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2022 Medicare Advantage

Summary of Advance Notice Part II

November 12, 2020

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Executive Summary

On October 30, 2020, CMS released the 2022 Advance Notice Part II[1]. This is about three months earlier than the typical timing in past years. CMS said the goal of the early release was to "give stakeholders the certainty they need to design policies to contend with COVID and other ongoing health priorities". Thus far, CMS has not yet released Part C and D benefit review and bidding instruction information that used to be published in the Call Letter, and last year was released via separate memoranda.

The CY2022 fee-for-service (FFS) growth rate, which is the major driver of Part C benchmark rates, is 4.52%. The growth rate is consistent with past projections prior to COVID, which would seem to imply CMS is assuming the impact of COVID on projected 2022 costs is minimal; although, this was not explicitly stated.

As noted in Part I of the Advance Notice, released September 14, 2020, CMS plans to fully transition to the encounter data submission (EDS) based risk model for CY2022. The 2020 CMS-HCC model will continue to be used as the basis of EDS Part C scores; however, CMS is proposing to discontinue the policy of supplementing encounter data diagnoses with diagnoses from RAPS inpatient records.

Changes to the Part D risk adjustment model were addressed by CMS in Part II of the Advance Notice. A new RxHCC model is proposed for 2022 that will also be entirely based on EDS diagnosis submissions.

CMS is continuing to observe substantial increases in Part C FFS risk scores. The proposed EDS CY2022 FFS normalization factor is 1.118, which compares with 1.097 for CY2021. This change implies a reduction in EDS scores of 1.9%, assuming no trend in MAO coding. A similar impact is implied by the RxHCC normalization factor; although, CMS did not provide an estimate of the impact of the new RxHCC model itself.

Following is a brief summary of the key changes and proposals in the 2022 Notice:

Part C Payment Methodology

The non-ESRD FFS growth rate percentage for CY2022 is 4.52%.

[1] https://www.cms.gov/files/document/2022-advance-notice-part-ii.pdf

Risk Scores

CMS is not changing 2020 EDS HCC Payment Condition model. Part C risk scores for CY2022 will be entirely based on this model, ending the phase in from the RAPS model.

The FFS Normalization factor for CY2022 is 1.118 for the EDS 2020 Payment Condition model.

CMS is proposing a new RxHCC model for CY2022 to reflect encounter-based diagnoses, updated data, and the updated catastrophic phase benefit parameter. The RxHCC FFS normalization factor is proposed to be 1.056.

The coding pattern adjustment is set at the statutory minimum of 5.90%, which represents no change compared with CY2020 and CY2021.

EGWPs

Plans will not need to file EGWP bid pricing tools (BPTs) for CY2022, as was the case in CY2021.

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.

Benefit Changes and TBC Threshold

CMS has not yet published cost sharing standards and requirements for MA and PD benefits, including the Total Beneficiary Cost (TBC) threshold.

Part D parameters were not updated due to the early release of the Notice, and the lack of updated data.

Star Rating Changes

The COVID pandemic has caused virtually all MA-PD contracts to qualify for “Extreme and Uncontrollable Circumstances” adjustments. Qualifying plans will receive the “higher of” measure from 2021 or 2022.

The hold harmless provision for improvement measures will be expanded to all contracts for the 2022 Star ratings to account for performance changes in 2020 due to COVID-19.

The definition of “new parent” in the “new contract under new parent org” star rating indicator is proposed to require that the parent organization has not offered a contract over the previous four years. The current definition is for the previous three years.

Overall MA Payment Impact

Wakely estimates that, on average, 2022 Part C standardized benchmarks will increase 4.44% over 2021 nationwide. This reflects the impact of the growth rate, change in star ratings and changes to applicable percentages (i.e. quartile rankings). We also estimate that the change in CMS revenue for 2022 versus 2021 is expected to be 2.95%. This takes into account changes in Part C risk score adjustments, including the FFS normalization factor and the MA Coding Pattern adjustment. It does not include any assumption for plan-specific trend in risk scores.

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 October 2020 CMS published MA enrollment and star ratings for payment year 2022.

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 CY2022

Section A. MA Growth Percentage

The preliminary estimate of the MA growth rate is +4.82% (last year the rate was +5.62%).

Section B FFS Growth Percentage.

The non-ESRD fee-for-service growth rate is estimated at +4.52% (last year's rate was +3.64%). In the Notice, CMS noted that the growth rate includes consideration for the impact of COVID in 2020 and beyond. Specifically, CMS noted that estimates for the following COVID-related costs were considered:

- COVID-19 vaccine with no cost sharing allowed
- Utilization of services (presumably both deferred services and pent-up demand)
- Changes to MA coverage created by COVID-related legislation
- Cost sharing in excess of Medicare FFS cost sharing
- Specified testing-related services
- Prohibition on utilization management requirements related to COVID lab testing and testing-related services

The restatements in CMS's FFS USPCC estimates by year reveal some notable changes likely impacted in part by COVID:

- The current estimate of 2020 FFS costs is 12.1% lower than the prior estimate in the April 6, 2020 Final Announcement.
- The restated FFS cost estimate for 2021 is 2.2% higher than the prior estimate.
- Restated 2022 costs are only 0.3% higher than the prior estimate.

In a November 12, 2020 Office of the Actuary (OACT) user group call, OACT said the 12.1% downward restatement for 2020 was mostly due to care projected to be forgone or deferred to

CY2021 due to COVID. Similarly, most of the 2.2% upward restatement for 2021 is due to projected increases in spending related to the care deferred from CY2020.

During the November 4, 2020 CMS Stakeholder call, an estimate of the impact of COVID Vaccine costs on the 2022 FFS cost estimate was provided in the following components:

- 52% of beneficiaries are expected to use the vaccine.
- Each user will need an average of 2.0 doses.
- The cost per dosage is $88

This translates to $7.63 PMPM.

Given the early release of the Advance Notice and potential release of the Final Announcement, it is possible that the experience underlying the growth rate will be based on runout through 3QQ2020 rather than 4Q2020 if the release timing had followed recent years' patterns. In past years, the growth rate has at times changed significantly between the Advance Notice (Part II) and Final Announcement. It is unclear what potential impact an earlier release of the Final Announcement could have on the final growth rate.

Wakely estimates that the nationwide average change in blended standardized (non-risk adjusted) MA Benchmarks from 2021 to 2022 will be 4.44% and the nationwide average change in the blended risk adjusted benchmark will be 2.95%. 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. While CMS will not publish the final geographic relativities (aka Average Geographic Adjustment, or AGA, factors) until the Final Announcement, we can still estimate the impact of changing county quartiles, average star ratings, and the minor impact of a change in how CMS will apply the reduction for the removal of kidney organ acquisition costs.

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

Rank	State	Change
1	CT	6.3%
2	OK	5.9%
3	NH	5.8%
4	PA	5.8%
5	MS	5.3%
47	NY	3.6%
48	GA	3.5%
49	WA	3.3%
50	ID	2.9%
51	HI	2.8%

Attachment II: Changes in the Part C Payment Methodology for Medicare Advantage and PACE for CY2022

Section A. MA Benchmark, Quality Bonus Payments and Rebate

CMS intends to rebase county FFS rates in 2022 (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. CMS acknowledged stakeholders' concerns that the benchmark cap may diminish incentives for MA plans to continuously improve care; however, CMS believes that "section 1853(n)(4) of the Act prevents elimination of the rate cap or excluding the bonus payment from the cap calculation."

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

- 2022 "Applicable Amount" (pre-ACA amount): The greater of a county's 2022 FFS cost and the 2021 Applicable Amount increased by the 2022 National Per Capita MA Growth Percentage of 4.82%.
- 2022 "Specified Amount" (FFS benchmark): 2022 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 2021 per capita FFS rate, assigned by quartiles, as shown in Table 2.

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.

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 2022, the 2022 QBP rating is based on 2021 Star Ratings released in 2020, 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 2022 per capita FFS spending lower than the national average.

The final 2022 rate notice will contain a list of all double bonus counties, as the third criterion above is not yet known.

- Cap on Benchmarks. The QBP-adjusted benchmark for a county cannot exceed the applicable amount.
- Rebates. Rebate levels are based on plan Star Ratings as follows in Table 3:

Table 3: MA Rebate Percentages

Star Rating	2022
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

2022 FFS County Cost

The FFS county cost for CY2022 is calculated as the USPCC x AGA, where:

USPCC = the National Average FFS Cost, called the U.S. Per Capita Cost

AGA = County-level Geographic Index, called the Average Geographic Index

- With the Advance Notice, CMS is releasing county-level 2019 FFS cost data used to develop 2022 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 2015 to 2019 is initially calculated (last year was 2014 to 2018), and is then adjusted.
- Costs for hospice and Cost plans are excluded.
- CMS will re-price 2015 to 2019 to the most current (FY2021) 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 may apply:

- 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). 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.

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

- Organ acquisition costs for kidney transplants. This adjustment was new for CY2021 benchmarks and is continuing for CY2022. The adjustment 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 2022, CMS will first calculate FFS rates including IME. The maximum reduction for any county in 2022 is 7.8% of the FFS rate. As in prior years, CMS will publish rates with and without the 2022 IME reduction. In the Economic Information section of the Notice, CMS notes that only three counties are affected by this change in the maximum IME reduction for 2022.

Section D. ESRD Rates

ESRD Rates = [2015-2019 FFS ESRD dialysis USPCC] x [trend to 2022] 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 2015 to 2019 divided by the national average for the same timeframe normalized for risk score.

- CMS proposes to reprice historical inpatient, outpatient and SNF claims for 2015 to 2019 to reflect the most recent wage indices (in this case FY2021), and reprice physician claims with the most recent Geographic Practice Cost Indices (CY2021). This is a continuation of an enhancement introduced last year.
- CMS is also proposing to reprice ESRD PPS dialysis claims for 2015 to 2019 to reflect the most current wage indices (CY2021).

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

Section F. Location of Network Areas for PFFS Plans in Plan Year 2023

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 2023 with the CY2022 Rate Announcement.

CMS will use January 1, 2021 enrollment data to identify the location of network areas for plan year 2023. The list of network areas for plan year 2022 was published in the April 6, 2020 Final Announcement for CY2021.

Section G. MA Employer Group Waiver Plans

For 2022, 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 2021 Rate Announcement, with one change. For 2022, the methodology for setting MA EGWP rates can be changed, specifically the enrollment data used to weight the bid-to-benchmark ratios, depending on the timing of the release of the CY2022 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 January 2021 individual market MA enrollment for weighting:

$$\textit{2021 individual market B2B ratio} = \frac{\textit{Weighted avg of ISAR adjusted 2021}}{\textit{Weighted avg of county standardized benchmarks}}$$

ISAR = Intra-Service Area Rate Adjustment

- In previous years, February enrollment data has been used. However, due to the earlier release of the CY2022 Rate Announcement, this has been shifted to January. If the Rate Announcement is published in the later timeframe, February enrollment will continue to be used.

- The 2021 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 2022 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 × 2022 Monthly Capitation Rate

  RPPO EGWP Regional Rebate = (1-B2B Ratio) × 2022 Regional Rate × Rebate %

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

- For 2022, 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 H. Medical Loss Ratio Credibility Adjustment

CMS is proposing to use the credibility factors as published in the CY2021 final rule (CMS-4190-F) (85 FR 33796). In the CY2021 final rule, CMS also amended § 422.2440 to add a deductible factor to the MLR calculation for MA MSA contracts that receive a credibility adjustment. The deductible factor functions as a multiplier on the credibility adjustment factor and applies to MLRs calculated for CY2021 and subsequent years.

Section I. CMS-HCC Risk Adjustment Model for CY2022

For CY2022, CMS is proposing to fully phase in the 2020 CMS-HCC model, thereby calculating 100% of the risk score using the 2020 CMS-HCC model. In addition, CMS proposes to calculate risk scores for payment to MA organizations and certain demonstrations, including MMPs, using

only risk adjustment-eligible diagnoses identified from encounter data and FFS claims for CY2022. For PACE organizations, CMS is proposing to continue to use the 2017 CMS-HCC model to calculate risk scores. Comments will be accepted until November 30, 2020 and will be addressed in the 2022 Final Announcement.

Section J. ESRD Risk Adjustment Models for CY2022

CMS is proposing continued use of the ESRD risk adjustment models applied in 2021. For CY2022, CMS is proposing to fully phase in the 2020 ESRD models, using only risk adjustment-eligible diagnoses from encounter data and FFS claims. For PACE organizations, CMS proposes to continue to use the 2019 ESRD dialysis and ESRD functioning graft models as well as the 2019 transplant factors to calculate ESRD risk scores.

Section K. Frailty Adjustment for PACE Organizations and FIDE SNPs

For CY2022, CMS estimated the frailty factors using ADLs from more recent survey results than those used in 2021. The proposed 2022 frailty factors for the 2020 CMS-HCC model are recalibrated using the 2014–2015 FFS CAHPS data, using an updated sample of respondents. For the frailty model calibration, CMS obtains ADL counts from surveys of the general FFS Medicare population.

For CY2022, CMS recalibrated the frailty factors for FIDE SNPs to be separated out by non-dual, partial-dual, and full-dual-eligible status to better align the frailty factors with the segments of the 2020 CMS-HCC model, which was calibrated with separate segments based on the three dual-eligible statuses.

As discussed in Part I of the CY2022 Advance Notice, for CY2022 CMS proposes to calculate risk scores for non-ESRD MA enrollees (including those in FIDE-SNPs) using the 2020 CMS-HCC model. Therefore, CMS proposes to calculate the frailty scores for FIDE SNPs using 100% of the recalibrated frailty factors associated with the 2020 CMS-HCC model.

Table 4: Frailty Factors Associated with the 2020 CMS-HCC Model – FIDE SNPs

Activities of Daily Living (ADL)	Non Medicaid	Partial Medicaid	Full Medicaid
0	-0.066	-1.140	-0.082
1-2	0.102	0.000	0.217
3-4	0.227	0.142	0.282
5-6	0.227	0.142	0.282

Table 5: Frailty Factors Associated with the 2017 CMS-HCC Model – PACE Organizations

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

Section L. Medicare Advantage Coding Pattern Adjustment

CMS is proposing the coding pattern adjustment for CY2022 is the statutory minimum of 5.90%. This is the same adjustment used for CY2021.

Section M. Normalization Factors

CMS is proposing the following normalization factors for CY2022:

Table 6: Normalization Factors

Model	2021 Payment Year	Proposed 2022 Payment Year	Year-to-Year Impact
2017 CMS-HCC Model	1.106	1.128	-1.99%
2020 CMS-HCC Model	1.097	1.118	-1.91%
ESRD Dialysis	1.079	1.077	0.19%
ESRD Functioning Graft	1.118	1.126	-0.72%
2022 RxHCC model [1]	N/A	1.056	N/A

[1] The 2021 and 2022 normalization factors are associated with different RxHCC models

Please note that the year-to-year impact values reflect the fact that the factors are applied by dividing the risk score by the normalization factor.

For CY2022, CMS is proposing to maintain the same linear slope projection method as was used in CY2021 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 expect 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.

CMS is proposing to update the RxHCC model for CY2022. CMS considered two alternatives for estimating the 2022 Part D normalization factor because, although average Part D risk scores increased from 2015 to 2016 when calculated with MA diagnoses from either encounter data or RAPS data, the increase is more pronounced for the encounter data-based scores.

The first alternative method considered was to project the slope, calculated from the observed trend, over four years of historical encounter data-based risk scores, specifically 2016-2019, thereby removing the 2015 data point from the trend. Second, CMS considered calculating the RxHCC normalization factor based on the current five-year slope methodology, but substituting a 2015 RAPS-based risk score for the first year in the trend. These two alternative methods resulted in similar trends to each other, and to the RxHCC trend using MA diagnoses from RAPS. CMS is seeking comment on both the proposed method and the alternative options considered.

Section N. Sources of Diagnoses for Risk Score Calculation for CY2022

The CY2022 Advance Notice Part I contained proposals regarding the Part C risk adjustment model and the use of encounter data and FFS claims as a diagnosis source for CY2022 risk adjustment payments for aged and disabled beneficiaries based on the 2020 CMS-HCC model.

CMS also proposed to calculate ESRD dialysis and ESRD functioning graft risk scores using 100% of the risk scores calculated using diagnoses from encounter data and FFS claims. Comments will be accepted until November 30, 2020 and will be addressed in the 2022 Rate Announcement.

CMS has also proposed to discontinue the use of diagnoses from RAPS inpatient records to supplement encounter data.

For PACE organizations for CY2022, 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).

Lastly, CMS intends to identify diagnoses for its risk score calculation from FFS claims using the HCPCS-based filtering logic that is used for identifying diagnoses from encounter data. This is consistent with how the models for Part C non-ESRD, ESRD, and Part D are being proposed to calculate risk scores for 2022. In the Economic Information section, CMS estimates that this change will produce a net savings of -0.08% to the Medicare Trust Fund.

Attachment III: Changes in the Payment Methodology for Medicare Part D for CY2022

Section A. RxHCC Model

CMS is proposing to update the RxHCC model for CY2022. The new model will incorporate the following changes:

- Inclusion of the MA-PD members in the calibration of the RxHCC model. That is, CMS is proposing to calibrate the model using diagnoses from 2017 FFS claims and 2017 MA-PD encounter data, and 2018 PDE records instead of 2014 FFS claims based on 2014 Risk Adjustment Processing System (RAPS) submission logic, and 2015 PDE records.
- Updates to the catastrophic phase benefit parameter.
- Incorporation of diagnoses identified using the same approach that is used to filter diagnoses from encounter data to calculate risk scores instead of RAPS submissions.

CMS believes the model update is important, as it reflects more recent drug cost patterns (which have changed significantly since 2014). Further, it is important to update frequently to minimize the impact of future updates, as the update adjusts coefficients to reset the average risk score to 1.0.

Section B. Encounter Data as a Diagnosis Source for 2021

CMS proposes calculation of CY2022 risk score based on diagnoses from encounter data (EDS) and fee for service (FFS) claims only. This is a change from prior years, where a blended percentage of risk adjustment processing system diagnoses were used in conjunction with EDS data to minimize the potential impact on risk scores from plans facing operational difficulties submitting encounter data records. For PACE, CMS proposes to continue the same method for CY2022 that has been in place since CY2015.

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

CMS does not have the data necessary to provide a reliable estimate of the Part D parameters at this time due to the early release of the Advance Notice. The actual values will be provided at the same time or earlier than in prior years. CMS provided the methodology they use to calculate these values. For a detailed description of the calculation and methodologies used for each value, consult sections III-C2 and III-C3 of the Advance Notice.

Section D. 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 CY2019 and for non-applicable (mainly generic) drugs in CY2020; therefore, the following coverage gap coinsurance provisions continue to apply for CY2022:

- 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 CY2021.

Section E. 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 F. 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 2022, 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 CY2019 EGWPs. This amount is $65.68 PMPM (versus $48.52 PMPM in 2021).

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

Section G. Part D Risk Sharing

There are no changes to the Part D risk corridor calculations for 2022.

Attachment IV: Updates for Part C and D Star Ratings

Legislative Changes to 2022 Star Ratings

- The March 31, 2020 COVID-19 IFC delays the application of guardrails until 2023 (was going to be implemented for 2022).
- Hold harmless provision for part C and D improvement measures will be expanded to all contracts for the 2022 Star ratings to account for performance changes in 2020 due to COVID-19.
- Change to the definition of a "new MA plan" to be a contract offered by a parent organization that has not had another MA contract in the previous 4 years (rather than 3 years). This definition will be used to address how 2021 Star ratings will partly incorporate 2018 performance period data.
- Modification to the application of the Extreme and Uncontrollable circumstances (EUC) policy for calculation of the 2022 Star ratings to address the effects of the PHE for COVID-19. Based on this policy, relatively all contracts will receive the "better of" EUC logic within the 2022 Star Ratings.

More on Extreme and Uncontrollable Circumstances

- Due to COVID-19, almost all MA and PD contracts will qualify for the EUC adjustments finalized in the CY2020 final rule (published on April 16, 2019).
- For plans that qualify for disaster adjustments, the adjustment will result in the higher of their measure-level rating from 2021 (either 2018 or 2019 performance) and 2022 (2020 performance) will be used.
- Several counties in California and Oregon received EUC status (wildfires).
- Several counties in Louisiana received EUC status (Hurricane Laura).

Removed Measures for 2022 Star Ratings

- Adult BMI Assessment no longer a measure in 2022
- Appeals Auto-Forward no longer a measure in 2022
- Appeals Upheld no longer a measure in 2022

Existing Star Rating Measures with Non-Substantive Changes for 2022

The majority of these measures are HEDIS measures that will be revised to include additional telehealth visits within the measure denominator.

- Controlling Blood Pressure
- Rheumatoid Arthritis Management
- Breast Cancer Screening
- Care for Older Adults
- Controlling High Blood Pressure
- Comprehensive Diabetes Care
- Colorectal Cancer Screening
- Osteoporosis Management in Women Who Had a Fracture
- Plan All-Cause Readmissions
- Statin Therapy for Patients with Cardiovascular Disease

Changes to Existing Star Rating Measures for Future Years (2023 and later)

- Statin Use in Persons with Diabetes (Part D) – Non-Substantive Change
- Kidney Health Evaluation for Patients with Diabetes (Part C) – With the policy change that now allowed ESRD beneficiaries to enroll in MA plans starting in 2021, CMS is considering adding this measure to the Overall Star Rating calculation. This measure will be a display measure for 2022 Star Ratings.

- Controlling Blood Pressure (Part C) – This measure was temporarily moved to the display page for the 2020 and 2021 Star Ratings due to a substantial measure change. Because HEDIS data was not collected for the 2021 Star Ratings, CMS has decided to keep this measure on the display page for the 2022 Star Ratings as well.

- Plan All-Cause Readmissions (Part C) – This measure was temporarily moved to the display page for the 2020 and 2021 Star Ratings due to a substantial measure change. Because HEDIS data was not collected for the 2021 Star Ratings, CMS has decided to keep this measure on the display page for the 2022 Star Ratings as well.

- Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS)/ Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH) (Part D) – This measure is a display measure undergoing change for the 2023 Star Ratings display page.

Potential New Measure Concepts for Future Years

CMS is considering two new measure concepts and is requesting feedback.

- Provider Directory Accuracy (Part C)

- COVID-19 Vaccination (Part C)

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

Wakely estimates that, on a nationwide average basis, compared with 2021, nationwide average 2022 Part C benchmarks will:

- Increase by 4.44% 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 implementation of the Kidney Acquisition Cost (KAC) removal adjustment 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 2.95% 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 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 October 2020 enrollment
- Risk Model Revision

Table A1 shows our estimates of the components that make up this change:

Table A1: Change in Blended Risk-Adjusted Benchmarks [1]

2021 to 2022	
Growth Rate	4.52%
Applicable %	0.26%
Star Rating/Quality Bonus	-0.33%
Kidney Acquisition Cost Removal	-0.01%
Benchmark Cap	0.02%
Total Benchmark Change	4.44%
FFS Normalization	-1.68%
MA Coding Pattern	0.00%
Risk Model Revision	0.25%
Total Risk Score Change	-1.43%
TOTAL	2.95%
[1] Based on October 2020 MA enrollment and Fall 2020 Star Ratings	

Below is a brief definition of each of the elements in Table A1.

Growth Rate. This is the impact of the FFS (+4.52%) growth rate.

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 due to star rating changes between 2021 and 2022. Note, the calculations assume October 2020 enrollment, therefore plans that are new in 2021 and 2022 are excluded from this analysis.

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. The 21st Century Cures Act requires that Medicare cover organ acquisition costs for kidney transplants for MA beneficiaries. The Act also stipulated that these costs be removed from the calculation of Part C benchmark rates. For 2022, CMS is revising the methodology for how they remove these costs. We estimate the average change nationwide to be -0.01%.

Part C Fee-for-Service (FFS) Normalization Factor. The RAPS/EDS blend for CY2022 is proposed to be 100% EDS as compared with a 75%/25% blend in 2021. The 2021 Part C FFS normalization factors were applied separately to the 2017 RAPS CMS-HCC model (1.106) and the CMS Payment Condition Count model (1.072) which were then blended 75%/25% to determine a beneficiary's risk score. For 2022, the FFS normalization factor is proposed to be

entirely based on the CMS Payment Condition Count model (1.118). Calculating the change between the blended 2021 factor (1.099), the impact is (1/1.118) / (1/1.099) = -1.68%.

Change in Coding Pattern Adjustment. The coding pattern adjustment for 2022 will be -5.90%, which is the minimum adjustment required by the Affordable Care Act. There will be no change from 2021.

Risk Model Revision. The CY 2022 impact on MA risk scores of the full transition to the 2020 CMS-HCC model, relative to CY 2021. This is a CMS estimate.

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 2021 and 2022 bids are 90% of the benchmark then we estimate the change in Part C payments from 2021 to 2022 to be an increase of +2.95% (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 +2.95%. If we include estimated changes in bid and rebate levels, then the impact to Part C revenue is +2.85%. This estimate is based on the following assumptions:

- Plans bid at 90% of the benchmark in 2022
- Bid trend from 2021 to 2022 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 62.5% in 2021 and 61.6% for 2022
- No consideration for sequestration or insurer fee

Table A2 shows the calculations underlying our estimates:

Table A2

Item	2021	2022	2022/2021
1.0 MA Benchmark [1]	$1,014.07	$1,059.10	4.44%
Raw Risk Adjustment Factor [2]	1.0000	1.0000	0.00%
FFS Normalization	1.0993	1.1180	-1.68%
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	0.8560	0.8438	-1.43%
Risk-Adjusted Benchmark	$868.08	$893.66	2.95%
Assumed Risk-Adjusted Bid [4]	**$781.27**	**$804.29**	2.95%
Savings (Benchmark less bid)	$86.81	$89.37	2.95%
Rebate (62.5% for 2021, 61.6% for 2022)	**$54.26**	**$55.05**	1.45%
Risk-Adjusted Bid + Rebate	**$835.53**	**$859.34**	**2.85%**
[1] Based on nationwide average MA enrollment by county as of October 2020			
[2] Assumed no trend in risk scores			
[3] Risk Model Revision changes as displayed in the Fact sheet published October 30, 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.