare Part D for CY 2021

Section A. RxHCC Model

CMS will continue to use the 2020 RxHCC model for 2021.

Section B. Encounter Data as a Diagnosis Source for 2021

Consistent with the approach used for CY 2020, CMS proposes calculation of CY 2021 risk score based on diagnoses with CY 2020 dates of service from two separate data sources:

1. Risk Adjustment Processing System (RAPS) and Fee-for-Service (FFS) data
2. Encounter Data System (EDS), FFS data, and inpatient RAPS data.

The final risk score will be a blend of the above two risk scores with 25% weight on the first and 75% on the second. For PACE, CMS proposes to continue the same method for CY 2021 that has been in place since CY2015.

Section C. Part D Risk Sharing

There are no changes to the Part D risk corridor calculations for 2021.

Section D. Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit

CY 2021 Part D Defined Standard benefit changes:

- $445 deductible ($435 in 2020)
- $4,130 ICL ($4,020 in 2020)
- $6,550 TrOOP ($6,350 in 2020)

$1.30/$4.00 copays for full subsidy full benefit duals ($1.30/$3.90 in 2020)

Part D Benefit Parameters	2020	2021
Standard Benefit		
Deductible	$435	$445
Initial Coverage Limit	$4,020	$4,130
Out-of-Pocket Threshold	$6,350	$6,550
Total Covered Part D Spending at Out-of-Pocket Threshold for Non-Applicable Beneficiaries	$9,038.75	$9,313.75
Estimated Total Covered Part D Spending for Applicable Beneficiaries	$9,719.38	$10,048.39
Minimum Cost-Sharing in Catastrophic Coverage Portion of the Benefit		
Generic/Preferred Multi-Source Drug	$3.60	$3.70
Other	$8.95	$9.20
Full Subsidy-Full Benefit Dual Eligible (FBDE) Individuals		
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]	$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	$1.30	$1.30
Other	$3.90	$4.00
Above Out-of-Pocket Threshold	$0.00	$0.00
Over 100% FPL [category code 1]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.60	$3.70
Other	$8.95	$9.20
Above Out-of-Pocket Threshold	$0.00	$0.00
Full Subsidy-Non-FBDE Individuals		
Applied or eligible for QMB/SLMB/QI or SSI and income at or below 135% FPL and resources ≤ $8,890 (individuals) or ≤ $14,090 (couples) [category code 1]		
Deductible	$0.00	$0.00
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.60	$3.70
Other	$8.95	$9.20
Maximum Copayments above Out-of-Pocket Threshold	$0.00	$0.00
Partial Subsidy		
Applied and income below 150% FPL and resources below $13,820 (individual) or $27,600 (couples) [category code 4]		
Deductible	$89.00	$92.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.60	$3.70
Other	$8.95	$9.20
Retiree Drug Subsidy Amounts		
Cost Threshold	$435.00	$445.00
Cost Limit	$8,950.00	$9,200.00

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

The Medicare coverage gap for non-LIS members was effectively closed for applicable (mainly brand) drugs in CY 2019 and for non-applicable (mainly generic) drugs in CY 2020; therefore, the following coverage gap coinsurance provisions continue to apply for CY 2021:

- Non-LIS 25% coinsurance for applicable and non-applicable drugs in the gap (same as 2020).
- Non-LIS 95% coinsurance for non-applicable drugs (mainly brand) in the gap (same as 2020). Note that member liability is approximately 25% after 70% manufacturer discount. This is the same cost sharing scheme used in CY 2020.

Section F. Dispensing Fees and Vaccine Administration Fees for Applicable Drugs in the Coverage Gap

Consistent with the gap cost sharing reductions discussed above, beneficiary/plan liability will be 25%/75%, respectively, for dispensing fees and vaccine administration fees related to applicable drugs in the gap.

Section G. Part D Calendar Year Employer Group Waiver Plans

Beginning in 2017, CMS began making prospective payments for Part D federal reinsurance for calendar year Employer Group Waiver Plans (EGWPs) offering Part D, due to rising specialty drug costs. Consistent with Part D non-EGWPs, the prospective payment will be reconciled with actual expenses several months after the conclusion of the plan year.

For 2021, CMS proposes to continue making prospective reinsurance payments to calendar year Part D EGWPs. The payment will be based on the average reinsurance amount paid to CY2018 EGWPs. This amount is $48.52 PMPM (versus $40.77 PMPM in 2020).

Consistent with 2020 and prior years, non-calendar year EGWPs are excluded from the Part D federal reinsurance program.

Attachment IV: Medicare Part D Parameters for the Defined Standard Benefit Annual Adjustments for 2021

Attachment IV contains detailed calculations of the annual adjustments to the Part D Defined Standard benefit parameters. Two annual percentage adjustments are calculated to develop the 2021 benefit parameters: the annual percentage increase (API) and the annual Consumer Price Index (CPI) increase. These adjustments are described below. The API is applied to all Part D parameters, except for copayments that apply to full benefit dual-eligible enrollees with incomes up to or at 100% FPL, which increase based on CPI.

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

The API is defined as the annual percentage increase in the average per capita expenditures for Part D for the 12-month period ending in July of the previous year.

Section B. Annual Percentage Increase in Consumer Price Index (CPI)

The CPI is defined as the annual percentage increase in the CPI, All Urban Consumers (all items, U.S. city average) as of September of the previous year.

Section C. Calculation Methodology

The API uses prescription drug event (PDE) data to calculate the per capita Part D costs from August 2019 to July 2020 divided by the per capita Part D costs from August 2018 to July 2019. Since PDE data are not yet available for 2020, the per capita costs for this time period are estimated using August 2019 to December 2019 PDE data. This calculation results in an estimated 3.16% annual increase in per capita costs. This increase is further adjusted based on revisions to prior years' estimates. The cumulative adjustment for prior year revisions is -0.30%, primarily driven by an update to last year's API. This results in a total 2021 API of 2.85%.

The CPI increase is based on the projected September 2019 CPI divided by actual September 2017 CPI, which results in an estimated increase of 2.44%. This increase is further adjusted based on revisions to prior years' estimates. The cumulative adjustment for prior year revisions is -0.54%. In total, this produces a 2021 CPI increase of 1.88%.

Section D. Retiree Drug Subsidy Amounts

The Part D parameters, including the retiree drug subsidy amount, are each multiplied by the appropriate increase (CPI or annual percentage increase). For 2021, the retiree subsidy cost threshold is $445 (was $435 in 2020) and the cost limit is $9,200 (was $8,950 in 2020).

Section E. Estimated Total Covered Part D Spending at Out-of-Pocket Threshold for Applicable Beneficiaries

The 2021 total covered Part D spending at out-of-pocket threshold for applicable beneficiaries is calculated to be $10,048.39 ($9,719.38 for 2020). This amount is calculated as the ICL plus 100 percent beneficiary cost sharing in the coverage gap divided by the weighted gap coinsurance factor. Further detail on these calculations and inputs is provided in the Advance Notice.

Attachment V: Updates for Part C and D Star Ratings

In the 2019 Final Rule, CMS solidified methodology for the Part C and D Star Ratings program. Through this rule, any changes to the Star Rating program or methodology, including changes to specific measures that must be documented in the Advanced and Final Notice each spring. Below are the proposed methodological changes for 2021 Star Ratings.

Improvement Measures (Part C & D)

No measures were removed or added to the calculation of the Improvement Measure. All measures will use their 2021 weighting in the calculation of the Improvement Measure.

Extreme and Uncontrollable Circumstances Policy

Similar to 2020, CMS is proposing to adjust the 2021 Star Ratings to take into account the effects of extreme and uncontrollable circumstances that occurred during the performance period. There are no changes to this methodology from 2020.

There was only one natural disaster in 2019 qualifying for the Star Rating extreme and uncontrollable circumstances policy adjustments for the 2021 Star Rating Year, and this was the December 2019 earthquakes in Puerto Rico. Sixteen counties in Puerto Rico received FEMA Individual Assistance in 2019. CMS will apply the extreme and uncontrollable circumstances policy to the 2021 Star Ratings for contracts with over 25% of enrollment in these counties.

CMS made one clarification to the policy for contracts with a designation of Extreme and Uncontrollable Circumstances. If the contract was in an area that was impacted by an Extreme and Uncontrollable Circumstance in two consecutive years (i.e. 2018 – 2019 disasters), the contract would receive the higher of the 2021 Star Rating or the 2020 Star rating, prior to any adjustments due to the 2018 disaster. This adjustment will be made at the measure level.

Categorical Adjustment Index (CAI)

The CAI was implemented to address the within-contract disparity in performance associated with a contract's percentages of beneficiaries with low-income subsidy and dual eligible (LIS/DE) and disability. There were no changes to the list of measures included within the 2021 CAI calculation.

The relative categorization of contracts into categories based on the percentage of their members that were LIS/DE or Disabled has been updated for 2021. See tables below for a summary of the 2020 to 2021 CAI changes in both categorization and adjustment for Overall Star Ratings.

Table 9: LIS/DE Initial Group

Percentage of Contract's LIS/DE Beneficiaries					
	2020 low	2020 high	2021 low	2021 high	Difference in high limit
L1	0.00	5.68	0.00	6.23	0.55
L2	5.68	8.95	6.23	9.49	0.54
L3	8.95	11.18	9.49	11.70	0.52
L4	11.18	14.78	11.70	15.73	0.95
L5	14.78	19.83	15.73	21.33	1.50
L6	19.83	28.12	21.33	30.24	2.13
L7	28.12	44.24	30.24	42.48	-1.76
L8	44.24	74.81	42.48	74.17	-0.64
L9	74.81	100.00	74.17	100.00	0.00
L10	100.00	100.00	100.00	100.00	0.00

Table 10: Disability Quintile

Percentage of Contract's Disabled Beneficiaries					
	2020 low	2020 high	2021 low	2021 high	Difference in high limit
D1	0.00	14.52	0.00	15.39	0.87
D2	14.52	20.62	15.39	22.22	1.60
D3	20.62	27.54	22.22	28.75	1.21
D4	27.54	39.48	28.75	40.96	1.48
D5	39.48	100.00	40.96	100.00	0.00

Table 11: Final Adjustment for Overall Star Rating

Category	2020 LIS/DE Group	2020 Disability Quintile	2021 LIS/DE Group	2021 Disability Quintile	2020 CAI Value	2021 CAI Value	Difference in CAI
1	L1-L3	D1-D2	L1-L3	D1	-0.04	-0.04	0.00
2	L4-L8	D1-D2	L4-L8	D1	-0.02	-0.01	0.01
	L4-L6	D2	L1-L7	D2			
3	L1-L6	D3	L1-L4	D3-D5	0.00	0.01	0.01
			L5	D3-D4			
			L6-L7	D3			
4	L9-L10	D1-D2	L9-L10	D1	0.04	0.06	0.02
	L7-L8	D2-D3	L98-L9	D2-D3			
	L1-L8	D4	L6-L8	D4			
	L1-L7	D5	L5-L7	D5			
5	L9-L10	D3-D4	L10	D2-D4	0.13	0.11	-0.02
	L8-L9	D5	L9	D4-D5			
			L8	D5			
6	L10	D5	L10	D5	0.17	0.20	0.04

Measure Changes for 2022 and beyond

Substantive Measure Changes

- **Care for Older Adults** – Functional Status Assessment Indicator (Part C) – Currently, there are four methods for which a plan can qualify as performing a functional status assessment on a member. One of the methods is by notating that at least three of the following four components were assessed: cognitive status, ambulation status, hearing, vision and speech, or other functional independence. Moving forward, this will no longer be considered an allowable method for a functional status assessment. This change will occur starting with the 2022 Star Ratings and will therefore be moved to a display measure for both the 2022 and 2023 Star Ratings.
- **Medication Adherence Measures (Part D)** – The Pharmacy Quality Alliance (PQA) has considered risk adjusting all three of their Medication Adherence Measures (Hypertension,

Diabetes, and Cholesterol) for socioeconomic status (SES) and sociodemographic status (SDS). They have recommended that these measures be changed to risk adjust for the following characteristics: age, gender, low-income status, and disability status. They have also recommended that measure results be stratified by the SDS characteristics to help plans better understand their population. CMS is currently considering these changes for the 2024 star ratings (2022 measurement year).

Non-Substantive Measure Changes

- **Reviewing Appeals Decisions (Part C)** – Currently the deadline for re-openings is May 1st prior to the measurement year. Plans have requested that CMS extend this deadline to June 30th of the same year in order to allow for more re-openings. This change will be implemented without moving the measure to the display page.
- **Controlling High Blood Pressure (Part C)** – Currently, if a member has two outpatient visits and a diagnosis of hypertension in the measurement year or the year prior they are included in the denominator of this measure. The plan must then get a good blood pressure reading prior to the end of the measurement year. In order to give the plan more time to get a favorable blood pressure reading, CMS is considering closing the denominator window to only include the first six months of the measurement period and the full year prior. This measure is currently on the display page and will return to the 2022 Star Ratings with this change.

Display Measure Changes

The following are display measures that will also be incorporating methodological changes for measurement year 2020:

- Transitions of Care (Part C)
- Patient-Used Device Data for HEDIS (Part C)
- Digital Specifications for HEDIS (Part C)
- HEDIS: Cross-Cutting Exclusions (Part C)
- Initiation and Engagement of Alcohol and Other Drug Abuse and Dependence Treatment (Part C)
- Hospitalization for Potentially Preventable Complications (Part C)
- Concurrent Use of Opioids and Benzodiazepines (COB), Use of Opioids at High Dosage in Persons Without Cancer (OHD), Use of Opioids from Multiple Providers in Persons

Without Cancer (OMP), and Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) (Part D)

- Antipsychotic Use in Persons with Dementia Overall (APD), Antipsychotic Use in Persons with Dementia, for Community-only Residents (APD-COMM), and Antipsychotic Use in Persons with Dementia, for Long-term Nursing Home Residents (APD-LTNH) (Part D)

Retired Display Measures for 2023

- Osteoporosis Testing in Older Women (Part C)

Potential New Measure Concepts

- End-Stage Renal Disease (ESRD) Measures (Part C)
- Prior Authorizations (Part C)
- HOS Measures (Part C)
- Osteoporosis Screening (Part C)
- Cardiac Rehabilitation (Part C)
- Diabetes Overtreatment (Part C)
- Home Health Services (Part C)
- Generic Utilization (Part D)
- Initial Opioid Prescribing (IOP) Measures (Part D)
- Net Promoter Score

Attachment VI: Economic Information for Part II of the CY 2021 Advance Notice

Attachment VI is new for CY 2021 and provides estimates of the economic impact of various aspects of the proposals in the Advance Notice, Part II. Key estimates are as follows:

- The effective growth rate for CY 2021 MA non-ESRD rates is 2.99%. This incorporates the FFS growth rate of 2.57%, but also includes other factors of the ratebook such as changes to the applicable percentage, impact of IME removal, and impact of the pre-ACA cap on benchmark rates.
- CMS estimates the following net impact on the Medicare Trust Fund for the following proposals in the Advance Notice:
    1. CY 2021 non-ESRD MA rates: $7.32 billion
    2. PACE rates: $70 million.
    3. Continued phase-out of IME from MA capitation rates: savings of $13.0 million.
    4. MA and PACE ESRD state rates: $400 million.
    5. Change in weights for ESRD risk adjustment model: $44 million.
    6. Change in weights for FIDE-SNP Frailty scores: savings of $10.1 million.
    7. MA Coding Pattern Adjustment: no impact.
    8. 2021 FFS Normalization Factors: no impact, by definition.
    9. Change in RAPS/EDS weights on Part D RxHCC risk scores: no impact
    10. Annual percentage change in Part D parameters: impact of parameter updates is dependent on behavior and bid assumptions of Part D Plan Sponsors.

CY 2021 Part C Benefits Review and Evaluation Memorandum

CMS will not issue a Call Letter for 2021 for the first time in many years. Unless otherwise noted in the CMS memo *Contract Year 2021 Part C Benefits Review and Evaluation*, other information released by CMS or an applicable final rule, the Final CY 2020 Call Letter applies for CY 2021.

Overview of CY 2021 Part C Benefits and Bid Review

Any organization whose bid fails the Part C Service Category Cost Sharing, PMPM Actuarial Equivalent Cost Sharing, Meaningful Difference (if applicable, see below), Total Beneficiary Cost (TBC), and/or Optional Supplemental Benefit requirements at any time prior to final approval will receive a compliance notice, even if the organization is allowed to correct the deficiency. The severity of compliance notice may depend on the type and/or severity of error(s). Medicare-Medicaid Plans in a capitated model under the Medicare-Medicaid Financial Alignment are not subject to the review criteria summarized in the table below; benefit review information for these plans will be provided separately by CMS.

Table 12: Plan Types and Applicable Bid Review Criteria

Bid Review Criteria	Applies to Non-Employer Plans (Excluding Dual Eligible SNPs)	Applies to Non-Employer Dual Eligible SNPs	Applies to 1876 Cost Plans	Applies to Employer Plans
Low Enrollment	Yes	Yes	No	No
Total Beneficiary Cost	Yes	No	No	No
Maximum Out-Of-Pocket (MOOP) Limits	Yes	Yes	No	Yes
PMPM Actuarial Equivalent Cost Sharing	Yes	Yes	No	Yes
Service Category Cost Sharing	Yes	Yes	Yes[1]	Yes
Part C Optional Supplemental Benefits	Yes	Yes	No	No

[1] Section 1876 Cost Plans and MA plans may not charge enrollees higher cost sharing than is charged under Original Medicare for chemotherapy administration, skilled nursing care and renal dialysis services (42 C.F.R. §§417.454(e) and 422.100(j)).

Maximum Out-of-Pocket (MOOP) Limits

With the changes by the 21st Century Cures Act ("Cures Act") in MA eligibility and enrollment for beneficiaries with diagnoses of ESRD, CMS will begin incorporating cost data for beneficiaries with diagnoses of ESRD into how MOOP limits are set. To ensure the MOOP limits take into account out-of-pocket costs for beneficiaries with diagnoses of ESRD, CMS plans on transitioning

from their current practice under of excluding all costs incurred by beneficiaries with diagnoses of ESRD to including all related costs into the Medicare FFS data that is used to set the MOOP limits beginning with CY 2021.

Table 13: CY 2021 Voluntary and Mandatory MOOP Range Amounts by Plan Type

Plan Type	Voluntary	Mandatory
HMO	$0 - $3,450	$3,451 - $7,550
HMO POS	$0 - $3,450 In-network	$3,451 - $7,550 In-network
Local PPO	$0 - $3,450 In-network and $0 - $5,150 Combined	$3,451 - $7,550 In-network and $3,451 - $11,300 Combined
Regional PPO	$0 - $3,450 In-network and $0 - $5,150 Combined	$3,451 - $7,550 In-network and $3,451 - $11,300 Combined
PFFS (full network)	$0 - $3,450 Combined	$3,451 - $7,550 Combined
PFFS (partial network)	$0 - $3,450 Combined	$3,451 - $7,550 Combined
PFFS (non-network)	$0 - $3,450	$3,451 - $7,550

As in the past, CMS explicitly evaluates cost sharing for certain service categories to ensure they are at least actuarially equivalent to Original Medicare. Table 14 shows the proposed actuarial equivalent cost sharing limits for CY 2021.

Table 14: PMPM Actuarial Equivalent (AE) Cost Sharing Limits

	1	2	3	4	5	6	
BPT Benefit Category	PMPM Plan Cost Sharing (Parts A&B) (BPT Col. l)	Original Medicare Allowed (BPT Col. m)	Original Medicare AE Cost sharing (BPT Col. n)	Part B Adjustment Factor to Incorporate Part B Cost Sharing (Based on FFS data)	Comparison Amount (#3 x #4)	Excess Cost Sharing (#1 - #5, min of $0)	Pass/Fail
Inpatient	$33.49	$331.06	$25.30	1.382	$34.95	$0.00	Pass
SNF	$10.83	$58.19	$9.89	1.073	$10.61	$0.22	Fail
DME	$3.00	$11.37	$2.65	1.000	$2.65	$0.35	Fail
Part B-Rx	$0.06	$1.42	$0.33	1.000	$0.33	$0.00	Pass

Part C Cost Sharing Standards

The cost sharing standards in Table 15 apply to in-network services.

Length of stay scenarios used to identify the cost sharing limits are based on recent, complete Medicare data, excluding beneficiaries with diagnoses of ESRD. OACT conducted an analysis to determine the impact of including all cost incurred by ESRD beneficiaries and found that including ESRD beneficiaries would increase average cost sharing for inpatient hospital acute stays but expect no impact for inpatient hospital psychiatric stays. Due to amendments made by the Cures Act, CMS expects ESRD beneficiaries to begin transitioning or choosing MA plans in greater numbers for 2021 and beyond. Because of these changes, it will be appropriate to use ESRD beneficiary data beginning in 2021. CMS cannot accurately project the rate at which ESRD beneficiaries will transition to MA plans and has therefore integrated 40% of the difference between Medicare FFS costs incurred by ESRD beneficiaries versus non-ESRD beneficiaries.

For other cost sharing limits, Medicare FFS data excluding ESRD beneficiaries was used.

Table 15: CY 2021 In-Network Service Category Cost Sharing Requirements

Service Category	PBP Section B data entry field	Voluntary MOOP	Mandatory MOOP
Inpatient Hospital – Acute - 60 days	1a	N/A	$4,816
Inpatient Hospital – Acute - 10 days	1a	$2,783	$2,226
Inpatient Hospital – Acute - 6 days	1a	$2,524	$2,019
Inpatient Hospital Psychiatric – 60 days	1b	$3,408	$2,726
Inpatient Hospital Psychiatric – 15 days	1b	$2,339	$1,871
Skilled Nursing Facility – First 20 Days[1,2]	2	$20/day	$0/day
Skilled Nursing Facility – Days 21 through 100[1,2]	2	$184/d	$184/d
Cardiac Rehabilitation	3	$50	$50
Intensive Cardiac Rehabilitation Services	3	$100	$100
Pulmonary Rehabilitation	3	$30	$30
Supervised exercise therapy (SET) for Symptomatic peripheral artery disease (PAD)	3	$30	$30
Emergency Care/Post Stabilization Care[3]	4a	$120	$90
Urgently Needed Services[3]	4b	$65	$65

Service Category	PBP Section B data entry field	Voluntary MOOP	Mandatory MOOP
Partial Hospitalization	5	$55/day	$55/day
Home Health	6a	20% or $35	$0
Primary Care Physician	7a	$35	$35
Chiropractic Care	7b	$20	$20
Occupational Therapy	7c	$40	$40
Physician Specialist	7d	$50	$50
Psychiatric and Mental Health Specialty Services	7e and 7h	$40	$40
Physical Therapy and Speech-language Pathology	7i	$40	$40
Therapeutic Radiological Services	8b	20% or $60	20% or $60
DME-Equipment	11a	N/A	20%
DME-Prosthetics	11b	N/A	20%
DME-Medical Supplies	11b	N/A	20%
DME-Diabetes Monitoring Supplies	11c	N/A	20% or $10
DME-Diabetic Shoes or Inserts	11c	N/A	20% or $10
Dialysis Services[1]	12	20% or $30	20% or $30
Part B Drugs-Chemotherapy/Radiation[1,4]	15	20% or $75	20% or $75
Part B Drugs-Other	15	20% or $50	20% or $50

Service Category	PBP Section B data entry field	Voluntary MOOP	Mandatory MOOP

[1] MA plans and 1876 Cost Plans may not charge enrollees higher cost sharing than is charged under Original Medicare for chemotherapy administration including chemotherapy drugs and radiation therapy integral to the treatment regimen, skilled nursing care, and renal dialysis services (42 CFR §§ 417.454(e) and 422.100(j)).

[2] MA plans that establish a voluntary MOOP may have cost sharing for the first 20 days of a SNF stay. The per-day cost sharing for days 21 through 100 must not be greater than the Original Medicare SNF amount. Total cost sharing for the overall SNF benefit must be no higher than the actuarially equivalent cost sharing in Original Medicare, pursuant to section 1852(a)(1)(B) of the Act.

[3] Emergency/Post Stabilization and Urgently Needed Services benefits are not subject to plan level deductible amount and/or out-of-network providers. The dollar amount included in the table represents the maximum cost sharing permitted per visit (copayment or coinsurance).

[4] Part B Drugs – Chemotherapy/Radiation cost sharing displayed is for services provided on an outpatient basis and includes administration services.

If a plan uses a copayment method of cost sharing, then the copayment for an in-network Original Medicare service category cannot exceed 50% of the average contracted rate of that service.

Total Beneficiary Cost (TBC)

CMS will be using the same TBC evaluation as in past years to calculate the TBC change amount. CMS will provide plan specific CY 2021 TBC values in mid-April 2020. CMS currently excludes ESRD beneficiaries from the OOPC model used to calculate and evaluate TBC. CMS believes that the change in MA eligibility allowing ESRD beneficiaries warrants an increase to the TBC threshold for most plans from $36 PMPM in CY 2020 to $37 PMPM for CY 2021.

Contract Year (CY) 2021 Final Part D Bidding Instructions

Formulary Submissions

The CY 2021 formulary submission window is May 11, 2020 through June 1, 2020. A limited update window will be provided in August 2020 where drugs new to the Formulary Reference File (FRF) may be added; negative changes are allowed if replaced by an equivalent generic or therapeutically similar drug.

CMS is expecting to release the CY 2021 FRF in March 2020 with an update prior to the June 1, 2020 formulary submission deadline. Newly added drugs on the May release of the CY 2021 FRF will not be included in the 2021 OOPC model.

Medication Therapy Management (MTM)

The 2021 annual threshold will be finalized in the CY 2021 Announcement of Medicare Advantage Capitation Rates and Part C and Part D Payment Policies, and will be the 2020 annual cost threshold adjusted for the annual percentage increase.

Part D Benefit Parameters for Non-Defined Standard Plans

Benefit Parameters for CY 2021 Threshold Values	CY 2021 Threshold Values
Minimum Meaningful Differences (PDP Cost-Sharing OOPC)	
Enhanced Alternative Plan vs. Basic Plan	$22
Maximum Copay: Pre-ICL and Additional Cost-Sharing Reductions in the Gap	Standard Retail Cost Sharing
Preferred Generic Tier	<$20
Generic Tier	$20
Preferred Brand/Brand Tier	$47
Non-Preferred Drug Tier	$100
Non-Preferred Brand Tier	$100
Injectable Tier	$100
Select Care/Diabetic Tiers	$11
Vaccine Tier	$0
Maximum Coinsurance: Pre-ICL (3 or more tiers)	Standard Retail Cost Sharing

Benefit Parameters for CY 2021 Threshold Values	CY 2021 Threshold Values
Preferred Generic Tier	25%
Generic Tier	25%
Preferred Brand/Brand Tier	25%
Non-Preferred Drug Tier	50%
Non-Preferred Brand Tier	50%
Injectable Tier	33%
Select Care/Diabetic Tiers	15%
Vaccine Tier	0%
Maximum Coinsurance: Additional Cost-Sharing Reductions in the Gap for Applicable Beneficiaries (all tier designs)	Standard Retail Cost Sharing
Preferred Generic Tier	15%
Generic Tier	15%
Preferred Brand/Brand Tier	50%
Non-Preferred Drug Tier	50%
Non-Preferred Brand Tier	50%
Injectable Tier	50%
Select Care/Diabetic Tiers	50%
Vaccine Tier	0%
Minimum Specialty Tier Eligibility	
1-month supply at in-network retail pharmacy	TBD

CMS is proposing a second, “preferred” specialty tier in the proposed rule, titled *Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly*. If finalized as proposed, the final specialty tier cost threshold would be published in the corresponding final rule.

Improving Drug Utilization Review Controls in Medicare Part D

In the same proposed rule as mentioned above, CMS also proposed changes to expand the drug management programs codified in the CY 2019 Final Rule.

As Part D sponsors prepare to implement opioid point-of-sale (POS) safety edit(s) for CY 2021, see the HPMS memo, "Contract Year (CY) 2020 Opioid Safety Edit Reminders and Recommendations" released on December 9, 2019.

Coordination of Benefits (COB) User Fees

A COB user fee of $0.087 PMPM ($0.1166 per month for 9 months) will be collected in 2021 and should be accounted for when developing 2021 bids.

Appendix A
Wakely Estimated Impact of Growth Rates Combined with Payment Reform

Wakely estimates that, on a nationwide average basis, and as compared with CY 2020, nationwide average CY 2021 Part C benchmarks will:

- Increase by 3.13% on a standardized (i.e. 1.00) risk score basis. This incorporates the FFS growth rate, changes in applicable percentage by county, average change in star ratings and quality bonus, the impact of benchmark cap and the removal of Kidney Acquisition Costs (KAC) by county. It does not include changes to GME adjustment factor, VA and DoD adjustment factor, credibility factors or county rebasing and repricing.

- Increase by 0.82% on a risk-adjusted basis. The risk-adjusted increase incorporates the year-over-year impact of FFS normalization factors, MA Coding Pattern adjustment and the risk model revision. The Wakely estimate does not include changes for encounter data transition and employer group waiver plan payment policy.

The Wakely risk-adjusted estimate is based on the following components:

- Change in 1.00 (Standardized) benchmarks
- Impact of change in fee-for-service normalization factor
- Change in coding pattern difference adjustment
- Assumption of no trend in raw risk scores
- Average change in star ratings based on January 2020 enrollment
- Risk Model Revision

Table A-1 shows our estimates of the components that make up this change:

Table A-1: Change in Blended Risk Adjusted Benchmarks [1]

2020 to 2021	
Growth Rate	2.55%
Applicable %	0.18%
Star Rating/Quality Bonus	0.52%
Kidney Acquisition Cost Removal	-0.43%
Benchmark Cap	0.32%
Total Benchmark Change	**3.13%**
FFS Normalization	-2.48%
MA Coding Pattern	0.00%
Risk Model Revision	0.25%
Total Risk Score Change	**-2.24%**
TOTAL	**0.82%**

[1] Based on January 2020 MA enrollment and Fall 2019 Star Ratings

Below is a brief definition of each of the elements in Table A-1.

Growth Rate. This is the impact of the FFS (+2.57%) growth rate. Please note there are still a handful of counties impacted by the IME phase out which produces an effective growth rate less than 2.57%.

Applicable %. Average nationwide change in applicable percentage, based on the enrollment by Medicare Advantage contract and county.

Star Rating/Quality Bonus. Difference in quality bonus impact on benchmarks between 2020 and 2021. This can be due to star rating improvements for MA plans from 2020 to 2021 as well as changing enrollment mix by MA plan.

Benchmark Cap. The ACA formula requires that the final blended benchmark can be no greater than the pre-ACA benchmark. The impact of this cap can year-to-year as plans change star ratings, and as the NPCMGP trend differs from the FFS trend.

Kidney Acquisition Cost Removal. Starting in 2021, CMS will remove costs attributable to kidney transplants in the Part C Benchmark calculation. This is due to the 21st Century Cures Act which allows ESRD beneficiaries to enroll in general enrollment plans.

Part C Fee-for-Service (FFS) Normalization Factor. The 2020 Part C FFS normalization factor was a 50%/50% blend of the 2017 RAPS CMS-HCC model (1.075) and the CMS Payment Condition Count model (1.069). For 2021, the FFS normalization factor is proposed to be a 25%/75% blend of the 2017 RAPS CMS-HCC model (1.106) and the CMS Payment Condition Count model (1.097). Calculating the change between the blended 2020 factor and the proposed blended 2021 factor, the impact is estimated to be (1/1.0993)/(1/1.0720) - 1 = -2.48%. This is a simplification, as the risk scores themselves will factor into the composite impact.

Change in Coding Pattern Adjustment. The coding pattern adjustment for 2021 will be -5.90%, which is the minimum adjustment required by the Affordable Care Act. There will be no change from 2020.

Change in Bid and Rebate Amounts

The actual revenue change for individual Medicare Advantage plans will depend on the trend in bids, and will further vary depending on star rating, counties served, risk score trends, population changes, and many other factors.

If we assume that both 2020 and 2021 bids are 90% of the benchmark then we estimate the change in Part C payments from 2020 to 2021 to be an increase of +0.82% (see Table A2).

In order to properly estimate the impact of the various MA payment components addressed in the Advance Notice, Medicare Advantage plans must consider the aggregate effect on actual payments from CMS, which is not necessarily the same as the change in benchmarks. As noted above, we estimate the change in risk-adjusted benchmarks to be +0.82%. If we include estimated changes in bid and rebate levels, then the impact to Part C revenue is +0.96%. This estimate is based on the following assumptions:

- Plans bid at 90% of the benchmark in 2021
- Bid trend from 2020 to 2021 will be 1% assuming a static population
- Annual risk score coding trend is 0% for a static population
- Nationwide average star ratings, which result in an average rebate percentage of 61.1% in 2020 and 62.5% for 2021
- No consideration for sequestration or insurer fee

Table A-2 shows the calculations underlying our estimates.

Table A-2: Estimate Calculations

Item	2020	2021	2021/2020
1.0 MA Benchmark [1]	$973.40	$1,003.86	3.13%
Raw Risk Adjustment Factor [2]	1.0000	1.0000	0.00%
FFS Normalization	1.0720	1.0993	-2.48%
MA Coding Pattern Adjustment	0.9410	0.9410	0.00%
Risk Model Revision [3]	1.0000	1.0025	0.25%
RAF after FFS Norm & Coding Pattern	0.8778	0.8582	-2.24%
Risk-Adjusted Benchmark	$854.45	$861.49	0.82%
Assumed Risk-Adjusted Bid [4]	**$769.01**	**$775.34**	**0.82%**
Savings (Benchmark less bid)	$85.45	$86.15	0.82%
Rebate (61.1% for 2020, 62.5% for 2021)	**$52.24**	**$53.81**	**3.00%**
Risk-Adjusted Bid + Rebate	**$821.24**	**$829.14**	**0.96%**

[1] Based on nationwide average MA enrollment by county as of January 2020
[2] Assumed no trend in risk scores
[3] Risk Model Revision changes as displayed in the Fact sheet published February 5, 2020
[4] Bid set at 90% of risk-adjusted benchmark

As in past years, CMS did not release county-specific benchmarks that reflect re-basing. The re-basing that CMS intends to perform prior to the Final Rate Announcement may result in dramatically difference changes in FFS benchmarks by county.