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Summary of Final Rate Notice, Part C, and Part D Bid Review Memo

Calendar Year 2023

Medicare Advantage Capitation Rates and Part C and Part D Payment Policies

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Executive Summary

On April 4, 2022, CMS released the CY2023 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Final Announcement), which finalizes various proposals from the February 2, 2022 Advance Notice.

The CY2023 fee-for-service (FFS) growth rate, which is the major driver of Part C benchmark rates, is calculated at 4.89%, which is five basis points higher than the proposed rate in the Advance Notice.

Beyond the minor update to the growth rate, CMS finalized virtually all of the payment policy proposals in the Advance Notice.

It is important to note that the Final Announcement does not provide guidance on key proposals in the January 12, 2022 proposed CY2023 Policy and Technical Changes rule[1]. The following proposals in the rule are proposed to be effective in 2023 and would impact MA bid filings:

- CMS proposes to mandate in 2023 that the negotiated price for Part D drugs reflect the lowest possible pharmacy reimbursement, inclusive of performance-based payment arrangements. In other words, all pharmacy direct and indirect remuneration must be reflected at the point of sale.
- CMS proposes to require all MA organizations to calculate cost sharing for the purposes of reaching the plan's maximum out-of-pocket (MOOP) level using all payments, whether submitted by the beneficiary, State Medicaid program, other secondary insurance, or if borne by providers as bad debt.

Following is a brief summary of the key payment policies finalized in the CY2023 Final Announcement.

Part C Growth Rates

The non-ESRD FFS growth rate percentage for CY2023 is 4.89%. The Total UPSCC non-ESRD growth rate percentage is 4.75%. The FFS Dialysis-only ESRD USPCC growth rate is 9.59%. County-specific rates were updated as usual for an updated average geographic adjustment calculations, which Wakely estimates to imply a nationwide average benchmark change of -0.1%. Note that CMS estimates this change to be +0.39%.

[1] https://www.govinfo.gov/content/pkg/FR-2022-01-12/pdf/2022-00117.pdf

Risk Scores and FFS Normalization

CMS is not changing the 2020 EDS HCC model for Part C risk scores, and will continue to base scores entirely encounter data submission (EDS) diagnoses.

The FFS Normalization factor for CY2023 will be 1.127 for the 2020 EDS HCC model. The factor used for CY2022 was 1.118. Notably, CMS saw numerous comments raising concerns about ignoring 2021 risk scores in the calculation of the 2023 FFS normalization factor. CMS did not specifically refute these concerns, but reiterated its belief that including 2021 risk scores would imply significantly lower scores in 2023 than were likely to occur.

CMS finalized use of an updated RxHCC model for CY2023. Similar to the HCC model, the updated RxHCC model will be entirely based on EDS diagnosis submissions. The 2023 RxHCC FFS normalization factor is 1.050. CMS did not provide a nationwide average estimate of the impact of the new RxHCC model; although, plan-specific scores under the current and updated RxHCC models can be downloaded in HPMS.

The coding pattern adjustment is set at the statutory minimum of 5.90%, which represents no change compared with CY2021. Several commenters cited MedPAC studies concluding that the coding pattern adjustment is insufficient and that CMS should consider updating its analysis. CMS stated that it finds that the minimum 5.9% adjustment sufficiently reflects the differences in coding patterns between MA plans and traditional Medicare providers

No changes are expected to the Part C risk models used for payment in CY2023 for ESRD and PACE populations. Risk scores will continue to be based on encounter data, RAPS data, and FFS claims.

EGWPs

Plans will not need to file EGWP bid pricing tools (BPTs) for CY2023, as was the case in CY2022.

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.

TBC Threshold

CMS has published a preliminary Total Beneficiary Cost (TBC) threshold amount of $41.00 PMPM in a March 3, 2022, memo characterized as preliminary. CMS has not yet finalized the TBC threshold.

Part D Parameters and Risk Sharing

Preliminary updates to the Part D parameters were announced. The annual percentage increases in average expenditures and the consumer price index were announced as 5.08% (down from 7.31% in 2022) and 7.44% (up from 1.12% in 2022) respectively.

No changes are expected to the risk sharing corridors.

Star Rating Changes

Various updates for the Star Rating measures are proposed. New areas related to "Extreme and Uncontrollable Circumstances" adjustments in 2021 include Texas, Louisiana, Mississippi, New York, and New Jersey related to the Texas severe winter storm and Hurricane Ida. Qualifying plans will receive the "higher of" measure from 2022 or 2023.

Overall MA Payment Impact

Wakely estimates that, on average, 2023 Part C standardized benchmarks will increase 5.79% over 2022 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 MA plan payment revenue for 2023 versus 2022 is expected to be 4.95%. 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, so the change in FFS normalization factor compared with 2022 causes a decrease.

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 March 2022 CMS published MA enrollment and star ratings for payment year 2023.

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

Racial Equity and Underserved Markets

In the CY 2023 Advance Notice, CMS described efforts to advance health equity through enhanced data collection and the development of quality measures. CMS fielded numerous comments on these efforts and will continue to work toward future changes reflecting these goals.

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

Attachment I: Final Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for CY2023

The final 2023 MA and FFS growth rates are shown in Table 1 and are compared with the Advance Notice and the 2022 growth rates.

Table 1 – Comparison of 2022 and 2023 Growth Rates

Component	2023 Final	2023 Advance Notice	2022 Final
MA Growth %	**4.75%**	4.25%	**6.30%**
FFS Growth %	**4.89%**	4.84%	**5.47%**

As has been the case in past years, the year over year change in Part C benchmarks can vary significantly depending on geographic area, plan star rating and applicable percentage. Table 2 shows the top five and bottom five growth rates by State (these changes include changes due to repricing/rebasing, direct graduate medical education (GME), kidney acquisition costs (KAC), indirect medical education (IME), Veteran's affairs and Department of Defense, credibility factors, star rating, double bonus status, applicable percentage, and the benchmark cap).

Table 2 - States with Highest and Lowest Benchmark Change

Rank	State	Change
1	DC	11.6%
2	NY	8.4%
3	MI	8.1%
4	KY	7.4%
5	KS	7.0%
47	VT	4.2%
48	UT	4.2%
49	MN	4.1%
50	ME	3.9%
51	CO	3.4%

Attachment II: Key Assumptions and Financial Information

As in past years, CMS published projections for the total United State Per Capita Costs (USPCCs) by year. Projections are provided for all Medicare services combined as well as more detailed projections by service category within Part A and Part B.

Table 3 shows how CMS FFS cost estimates have restated from the 2022 Announcement to the 2023 Announcement. The increased costs for 2022 and 2023 lead directly to a higher growth rate than what would have been implied using the USPCC projected FFS costs from the 2022 Announcement.

Table 3 – Non-ESRD FFS Cost Estimates – 2023 Final Announcement versus 2022 Final Announcement

Year	CY2023 Final Announcement	CY2022 Final Announcement	Restatement
2021	$935.10	$929.69	-0.5%
2022	$1,023.31	$1,028.38	2.1%
2023	$1,078.63	$1,056.60	2.2%

A primary cause of these restatements is that CMS is now projecting that deferred care caused by COVID will be more intense in 2021, and that beneficiaries will make up for some of this deferred care in 2022 and 2023. The net result is that CY2023 costs are now higher, which directly translates into a higher FFS growth rate.

It is also interesting to note that CMS is continuing to project that Medicare Advantage enrollment will outpace the change in total Medicare beneficiaries for 2023 through 2025. In fact, FFS enrollment is projected to decrease from 2022 to 2023. Table 4 shows the annual increase in CMS's projected enrollment for these years.

Table 4 – Projected Annual Percentage Change in Medicare Enrollment

Year	Total	FFS	MA
2023	2.5%	-0.7%	6.2%
2024	2.6%	1.1%	4.3%
2025	2.5%	1.0%	4.0%

Attachment III: Responses to Public Comments

Section A. Estimates of the MA and FFS Growth Percentages for CY 2023

Notable comments and CMS responses on 2023 growth rates include the following:

COVID-19 COMMENTS AND RESPONSES:

One commenter requested additional information on projected CY 2023 inpatient treatment costs (excluding testing) including utilization and unit cost assumptions. They specifically requested that CMS provide more detail around how they adjusted COVID-19 treatment claims in 2020 as part of the CY 2023 growth rate, if the inpatient costs could not be split out.

In response, CMS provided the following information:

Approximately 0.46% of the 2023 USPCC in the Advance Notice of $1,078.12 is estimated to be for COVID-19 related inpatient spending. In 2020, about 3.20% of the 2020 FFS USPCC of $848.65 is attributed to COVID related inpatient spending.

Several commenters asked for additional detail and transparency regarding CMS's COVID-19 model assumptions. In response, CMS provided the following detail on their assumptions and methodology:

For COVID-19 modelling, they began with the historical spending for both COVID and non-COVID costs by service type. They have worked with the CDC and HHS to make projections of the number of cases, hospitalizations and deaths associated with COVID-19. These projections are then used to project the direct costs for COVID-19.

The 20% payment bump for COVID-19 hospitalizations only occurs during the Public Health Emergency (PHE) and for their modelling, they assumed that the PHE ended in mid-CY 2022. Non-COVID costs have been significantly lower than normal and are inversely related to the path of the pandemic – they have continued this relationship in the projections.

Additionally, CMS has assumed that a portion of the services that have been forgone are deferred until a later date, including CY 2023, and that those deferred services will be more intensive when they do occur.

Costs for Medicare beneficiaries who died with a COVID-19 diagnosis tended to be much more expensive than the average Medicare beneficiary. As a result, the surviving population on average has lower projected per capita spending. CMS included this reduction in average morbidity of the population in their estimates. Their current projection is that in CY 2024, health

care spending patterns will return to pre-pandemic levels, but the lingering effects of the shift in morbidity will continue through CY 2028.

One commenter asked for an estimate of the costs covering COVID-19 testing, at home OTC COVID-19 tests, and the elimination of cost sharing for certain testing and testing related services. CMS responded that tests provided by Medicare providers are covered under Part B and are reflected in the direct COVID-19 projection factors applied to the USPCC estimate. At-home OTC tests are not currently covered under Part A or B, and are not included in the USPCC estimate. These tests will be covered through the recently announced demonstration in which Original Medicare will cover the tests for all Part B beneficiaries, including those in MA plans.

Several commenters asked clarifying questions relating to the COVID-19 vaccine assumptions stated by OACT during the February 4th advance notice stakeholder call.

In response, CMS clarified their methodology in developing these assumptions. They developed various scenarios of utilization, accounting for a range of assumptions for level of waning immunity, level of virus mutation, and availability of effective therapeutics. They applied weights to these various scenarios, resulting in a 52% utilization estimate in 2023.

Additionally, CMS stated that the vaccination rate is expected to decrease somewhat over time, reflecting the possibility that the prevalence or seriousness of COVID-19 will decrease due to changing levels of immunity, virus mutation and the availability of effective therapeutics. They have projected that immunity will likely last longer as time goes on, and frequency and severity of variants will decline.

Further, they provided the following assumptions:

- 52% of the vaccines assumed to be covered by Medicare
- On average, a vaccinated individual will get 1.4 doses in 2023
- The average per dose vaccine cost is $64 and the administration cost is $40 for CY 2023

One commenter expressed that the 2023 Advance Notice states that 2019 National Claims History (NCH) data was used as the based year for projected FFS USPCCs for most services. They asked if more recent data was not used because of COVID-19 or whether 2019 was the most recent data that could be compiled and analyzed for purposes of rate setting.

CMS responded that CY 2019 NCH represents the last year of pre-pandemic experience, allowing for projection of base excluding COVID-19 impacts. Accordingly, CY 2019 data was used as the base in the USPCC projections supporting the CY 2022 Rate Announcement, the CY 2023

Advance Notice and CY 2023 Rate Announcement. Projections from 2019 to 2023 including factors to represent the impact of COVID-19 on expenditures.

For Medicare Advantage projections, 2020 was used as the base year as expenditure data is mostly complete, and the results are more current than 2019. Since MA payments are capitated based in part on projected bids, the pandemic has less of an impact on MA expenditures than FFS. The MA USPCC projection uses the CY 2020 MMR as the base year, and is trended to CY 2021 and CY 2022 using MA BPT data.

NON-COVID-19 COMMENTS AND RESPONSES:

Some commenters noted that the CY 2023 Advance Notice does not address CMS estimates of potential costs associated with aducanumab (brand name Aduhelm), a treatment for Alzheimer's Disease approved in 2021. A second commenter asked CMS to clarify the implications for cost estimates if a final Medicare national coverage determination allows relatively broad access to aducanumab.

CMS responded that the USPCC projections are consistent with the NCD issued on January 11, 2022. The projected cost associated with Aduhelm was modeled on the proposed NCDs policy. In the USPCCs supporting both the 2023 Advance Notice and Rate Announcement, the 2023 FFS spending for these treatments was estimated to be $106M based on the proposed NCD. CMS does intend to provide additional information if the final NCD varies significantly from the proposed.

It should be noted that subsequent to the publication of the 2023 Announcement, CMS released its final decision regarding Medicare coverage for Aduhelm, which is consistent with the assumptions made in the Announcement in that beneficiaries will be required to enroll in a clinical trial in order to be eligible for coverage.

Section B. MA Benchmark, Quality Bonus Payments, and Rebate

Several commenters expressed concern that the rate prior to the enactment of the Patient Protection and Affordable Care Act rate cap limits health plans' ability to improve coverage for enrollees including adding supplemental benefits and reducing cost sharing. Another commenter stated the caps hamper plans' ability to support equity. Commenters suggested CMS review available options for exercising discretionary, regulatory, and/or demonstration authority to eliminate the cap or to remove quality bonuses from the cap calculation and reward high performing plans. Two commenters referred to legal analyses provided to CMS in previous years regarding this issue that showed that they believed such changes were legally permissible.

In response, CMS stated that they have not identified discretion under section 1853(n)(4) of the Act to eliminate application of pre-ACA rate caps or exclude the bonus payment from the cap calculation.

Section C. Calculation of Fee-for-Service Costs

One commenter expressed concern with the CMS proposal to limit the adjustment of the average geographic adjustments (AGAs) for Innovation Center payment and service delivery models to those listed in Table B1-1 of the CY 2023 Advanced Notice, and with the proposed exclusion of certain payments under those models that are funded through Innovation Center rather than Medicare Part A or B Trust Funds.

In response, CMS referred to page 29 of Part II of the CY 2023 Advance Notice, which discussed their consideration for adjusting the FFS claims experience for care management fees, per beneficiary per month fees, and/or advance payment of shared savings paid using the Innovation Center appropriation instead of the Medicare Part A or B Trust Funds. However, in continuing prior policy, they will not take fees of this type into account in adjustments to FFS historical experience when they were not funded under Medicare Part A or B Trust Funds.

Two commenters suggested that the impact of rebasing county FFS rates for CY 2023 reveals a much larger, negative impact in Florida than in most states.

CMS responded by referring to their tool and corresponding glossary information, which provides stakeholders the means to replicate the FFS rate development. The CMS analysis of the rate development for Florida counties reveals that there is not a disproportionally negative impact of changes in the AGAs from 2022 to 2023.

As with several prior rate announcements, many commenters questioned the appropriateness of continuing to include FFS beneficiaries with either only Part A or Part B in the calculation of FFS costs. CMS responded similarly to prior years, that there is no statutory requirement to exclude beneficiaries with only Part A or Part B coverage.

A number of commenters expressed concern regarding the disparity between payment rates in Puerto Rico and the mainland. CMS responded indicating that they have not found evidence that FFS costs in Puerto Rico are higher than the costs observed in the FFS claims data, and thus there is no basis for methodological changes.

Section D. Direct Graduate Medical Education

CMS did not report any respondent concerns pertaining to the 2023 Advance Notice's proposed new methodology.

Section E. Organ Acquisition Costs for Kidney Transplants

Commenters raised the concern that the relative newness of the kidney acquisition cost (KAC) adjustment, in combination with other proposed changes, could result in large changes in MA benchmarks for some counties in CY2023. Commenters requested that steps be taken to limit large decreases, and that the impact of KAC carve-out be monitored.

CMS indicated that they will "continue to monitor these amounts to determine the most accurate methodology for these adjustments".

Section F. ESRD Rates

Commenters raised the concern that the current ESRD payment rates are not sufficient to cover associated costs, and made suggestions to change the payment calculation. Suggestions included utilizing smaller geographic areas, applying the quality bonus payment (QBP) or applicable percentages to ESRD rates, and adjusting rates to reflect the impact of the Maximum Out-of-Pocket (MOOP) requirement in the MA program.

CMS noted that any major changes to ESRD methodology would have to be raised in the Advance Notice. CMS also noted that many of the suggestions would not be consistent with various laws dictating calculations of benchmarks, but they said they would continue to analyze whether "any refinements to the methodology may be warranted in future years." More specifically, CMS noted it believed that applying QBP, applicable percentage or MOOP adjustments would be inconsistent with Section 1853 of the Social Security Act.

Commenters recommended CMS change the BPT so that the ESRD subsidy falls under Medicare-covered benefits instead of under Mandatory Supplemental benefits. CMS declined to make this adjustment and stated that the ESRD subsidy that is permitted in plan bids for non-ESRD beneficiaries will remain a Mandatory Supplemental benefit.

Section G. MA Employer Group Waiver Plans

CMS reaffirmed the bid-to-benchmark ratios will be developed using the methodology described in the Advance Notice. CMS also released the final bid-to-benchmark ratios, updating to use February 2022 enrollment. Table 5 compares the 2023 ratios with 2022.

Table 5 - EGWP Bid-to-Benchmark Ratios

	EGWP Bid-to-Benchmark Ratio	
Quartile	2022 Payment	2023 Payment
0.950	83.0%	80.7%
1.000	82.6%	79.8%
1.075	82.6%	79.7%
1.150	82.9%	79.8%

Many commenters expressed concern related to adjusting the bid-to-benchmark ratios to account for negative margin plans. CMS rejected these concerns, noting that negative margin plans are considered in the non-EGWP market as well. In the same genre, CMS rejected a suggestion to calculate EGWP rates separately for HMOs and PPOs.

Section H. CMS-HCC Risk Adjustment Model for CY 2023

CMS confirmed they are finalizing the continuation of the CY 2022 policy to calculate 100% of risk score using the 2020 CMS-HCC model for Non-Pace organizations

Many commenters expressed concerns about the current risk score models and the impact of COVID-19 and offered several suggestions for potential changes. CMR responded that the CMS-HCC risk adjustment model is not changing due to COVID. However, CMS noted that the submission windows were extended in 2020, 2021, and 2022

Some commenters expressed concern about using the 2017 CMS-HCC model for payment to PACE organizations, noting that the model excludes dementia and other chronic conditions. CMS acknowledges that the model does not include dementia HCCs but noted that the 2020 CMS-HCC model cannot be used for PACE beneficiaries as risk scores are not developed using solely encounter data and FFS claims. CMS will use the 2020 CMS-HCC model for PACE as soon as PACE organizations begin to fully submit encounter data. For 2023, PACE will still use the 2017 CMS-HCC model

Several comments on how to implement social determinants of health (SdoH) into a future risk score model, with specific ideas and commentary shown in the final rate notices. CMS acknowledged the discussion and said they would take it into careful consideration as they develop any methodological changes.

Section I. End Stage Renal Disease (ESRD) Risk Adjustment Models for CY 2023

CMS confirmed for CY 2023 that risk scores for beneficiaries with ESRD in MA plans will use the CY 2023 ESRD models as proposed in the Advance Notice. CMS clarified many points about how the model was developed and the impact in the Final Rate Notice.

In response to commenter concerns, CMS clarified that that the lower normalization trend adjustment and risk model adjustment model impact offset each other when comparing to risk adjusted payment for CY222.

Section J. Medicare Secondary Payer (MSP)

There were no comments received on this section. The MSP factor is confirmed to be 0.136 for non-ESRD and ESRD functioning graft beneficiaries. The MSP is confirmed to be 0.135 for ESRD dialysis/transplant beneficiaries.

Section K. Frailty Adjustment for PACE Organizations and FIDE SNPs

For fully integrated dual eligible (FIDE) SNPs and PACE organizations in CY 2023, CMS will use the frailty factors as proposed in the CY2023 Advance Notice and summarized in Tables 6 and 7.

Table 6: 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	-0.140	-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 7: 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

Several comments on the calculation of frailty factors were submitted that CMS considered, but ultimately rejected. A brief summary is shown below.

Some commenters requested that CMS consider flexibility in the administration of HOS-M Surveys for patients with dementia. CMS responded that its approach to developing the HCC

model already adjusts for residual costs by way of frailty factors. Permitting variation in how the survey is administered for participants with specific conditions may disproportionately affect frailty scores for certain organizations.

Commenters also requested that CMS consider applying frailty adjustment more broadly (e.g., HIDE SNPs or certain C-SNPs). In responding, CMS noted it cannot make frailty payments to any SNP that does not meet these criteria without implementing frailty payments program-wide.

Finally, some commenters requested CMS consider different approaches for estimating frailty adjustments. CMS said that it believes HOS and HOS-M continue to provide an accurate and representative measurement of frailty.

Section L. Medicare Advantage Coding Pattern Adjustment

CMS has finalized the proposed coding pattern adjustment for CY 2023 as the statutory minimum of 5.90%.

CMS responded to several varying comments regarding the Coding Pattern Adjustment, including:

- A higher adjustment factor is needed, in particular citing MedPAC analysis supporting this view.
- Use different calculation approaches such as controlling for demographics and applying coding patterns to plans differently (according to the aggressiveness of coding).
- Use Medicare Advantage data to calibrate scores.

The CMS response was that they found the minimum adjustment sufficient to reflect the differences in coding patterns between MA plans and traditional Medicare providers.

Section M. Normalization Factors

CMS is finalizing the normalization factors as proposed in the Advance Notice. The CMS-HCC and CMS-HCC ESRD models will use historical scores from 2016 through 2020, and exclude 2021 scores due to the impact of COVID. Table 8 compares the normalization factors for CY 2023 to those used in CY 2022:

Table 8 – Comparison of 2023 FFS Normalization Factors with 2022

Model	2023 Payment Year	2022 Payment Year	Year-to-Year Impact
2020 CMS-HCC Model	1.127	1.118	-0.81%
2017 CMS-HCC Model (PACE)	1.140	1.128	-1.1%
ESRD Dialysis (non-PACE)	1.034	1.077	NA[1]
ESRD Functioning Graft (non-PACE)	1.048	1.126	NA[1]
2023 RxHCC model	1.050	1.043	NA[1]

[1]A year-to-year impact is not applicable since the two models have different denominator years

Numerous commenters expressed concerns about excluding 2021 risk scores from the CMS-HCC normalization factor calculation, and a majority of commenters were concerned that the impact of COVID on utilization is ongoing. While CMS did not specifically refute these concerns, it did state that it believed the inclusion of 2021 scores in the calculation would produce a normalization factor significantly below what the average is likely to be for 2023.

Section N. Encounter Data as a Diagnosis Source for CY 2023

CMS finalized the continuation of using only MA encounter data and FFS claims as the basis for non-PACE organization risk score calculations in CY2023. EDS Part C risk scores will be calculated with the 2020 CMS-HCC model.

For PACE organizations, CY2023 scores will continue to use the 2017 CMS-HCC model for non-ESRD aged/disabled participants and the 2019 ESRD models for participants with ESRD. CMS will 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 IV: Responses to Public Comments on Part D Payment Policy

Section A. RxHCC Model

CMS received support from commenters on the proposed recalibration of the RxHCC risk adjustment model, which included the following changes:

- Recalibrate using more current diagnosis and cost data
- Revised clinical classification using ICD-10-CM diagnosis codes

CMS received comments on the following:

- Concern that the recalibrated model does not account for the impact of COVID-19
- The potential considerable impact of recent congressional proposals with regard to the direct subsidy
- Adding concurrent data markers for certain drug classes/drugs to help improve predictive accuracy of relative costs
- Request for a sixty-day comment period
- Concern over removal of specific RxHCCs, including morbid obesity

CMS clarified that it is not going to make any further changes or adjustments to the model to account congressional proposals unless they become law. CMS will consider responding to policy changes after enactment. CMS further clarified that it has the authority to only provide a thirty-day comment window.

Section B. Encounter Data as a Diagnosis Source for 2023

CMS is finalizing the move to continue exclusively using encounter data and FFS claims for Part D risk scores, in the same manner as Part C scores (see Section N in Attachment III).

Section C. 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 2023, CMS will continue making prospective reinsurance payments to calendar year Part D EGWPs. The CY 2023 prospective reinsurance payment for EGWP sponsors will be based on the average reinsurance amount paid to CY 2020 EGWPs. This amount is $67.56 PMPM (versus $65.68 PMPM for CY2022 payments).

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

One commenter suggested adding a trend adjustment to the reinsurance amount to account for the amount that reinsurance payments are expected to increase. CMS will consider this suggestion for future years.

Section D. Part D Risk Sharing

There are no changes to the Part D risk corridor calculations for 2023. CMS confirmed that they used all available payment reconciliation amounts (CYs 2008-2020) when examining the risk corridor. A typographical error in the Advance Notice originally misstated that CMS had only looked at CYs 2008-2018.

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

CMS provided the final Part D benefit parameters for 2023 in Attachment V.

Attachment V: Final Updated Part D Benefit Parameters for Defined Standard Benefit, Low Income Subsidy, and Retiree Drug Subsidy

Attachment V contains detailed calculations of the annual adjustments to the Part D Defined Standard benefit parameters. Two annual percentage adjustments are calculated to develop the CY 2023 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 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 B. Calculation Methodology

The API uses prescription drug event (PDE) data to calculate the per capita Part D costs from August 2021 to July 2022 divided by the per capita Part D costs from August 2020 to July 2021. Since PDE data are not yet available for 2022, the per capita costs for the latter time period are estimated using August 2021 to December 2021 PDE data. This calculation results in an estimated 5.80% 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 -0.68%. This results in a total 2023 API of 5.08%.

The CPI increase is based on the projected September 2022 CPI divided by actual September 2021 CPI, which results in an estimated increase of 4.17%. This increase is further adjusted

based on revisions to prior years' estimates. The cumulative adjustment for prior year revisions is 3.13%. In total, this produces a 2023 CPI increase of 7.44%.

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

The CY 2023 total covered Part D spending at out-of-pocket threshold for applicable beneficiaries is calculated to be $11,206.28 ($10,690.20 for 2022). 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 Final Notice.

Section E. 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 CY 2023, the retiree subsidy cost threshold is $505 (was $480 in 2022) and the cost limit is $10,350 (was $9,850 in 2022).

Attachment VI: Updates for Part C and D Star Ratings

Extreme and Uncontrollable Circumstances for 2023 Star Ratings

For plans that qualify for disaster adjustments, the adjustment will result in the higher of their raw/unadjusted measure-level rating from 2022 (2020 performance) and 2023 (2021 performance) being used.

Because the COVID-19 disaster adjustment delayed the HOS survey one year, CMS is proposing to remove the 60 percent rule for HEDIS measures derived from the 2021 HOS Survey. This would ensure that Star Ratings cut points for the three HOS measures are able to be calculated. It would also allow these measures to be included in the determination of the performance summary and variance thresholds for the reward factor.

Several counties in Texas received EUC status (winter storms).

Several counties in Louisiana, Mississippi, New York, and New Jersey received EUC Status (Hurricane Ida).

New Measures for 2023 Star Ratings

Controlling Blood Pressure will be transitioned off the display page as a new measure with a weight of 1 in 2023 and a weight of 3 thereafter.

Removed Measures for 2023 Star Ratings

Rheumatoid Arthritis Management will no longer a measure in 2023.

Existing Star Rating Measures with Changes for 2023

The weights for Patient Experience/Complaints and Access Measures will be changed from 2 to 4.

The measure category "Statin Use in Persons with Diabetes (Part D)" will change from an Intermediate Outcome Measure (weight of 3) to a Process Measure (weight of 1).

Changes to Existing Star Rating Measures for Future Years (2024 and later)

The following existing measures have potential changes being considered by CMS. Any actual measure changes will need to come in future rulemaking. Unless otherwise noted, any substantive changes to measure methodology would prompt the measure to be moved to the display page for a period of two years.

- Diabetes Care – Kidney Disease Monitoring (Part C) – CMS will be removing this measure from the 2024 Star Ratings. It may be replaced by the Kidney Health Evaluation for Patients with Diabetes (Part C) measure.
- Complaints about the Health/Drug Plan (Part C and D) – CMS is considering adding a category of complaints (1.30 – CMS Lead Marketing Misrepresentation) that plans will be accountable for in the future. The current complaints measures would remain in the Star Rating until the updated complaints measures have been on the display page for at least two years, then the updated complaints measures would move into the Star Rating as a new measure.
- Medication Adherence for Diabetes Medication / Medication Adherence for Hypertension (RAS Antagonists) / Medication Adherence for Cholesterol (Statins) Measures (Part D) – CMS is testing the implementation of the sociodemographic status (SDS) risk adjustment for these Star Ratings measures.
- Colorectal Cancer Screening (Part C) – NCQA is adding ages 45-49 to the denominator in 2024. The current measure will remain in the Star Rating until the updated measure has

been on the display page for at least two years, then the updated measure will move into the Star Rating as a new measure.

- Diabetes Care Measures (Part C) – NCQA is considering developing new measures focused on eye exams and controlling blood sugar for diabetics using electronic clinical data.
- Controlling Blood Pressure (Part C) – NCQA is considering developing a new measure to assess blood pressure control over time using electronic clinical data.
- Care for Older Adults (Part C) – NCQA is considering updates to the three indicators (Medication Review, Functional Status Assessment, and Pain Assessment).
- Adult Immunization Status (Part C) – NCQA is considering several changes to this measure, including updating the pneumococcal indicator, capturing members aged 18 and older for all product lines, changing the data source used to capture influenza vaccinations to use the HEDIS results instead of the CAHPS survey, and developing a COVID-19 vaccination measure.
- The following measures have non-substantive changes in 2024 star ratings and later:
    - Statin Use in Persons with Diabetes (Part D).
    - Medication Adherence for Diabetes Medication / Medication Adherence for Hypertension (RAS Antagonists) / Medication Adherence for Cholesterol (Statins) Measures / Statin Use in Persons with Diabetes (Part D).
    - Medicare Plan Finder Price Accuracy (Part D).
    - Colorectal Cancer Screening (Part C).
    - Breast Cancer Screening (Part C).
    - All measures using a Frailty & Advanced Illness exclusion (Part C).

Potential New Measure Concepts and Methodological Enhancements for Future Years

CMS is considering the following new measure concepts and methodological enhancements and have collected feedback from commenters. See below for the current status of each of these proposed enhancements.

- Driving Health Equity (Part C and D) – still taking comments into consideration

- Stratified Reporting (Part C and D) – CMS will begin providing confidential stratified report with contracts through HPMS this spring.
- Health Equity Index (Part C and D) – still taking comments into consideration.
- Measure of Contracts' Assessment of Beneficiary Needs (Part C) – *still taking comments into consideration.*
- Screening and Referral to Services for Social Need (Part C) – this measure is currently being considered by NCQA and is in development phase.
- Value-based Care (Part C) – still taking comments into consideration.
- Kidney Health (Part C) – this measure is currently being considered by NCQA and is in development phase.
- Persistence to Basil Insulin (PST-INS) Measure (Part D) – this measure will be added to the display page for the 2024 and 2025 Star Ratings (2022 and 2023 performance years)
- Beneficiary Access and Performance Problems (Part C and D) – *still taking comments into consideration.*
- CAHPS (Part C and D) – still taking comments into consideration

Attachment VII: Economic Information for the CY 2023 Rate Announcement

Attachment VII provides estimates of the net impact to the Medicare Trust Funds of changes to the Medicare Advantage and PACE plans for CY 2023. Items not identified in Attachment VII indicate a continuation of CY 2022 policies so have not been called out in this section of the final announcement. Following are changes from the CY 2023 Advance Rate Notice

Section A – Changes in Payment Methodology for Medicare Advantage and PACE for CY 2023

- Medicare Advantage and PACE non-ESRD Ratebook
- Effective growth rate for 2023 MA non-ESRD rates estimate – **4.88% a change from 4.75% in the Advance Notice**
- Net impact $17.3 billion cost to Medicare Trust Funds - up from $17.2 in the Advance Notice.

- MA growth percentage used to calculate the 2023 PACE non-ESRD is estimated to be **4.75% a change from 4.25% in the Advance Notice**
- Net Impact $70 million cost to Medicare Trust Funds – up from $60million in the Advance Notice.
- Medicare Advantage and PACE ESRD Ratebooks
- FFS growth percentage for the 2023 MA ESRD rates is estimated to be **9.59% up from 5.58% in the Advance Notice**
- Net impact $2.3 billion cost to Medicare Trust Funds – up from $1.3 billion in the Advance Notice.
- ESRD Risk Adjustment
- CMS is proposing a revised ESRD risk adjustment model to use more recent data and an updated clinical version with dual segmentation.
- Relative to 2022, the net savings to the Medicare Trust Funds in 2023 is estimated to be $**500 million up from an estimate of $470 million in the Advance Notice**.
- MSP (Medicare Secondary Payer)
- CMS is implementing updated MSP factors for working aged/disabled and ESRD beneficiaries. Noted in Section J of Attachment IIII- the CY 2023 MSP factor for working aged / disabled and ESRD functioning graft beneficiaries is 0.136 and the MSP factor for ESR dialysis/transplant beneficiaries is 0.135.
- The estimated impact to the Medicare Trust Funds in 2023 is **$70 million net savings**.

Section B Changes in the Payment Methodology for Medicare Part D for CY 2023

- Part D Risk Adjustment Model
- For CY 2023 –CMS is implementing the updated version of the RxHCC risk adjustment model proposed in the 2023 Advance Notice. Risk scores may change for individual beneficiaries and plans however the average risk score in the denominator year remains 1.0 in the payment year.
- The economic impact of the recalibrated model is $0.

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

Wakely estimates that, on a nationwide average basis, and as compared with 2022, nationwide average 2023 Part C benchmarks will:

- Increase by 5.79 % on a standardized (i.e. 1.00) risk score basis. This incorporates changes driven by FFS growth rate, rebasing/re-pricing, GME, KAC, VA DoD, IME, credibility, applicable percentage by county, average change in star ratings and quality bonus, and the impact of benchmark.
- Increase by 4.95% 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 risk-adjusted estimate is based on the following components:

- Change in 1.00 benchmarks
- Impact of change in fee-for-service normalization factor
- Assumption of no trend in raw risk scores
- Average change in star ratings based on March 2022 enrollment

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

Table A1 Change in Blended Risk-Adjusted Benchmarks [1] 2022 to 2023	
Growth Rate	5.23%
Rebasing/Re-pricing	-0.01%
Applicable %	0.19%
Star Rating/Quality Bonus	0.60%
Benchmark Cap	-0.23%
Total Benchmark Change	**5.79%**
FFS Normalization	-0.80%
MA Coding Pattern Change	0.00%
Total Risk Score Change	**-0.80%**
TOTAL	**4.95%**
[1] Based on March 2022 MA enrollment and Fall 2021 Star Ratings	

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

Growth Rate. This is the impact of the FFS (+4.84%) growth rate and the following adjustment factors:

> *Direct Graduate Medical Education (GME).* CMS is required to remove costs directly related to graduate medical educate. For CY2023, CMS is adapting a new methodology for calculating GME carve out costs. The total impact of this factor increased rates by about 0.22%.
>
> *Veteran's Affairs and Department of Defense (VA and DoD).* The change in these carve out factors from 2022 to 2023 had a minimal impact (0.02%).
>
> *Credibility.* As FFS enrollment decreases, credibility adjustments are necessary when developing the rates used for MA payment. We anticipate more counties will require a credibility adjustment in future years. The change from 2022 to 2023 was insignificant (+0.01%).
>
> *Kidney Acquisition Costs (KAC).* Due to the 21st Century Cures Act, CMS is required to remove kidney acquisition costs from the development of the MA payment rates. Similar to the GME costs, CMS implemented a new methodology for 2023. The nationwide average change from 2022 to 2023 was 0.12%.
>
> *Indirect Medical Education (IME).* Costs attributable to indirect medical education are also removed from the payment rates. The change from 2022 to 2023 was insignificant (-0.04%).

Rebasing/Re-pricing. The Average Geographic Adjustment (AGA) factors are derived via the compilation of five years of historical Medicare Parts A & B claim costs at the county level. For payment year 2023, historical claims from 2016 to 2020 are repriced to reflect the most current wage indices (Fiscal year 2022). Wakely calculated the overall impact to MA plans is -0.01%. The impact of the rebasing and re-pricing for 2023 payment rates varies significantly by region. Note, 2020 costs were not adjusted for impacts of COVID-19.

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 2022 and 2023. This is based on a static enrollment mix, so it only reflects changes in average star ratings by contract, and not a shift in enrollment toward plans with higher or lower star ratings. In addition, it does not include terminated contracts or the potential for new contracts with a 3.5% bonus in 2023.

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.

Part C Fee-for-Service (FFS) Normalization Factor. The 2022 Part C FFS normalization was 1.118. For 2023, the FFS normalization factor is proposed to be 1.127. The impact is (1/1.118)/(1/1.127) = -0.80%.

Change in Coding Pattern Adjustment. The coding pattern adjustment for 2023 will be -5.90%, which is the minimum adjustment required by the Affordable Care Act. There will be no change from 2022.

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 2022 and 2023 bids are 80% of the benchmark then we estimate the change in Part C payments from 2022 to 2023 to be an increase of +4.46% (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 +4.64%. If we include estimated changes in bid and rebate levels, then the impact to Part C revenue is +5.01%. This estimate is based on the following assumptions:

- Plans bid at 80% of the benchmark in 2023. This is based on the published bid-to-benchmark ratios in the 2023 Advance Notice.
- Annual risk score coding trend is 0% for a static population
- Nationwide average star ratings, which result in an average rebate percentage of 65.7% in 2022 and 67.3% for 2023
- No consideration for sequestration or insurer fee

Table A2 shows the calculations underlying our estimates.

Table A2			
Item	**2022**	**2023**	**2023/2022**
1.0 MA Benchmark [1]	$1,069.00	$1,130.92	5.79%
Raw Risk Adjustment Factor [2]	1.0000	1.0000	0.00%
FFS Normalization	1.1180	1.1270	-0.80%
MA Coding Pattern Adjustment	0.9410	0.9410	0.00%
RAF after FFS Norm & Coding Pattern	0.8417	0.8350	-0.80%
Risk-Adjusted Benchmark	$899.75	$944.28	4.95%
Assumed Risk-Adjusted Bid [4]	**$719.80**	**$755.42**	**4.95%**
Savings (Benchmark less bid)	$179.95	$188.86	4.95%
Rebate	$118.31	$127.13	7.45%
Risk-Adjusted Bid + Rebate	**$838.11**	**$882.55**	**5.30%**
[1] Based on nationwide average MA enrollment by county as of March 2022			
[2] Assumed no trend in risk scores			
[3] Bid set at 80% of risk-adjusted benchmark			
[4] 65.7% for 2022 and 67.3% for 2023			