2021 Medicare Advantage

Summary of Final Rate Notice and Part C Bid Review Memo

April 14, 2020

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Executive Summary

On April 6, 2020, CMS released the 2021 Final Announcement (the Notice). Shortly thereafter, CMS also released the "Final Contract Year 2021 Part C Benefits Review and Evaluation" memorandum on April 8, 2020. This memo along with a similar Part D memo released in February 2020 replace the information historically addressed in the Call Letter.

CMS largely maintained the recommendations in the Advance Notice and Part C Benefits Review memo; however, there were some notable changes.

The most impactful change for MAPD plans is an increase to the CY2021 fee-for-service (FFS) growth rate, which is now the major driver of Part C benchmark rates. The 2020 growth rate is 3.64%, more than a full point above the 2.57% growth rate in the Advance Notice, Part 2. At the time this summary was completed, CMS had not yet provided any explanation as to the cause of the increase.

Following is a brief summary of the key changes and proposals in the 2019 Notice.

Part C Payment Methodology

- Non-ESRD FFS growth rate percentage for CY2019 is 3.64%.

Risk Scores

- CMS will use the existing RAPS-based 2017 HCC model and 2020 EDS-based HCC model. The blend is 25%/75% of the 2017 HCC/2020 HCC models.
- The FFS Normalization factor for CY2021 is proposed to be a 1.106 and 1.097 for the 2017 RAPS and 2020 EDS models, respectively. These are the same factors proposed in the Advance Notice, Part 2. Factors used in CY2020 were 1.075 and 1.069, respectively.
- CMS will maintain use of the 2020 RxHCC model for PY2021. The RxHCC FFS normalization factor will be 1.063. The PY2020 normalization factor was 1.043.
- The CY2021 blend of RAPS/EDS risk scores for MA and PD will be 25%/75%, as proposed in the Advance Notice, Part 2. EDS-based risk scores will continue to use diagnosis data from encounter submissions as well as RAPS based on diagnoses from inpatient services.
- The coding pattern adjustment is set at the statutory minimum of 5.90%, which represents no change compared with CY2020.

EGWPs

- CMS confirmed all EGWP proposals in the Advance Notice, Part 2.
- The 2021 bid-to-benchmark ratios are lower than those used to determine 2020 EGWP payments for all quartiles except the 1.150 quartile. Table 1 compares the ratios.

Table 1 – EGWP Bid-to-Benchmark Ratios

	EGWP Bid-to-Benchmark Ratio	
Quartile	2020 Payment	2021 Payment
0.950	84.7%	84.2%
1.000	86.6%	85.1%
1.075	86.1%	84.9%
1.150	86.5%	86.5%

- Cost sharing standards were updated for MA and PD benefits. All thresholds stayed the same as those presented in the Advance Notice, Part 2, with the exception of a change to the factor used for the inpatient actuarial equivalent cost comparison.
- The voluntary ($3,450) and mandatory MOOP ($7,550) amounts were adopted as proposed.
- Part D parameters were implemented as proposed. The changes for 2021 were modest increases over 2020 for all parameters.

TBC Thresholds

- The CY2021 TBC threshold will be $39, which is $3 higher than the 2020 threshold. CMS noted that the increase is "to account for changes in ESRD enrollment policy and provide greater flexibility in navigating related MOOP limit changes…"
- As in CY2020, 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

- Due to COVID-19, CMS will implement the following key changes for 2021 Star Ratings (i.e. which apply to payment year 2022):
- The 2021 Star Ratings measures based on HEDIS and CAHPS data will use the same data as the 2020 Star Ratings.
- The "new MA plan" definition will be extended for one additional year. New MA plan means an MA contract offered by a parent organization that has not had another MA contract in the previous four years.
- 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 changes:
- 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.

- 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.

Overall MA Payment Impact

Wakely estimates that, on average, 2021 Part C standardized benchmarks will increase 4.1% over 2020 nationwide. This reflects the impact of the growth rate, change in star ratings, changes to applicable percentages (i.e. quartile rankings), county rebasing, 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 +1.9%. 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 with 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 2020 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 document includes many details discussed at length in the Notice, in the order presented in the Notice.

Attachment I: Final Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2021

The final 2021 MA and FFS growth rates are shown in Table 1 and are compared with the Advance Notice, Part II and the 2020 growth rates.

Table 1 – Comparison of 2020 and 2021 Growth Rates

Component	2021 Final	2021 Advance Notice, Part II	2020 Final
MA Growth %	**5.62%**	4.52%	5.79%
FFS Growth %	**3.64%**	2.57%	5.58%

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 star rating, double bonus status, applicable percentage, benchmark cap, and the removal of kidney acquisition costs).

Table 2 - States with Highest and Lowest Benchmark Change

Rank	State	Change
1	AL	7.8%
2	PR	7.5%
3	NJ	6.8%
4	NY	6.6%
5	NE	6.0%
47	HI	2.6%
48	AZ	2.6%
49	FL	2.0%
50	DC	2.0%
51	MA	1.5%

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.

Compared with the February 5, 2020 Advance Notice Part II, the estimated Part A + Part B costs for 2020 through 2021 increased by about 1.0%. These restatements directly contributed to the higher FFS growth rate (3.64%) as compared with the Advance Notice Part II preliminary estimate (2.57%). CMS did not provide an explanation for the increase in the FFS growth rate in the Final Notice.

It is also interesting to note that CMS is projecting Medicare Advantage enrollment to outpace the change in total Medicare beneficiaries for 2021 through 2023. Table 3 shows the annual increase in CMS's projected enrollment for these years.

Table 3 – Projected Annual Percentage Change in Medicare Enrollment

Year	Total	FFS	MA
2021	2.5%	1.0%	4.7%
2022	2.6%	1.9%	3.7%
2023	2.5%	2.1%	3.0%

Attachment III: Responses to Public Comments

Section A. Estimates of the MA and FFS Growth Percentages for 2021

Notable comments and CMS responses on 2021 growth rates include the following:

- Many commenters expressed concern at the significant fluctuation in growth rates between the early preview of growth rates (typically released in late November or early December) and the rates published in the Advance Notice. In its response, CMS noted that growth rates estimates at different points in time are based on the latest information available. Given commenters' concerns, CMS said it will consider whether to discontinue the Early Preview in the future.
- Several commenters questioned why the MA growth rate is so much higher than the FFS growth rate. CMS provided the following reasons:
- Higher trends in MA risk scores
- Increased enrollment in plans with four or more stars
- Increase in the share of duals enrolled in MA
- In response to questions on potential costs related to new Medicare coverage (effective August 7, 2019) for Chimeric Antigen Receptor T-Cell (CAR-T) therapy, CMS published its estimates of potential FFS costs. Table 4 shows estimated costs of CAR-T under Medicare FFS.

Table 4 – CMS Estimated CAR-T FFS Costs

Year	Hospital Outpatient Cost PMPM
2018	$0.02
2019	$0.03

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

As in past years, commenters requested that CMS consider removing the pre-ACA benchmark cap on the calculation of MA benchmark rates. In its response, CMS indicated it did not have discretion under the Social Security Act to implement such a change

Section C. Calculation of Fee-for-Service Costs

Several commenters questioned whether it was appropriate for CMS to continue to include FFS beneficiaries with either only Part A or only Part B coverage in the calculation of FFS costs. They pointed out that MA enrollees must be eligible for both Parts A and B.

Without directly refuting the commenters' points, CMS noted that there was no statutory requirement to exclude beneficiaries with either only Part A or only Part B coverage. CMS also indicated it "will continue to analyze this issue and consider whether any adjustments to the methodology on this point may be warranted in future years".

Section D. Kidney Acquisition Costs

Many respondents requested additional clarity on the process CMS used to calculate kidney acquisition costs (KAC) under FFS, and the related calculation of KAC carve-out factors applied to Part C benchmark rates by county.

Some of the most important explanations CMS provided related to KAC are as follows:

- KAC are currently paid to hospitals on a "pass-through" basis, and are not linked to individual claims.
- Past MA benchmark rate calculations have included these FFS pass-through amounts.
- Pass-through amounts paid by the FFS program are allocated to all inpatient claims of a certified transplant center and are tabulated based on the enrollees' county of residence. This means that the KAC are spread across ESRD and non-ESRD enrollees, and will reflect enrollees' county of residence rather than the location of the certified transplant center.

Section E. ESRD Rates

Commenters raised the concern that the current ESRD payment rate is inadequate to cover associated costs, and made different suggestions to change the payment calculation. Suggestions included 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 rejected these concerns and suggestions for 2021 and said it 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 consistent with Section 1853 of the Social Security Act.

Section F. MA Employer Group Waiver Plans

CMS reaffirmed the bid-to-benchmark ratios in Table 1 of this summary. In general, commenters were supportive of CMS's intent to continue using the same payment and filing requirements for EGWPs.

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

For CY 2021, CMS will apply the phase-in of the 2020 CMS-HCC model as proposed in the Advance Notice:

A weight of 75 percent will be applied to scores from the 2020 CMS-HCC model.

A weight of 25 percent will be applied to risk scores calculated with the 2017 CMS-HCC model.

CMS acknowledged that it has received comments suggesting that telehealth encounters be allowed for risk adjustment purposes and has received requests for clarifying guidance regarding the inclusion of diagnoses from telehealth encounters in risk adjustment. CMS indicated it will issue separate guidance on the topic.

CMS clarified that in the 2020 CMS-HCC model, the count variable includes any of the 86 HCCs that are included in that model for payment, including HCCs that have a coefficient of zero.

Section H. ESRD Risk Adjustment Models for CY 2021

CMS will adopt the methodology as proposed in the Advance Notice. That is, 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).

CMS will continue to apply the adjustments finalized in the CY 2020 Rate Announcement to the dialysis new enrollee, post-graft new enrollee, and post-graft LTI segments of the 2020 ESRD models.

Section I. CMS-HCC Risk Adjustment Used for PACE Organizations in CY 2021

For CY 2021, CMS will continue to use the risk adjustment policy introduced in CY 2020, which is to calculate PACE risk scores using the 2017 CMS-HCC model.

Section J. Frailty Adjustment for PACE Organizations and FIDE SNPs

For fully integrated dual eligible (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. As proposed in the Advance Notice, CMS will 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.

CMS will use the frailty factors associated with the 2017 CMS-HCC model to calculate frailty scores for PACE organizations in CY 2021. Tables 5 and 6 show the frailty factors to be used.

Table 5- 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 6 - 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 K. Medicare Advantage Coding Pattern Adjustment

CMS has finalized the proposed coding pattern adjustment for CY 2021 as the statutory minimum of 5.90%.

Section L. Normalization Factors

CMS is finalizing the normalization factors as proposed in the Advance Notice. Table 7 compares the normalization factors for CY 2021 to those used in CY 2020:

Table 7 – Comparison of 2021 FFS Normalization Factors with 2020

Model	2020 Payment Year	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%

In response to comments suggesting the normalization factors are too high, CMS stated that their projection of FFS risk scores (i.e., the normalization factor) has underestimated the actual FFS risk score since 2015 by an average of 2.75%.

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

CMS finalized the following EDS/RAPS mix for 2021:

- 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 operating in CY2021, CMS has finalized the continued use of 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 is also continuing to calculate 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) for each PACE participant.

Attachment IV: Responses to Public Comments on Part D Payment Policy

Section A. Update of the RxHCC Model

Commenters requested an update to the model to more closely align with the current marketplace. CMS will continue to use the 2020 RxHCC model to calculate Part D risk scores, which is calibrated using 2014/2015 data. CMS intends to update the underlying data in the near future.

Section B. Encounter Data as a Diagnosis Source for 2021

(See Section M in Attachment III)

Section C. Part D Risk Sharing

There are no changes to the Part D risk corridor calculations for 2021 announced in the Final Rate Notice.

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

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)

See Table 8 for detail of all Part D defined standard parameters.

Table 8 – CY2021 Part D Defined Standard Benefit Parameters

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 (6)	$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

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 CY2021 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 -0.3%, 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 2020 CPI divided by actual September 2019 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 CY2021, 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 CY2021 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 Final Notice.

Attachment VI: Updates for Part C and D Star Ratings

Interim Final Rule

In responses to the COVID-19 Public Health Emergency Interim Final Rule[1], CMS has adopted a series of changes to the Star Ratings:

2021 Star Rating Changes

- Eliminates the requirement to collect and submit Healthcare Effectiveness Data and Information Set (HEDIS) and Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) data otherwise collected in 2020. Instead, the 2021 Star Ratings measures based on HEDIS and CAHPS data will use the same data as the 2020 Star Ratings.
- The "new MA plan" definition will be extended for one additional year. New MA plan means an MA contract offered by a parent organization that has not had another MA contract in the previous 4 years.
- In the event that CMS's functions become focused on only continued performance of essential Agency functions, they may use the 2020 Star Ratings as the 2021 Star Ratings.

2022 Star Rating Changes

- The Health Outcomes Survey (HOS) was scheduled to be from April through July 2020. This survey has been postponed to late summer. In the event that CMS is unable to complete the HOS in 2020 (for the 2022 Star Ratings), the measures calculated based on HOS results will use the same data as the 2021 Star Ratings.
- The implementation of guardrails has been delayed one year and will not apply to the 2022 Star Ratings.
- The hold harmless provision for the Part C and D improvement measures will be expanded to include all contracts.

Reminders for the 2021 Star Ratings

CMS is announcing a deadline of June 30, 2020 for contracts to submit requests for review of the 2021 Star Rating appeals and Complaints Tracking Module (CTM) measure data. Sponsoring organizations can view their Part C appeals data on the website medicareappeal.com/AppealSearch, and Part D plan sponsors should use the

[1] https://www.cms.gov/files/document/covid-final-ifc.pdf

medicarepartdappeals.com website to monitor their appeal timeliness and effectuation compliance data.

Changes to Measures for the 2021 Star Ratings

Other than the changes defined in the Interim Final Rule (IFR), the general methodology and measures used to calculate the 2021 Star Ratings will be similar to 2020. For reference, a list of measures and methodology included in the 2020 Star Ratings is described in the Technical Notes[2]. The major changes to 2021 Star Ratings are described below.

Improvement Measures (Part C & D)

CMS will carry forward the measure-level improvement scores from the 2020 Star Ratings for all HEDIS and CAHPS measures for the 2021 improvement measure calculations. The remaining measures will use the methodology finalized at §§ 422.164(f) and 423.184(f) and weights finalized in §§ 422.164(e) and 423.184(e).

2021 Categorical Adjustment Index (CAI) Values

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 are no changes to the list of measures included within the 2021 CAI calculation. These include 14 Part C measures and 5 Part D measures. CAI values will be based on 2019 HEDIS and CAHPS data collected in 2019, and they are not affected by any changes in the IFR. A summary of the analysis of the candidate measure set is posted at http://go.cms.gov/partcanddstarratings.

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 as outlined in the CY2021 Advance Notice and Call Letter. See Tables 9 through 11 for a summary of the 2020 to 2021 CAI changes in both categorization and adjustment for Overall Star Ratings.

[2] https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Star-Ratings-Technical-Notes-Oct-10-2019.pdf

Table 9: Categorization of MA Contracts into Initial LIS/DE Groups for the Overall Star Rating

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: Categorization of MA Contracts into Disability Quintile for the Overall Star Rating

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 Categories and CAI Values for the 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

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. This policy will apply to all measures that do not revert back to the 2020 measure-level Star Ratings and measure scores as a result of the IFR. For the measures that revert back to measure-level Star Ratings and scores from the 2020 Star Ratings, there is no need to revert back as a result of any extreme and uncontrollable circumstances during the 2019 measurement year. For all other measures, the extreme and uncontrollable circumstances policy used in prior years will continue to be used for the 2021 Star Ratings.

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. Thirty-three (33) 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.

Changes to Existing Star Ratings and Display Measures for 2022 and Beyond

- ***Substantive Measure Changes***
    1. **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.

    2. **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 in the future for the 2024 star ratings or beyond (2022 measurement year or beyond).

- ***Non-Substantive Measure Changes***
    1. **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.

    2. **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 (Part C & D)

Attachment VII: Economic Information

This section of the Final Notice presents CMS estimates of the economic impact of various finalized provisions for CY2021 on plans and the Medicare Trust Fund.

One notable item for MA plans is that CMS estimates the impact on MA risk scores of the transition to the 2020 CMS-HCC model for CY2021 relative to CY 2020, is 0.25%. CMS further notes that it projects the differential between the RAPS-based risk score and the encounter data-based risk score, calculated using the risk adjustment models proposed for 2021, to be 0.00%.

Part C Bid Review Memorandum

CMS will not issue a Call Letter for 2021 for the first time in many years. Unless otherwise noted in the Part C Bid Review Memorandum, other information or an applicable final rule, the instructions issued in the Final CY 2020 Call Letter applies for CY 2021, which can be found at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf

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 1: 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 implemented by the 21st Century Cures Act ("Cures Act") regarding MA eligibility and enrollment for beneficiaries with ESRD diagnoses, CMS will begin incorporating cost data for ESRD beneficiaries into the determination of MOOP limits. To ensure the MOOP limits take into account out-of-pocket costs for ESRD beneficiaries, CMS plans will transition from the current practice of excluding all costs incurred by beneficiaries with ESRD to including all related costs into the Medicare FFS data that is used to set the MOOP limits beginning with CY 2021.

For 2021, the Mandatory MOOP will be $7,550, which is a significant increase over the $6,700 level for 2020. The Voluntary MOOP increased by $50 to $3,450 for 2021. Table 13 shows the MOOP amounts by plan type.

Table 2: 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 actuarial equivalent cost sharing limits for CY 2021.

Table 3: 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	1.367	$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

Cost sharing limitations according to the whether the plan falls at or below the Voluntary MOOP amount or up to the Mandatory MOOP amount are shown in Table 15. These cost sharing standards 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.

See Table 15 for detail of in-network service category cost sharing requirements.

Table 15 - CY2021 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
Partial Hospitalization	5	$55/day	$55/day
Home Health	6a	20% or $35	0% or $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

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.

MA plans may not charge enrollees higher cost sharing than is charged under Original Medicare for:

1. COVID19 testing and COVID-19 testing-related services during the period from March 18, 2020 through to the end of the emergency period
2. COVID-19 vaccine and its administration

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 $39 PMPM for CY 2021.

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

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

- Increase by 4.12 % on a standardized (i.e. 1.00) risk score basis. This incorporates the FFS growth rate, changes in applicable percentage by county, county rebasing and re-pricing, average change in star ratings and quality bonus, and the impact of the benchmark cap and the removal of KAC by county. It also includes changes to the GME adjustment factor, VA and DoD adjustment factor, and credibility factor which are used in the FFS rate calculation.

- Increase by 1.79% on a risk-adjusted basis. The risk-adjusted increase incorporates the year-over-year impact of FFS normalization factors, the 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 March 2020 MA enrollment
- Risk Model Revision

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

Table A1 – Estimated Change in Risk-Adjusted Benchmarks

Change in Blended Risk-Adjusted Benchmarks [1] 2020 to 2021	
Growth Rate	3.18%
Applicable %	0.18%
Star Rating/Quality Bonus	0.52%
AGA	0.28%
Kidney Acquisition Cost Removal	-0.32%
Benchmark Cap	0.26%
Total Benchmark Change	**4.12%**
FFS Normalization	-2.48%
MA Coding Pattern	0.00%
Risk Model Revision	0.25%
Total Risk Score Change	**-2.24%**
TOTAL	**1.79%**
[1] Based on March 2020 MA enrollment and Fall 2019 Star Ratings	

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

Effective Growth Rate. This is the impact of the FFS (+3.64%) 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 3.64%. There are also other factors (GME adjustment, VA and DoD adjustment, Credibility adjustment) used in the calculation on the FFS Rate which impact the effective growth rate.

Applicable %. Average nationwide change in applicable percentage, based on the enrollment by Medicare Advantage contract and county. The 2021 county quartiles are determined by the 2020 FFS rates. The increase is driven by increased enrollment in MA plans with higher than average applicable percentages.

Star Rating/Quality Bonus. Difference in quality bonus impact on benchmarks between 2020 and 2021. 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 2021.

***AGA*.** Average Geographical Adjustment (AGA) factors are derived via the compilation of five years of historical Medicare Parts A&B claim costs at the county level. For 2021 payment year, historical claims from years 2014 to 2018 are repriced to reflect the most current wage indices (Fiscal Year 2020).

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.

The removal of these costs at the county level are similar to the process for removing Indirect Medical Education (IME) payments. Wakely estimates the average impact nationwide to be -0.32%, due to March 2020 enrollment being disproportionally in counties impacted more adversely than average by the change.

It is important to note that the nationwide non-ESRD FFS growth rate of 3.64% includes KAC. The removal is only reflected at the county level. It should also be noted that the carve-out factors vary quite drastically at a county level (from 0.0% to 4.29%). Many counties in Puerto Rico are among the highest in terms of KAC

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 vary year-to-year as plans change star ratings, and as the NPCMGP trend differs from the FFS trend. The 2021 MA growth rate of 5.62% is higher than the FFS growth rate of 3.64%, which contributes to a positive year-over-year impact of +0.26% (i.e. the cap applies for fewer contracts than before). The impact of benchmark caps by county vary depending on a contract's star rating. Note that our measure does not include consideration for changes in star rating from payment year 2020 to payment year 2021.

Part C Fee-for-Service (FFS) Normalization Factor. The RAPS/EDS blend for CY 2021 will be 25%/75% as compared with 50%/50% for CY 2020. The 2020 Part C FFS normalization factors were applied separately to the 2017 RAPS CMS-HCC model (1.075) and the CMS Payment Condition Count model (1.069), which were then blended 50%/50% to determine a beneficiary's risk score. For 2021, the blend of the two models is 25%/75% of the 2017 RAPS CMS-HCC model (1.106) and the 2020 CMS-HCC Payment Condition Count model (1.097), respectively. Calculating the change between the blended 2020 factor (1.072) and the blended 2021 factor (1.0993), the impact is (1/1.072)/(1/1.0993) - 1 = -2.48%.

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 plan star rating, counties served, risk score trends, population changes and many other factors.

If we assume that both 2021 and 2020 bids are 90% of the benchmark then we estimate the change in Part C payments from 2020 to 2021 to be an increase of +1.93% (see Table A2).

In order to properly estimate the impact of the various MA payment components addressed in the Final Rate Announcement, 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 +1.79%. If we include estimated changes in bid and rebate levels, then the impact to Part C revenue is nearly the same at +1.93%. 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 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 61.2% in 2020 and 62.5% for 2021.
- No consideration for sequestration or insurer fee

Table A2 shows the calculations underlying our estimates.

Table A2 – Estimated Change in Plan Revenue 2021 versus 2020

Item	2020	2021	2021/2020
1.0 MA Benchmark [1]	$973.77	$1,013.87	4.12%
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	$854.77	$870.08	1.79%
Assumed Risk-Adjusted Bid [4]	**$769.30**	**$783.07**	1.79%
Savings (Benchmark less bid)	$85.48	$87.01	1.79%
Rebate (64.4% for 2019, 64.1% for 2020)	**$52.31**	**$54.42**	4.02%
Risk-Adjusted Bid + Rebate	**$821.61**	**$837.49**	**1.93%**
[1] Based on nationwide average MA enrollment by county as of March 2020			
[2] Assumed no trend in risk scores			
[3] Risk Model Revision Changes as displayed in the Fact Sheet published April 6, 2020			
[4] Bid set at 90% of risk-adjusted benchmark			