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2022 Medicare Advantage

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

January 26, 2021

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Executive Summary

On January 15, 2021 CMS released the 2022 Final Rate Announcement. This is about three months earlier than the typical timing in past years. CMS said it is "publishing the Rate Announcement earlier in 2021 in light of the challenges for MA organizations, PACE organizations, and Part D sponsors posed by the uncertainty associated with the COVID-19 pandemic."

On January 20, 2021, the newly appointed Biden Administration froze many regulations, including the 2022 Final Medicare Rate Announcement for 60 days. Any changes to these regulations would require notice and comment. This document summarizes the information as originally published.

Most proposals in the October 30, 2020 Advance Notice, Part II were finalized, with the following notable exceptions:

- The FFS growth rate of 5.47% is nearly 100 basis points higher than the previous estimate of 4.52%. This increase is the result of CMS now assuming deferred care related to COVID-19 is now expected to be more intensive than was assumed in the Advance Notice, Part II. The deferred care is now estimated to continue to return in 2022, which produces higher 2022 FFS projected spending than the previous estimate.
- CMS was directed to exclude the impact of the CMS Innovation Center's Most Favored Nation Model on growth rates. The Model would test methods to lower high-cost Part B drug costs by paying no more than the lowest price drug manufacturers receive in other similar countries.
- The 2022 RxHCC model proposed in the Advance Notice, Part II was finalized; however, the FFS normalization factor will be 1.043, as compared with 1.056 in the Advance Notice.

CMS has not yet released Part C and D memos that cover key benefit limitations such as the maximum out-of-pocket thresholds and total beneficiary cost. It is unclear whether these memos will be released soon or on the schedule followed in past years, which would be early April.

One important topic that was not addressed in the Notice is the removal of safe harbor protection for drug manufacturer rebates from the Federal anti-kickback statute. This change in regulation was finalized in a November 30, 2020 Department of Health and Human Services Rule. Although the Rule is final, many industry stakeholders have concern that the Rule may be delayed or overturned due to litigation or different policy directives put forth by the Biden Administration.

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

Part C Payment Methodology

- The non-ESRD FFS growth rate percentage for CY2022 is 5.47%.

Risk Scores

CMS is not changing the 2020 EDS HCC model. Part C risk scores for CY2022 will be entirely based on this model, ending the phase in from the RAPS model. CMS will no longer consider diagnoses from RAPS inpatient records as a supplement to EDS diagnoses.

The FFS Normalization factor for CY2022 is 1.118 for the 2020 EDS HCC model. The factor used for CY2021 is 1.097.

CMS finalized use of an updated RxHCC model for CY2022. Similar to the HCC model, the updated RxHCC model will be entirely based on EDS diagnosis submissions. The 2022 RxHCC FFS normalization factor is 1.043. 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.

EGWPs

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

CMS finalized the payment methodology proposed in the Advance Notice, Part II and published bid to benchmark ratios (the ratios are shown in the summary of Attachment III, Section F). Relative to 2021, the bid to benchmark ratios are 2.0 to 2.5 percentage points lower.

Benefit Changes and TBC Threshold

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

Part D parameters were published (preliminary estimates were not published in the Advance Notice, Part II due to lack of available data at the time).

Star Rating Changes

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

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

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

Overall MA Payment Impact

Wakely estimates that, on average, 2022 Part C standardized benchmarks will increase 5.4% over 2021 nationwide. This reflects the impact of the growth rate, change in star ratings and changes to applicable percentages (i.e., quartile rankings). We also estimate that the change in CMS revenue for 2022 versus 2021 is expected to be +3.89%. This takes into account changes in Part C risk score adjustments, including the FFS normalization factor and the MA Coding Pattern adjustment.

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 January 2021 CMS published MA enrollment and star ratings for payment year 2022.

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

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

Attachment I: Final Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2022 MA Growth Percentage (also known as NPCMAGP)

Section A. MA Growth Percentage (also known as NPCMGP)

Preliminary estimates of the Medicare Advantage (MA) growth rates were announced as +6.30% (Advance Notice growth rate was +4.82%).

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 2021 and 2022 Growth Rates

Component	2022 Final	2022-Advance Notice, Part II	2021 Final
MA Growth %	6.30%	4.82%	5.62%
FFS Growth %	5.47%	4.52%	3.64%

Section B. FFS Growth Percentage

Fee-for-service growth rate estimated at +5.47% (Advance Notice growth rate was +4.52%).

Wakely estimates that the nationwide average change in blended standardized (non-risk adjusted) MA Benchmarks from 2021 to 2022 will be +5.39% and the nationwide average change in the blended risk adjusted benchmark will be +3.89%. See Appendix A at the end of this summary for additional detail.

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	CT	7.2%
2	NH	7.2%
3	MN	7.1%
4	NY	6.8%
5	WY	6.5%
47	FL	4.1%
48	HI	4.0%
49	MI	3.7%
50	ID	3.2%
51	LA	2.7%

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 October 30, 2020 Advance Notice Part II, the estimated Part A and Part B non-ESRD FFS costs for 2020 through 2022 changed significantly. These restatements directly contributed to the higher FFS growth rate (5.47%) as compared with the Advance Notice Part II preliminary estimate (4.52%). Table 3 shows the restatements.

Table 3 – Non-ESRD FFS Cost Estimates – Final Announcement versus Advance Notice

Year	CY2022 Final Announcement	CY2022 Advance Notice, Part II	Restatement
2020	$832.18	$819.64	1.5%
2021	$929.69	$996.90	-6.7%
2022	$1,028.38	$1,019.09	0.9%

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. The net result is that CY2022 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 2022 through 2024. 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
2022	2.5%	-0.3%	6.3%
2023	2.5%	1.4%	4.0%
2024	2.3%	1.2%	3.8%

Attachment III: Responses to Public Comments

Section A. Estimates of the MA and FFS Growth Percentages for 2022

Notable comments and CMS responses on 2022 growth rates include the following:

Several commenters requested that CMS provide additional information on COVID assumptions. In response, CMS provided some additional detail regarding changes in CY2020 estimated costs by service category. Table 5 shows these changes.

Table 5 – Change in CY2020 FFS Cost Estimates

Service Category	Change in CY2020 Cost Estimate [1]
Inpatient Hospital	-9%
SNF	-1%
Home Health	-25%
Physician	-13%
Outpatient Hospital	-17%
Physician Administered Drugs	-3%

[1] CY2022 vs CY2021 Final Announcement

CMS also provided updated cost estimates of COVID vaccines for CY2021 and CY2022, as shown in Table 6.

Table 6 – Estimated COVID Vaccine Utilization and Costs

Year	Utilizers as % of all Beneficiaries	Average Doses per Utilizer	Vaccine Cost/Dose	Administration Cost/Dose	Cost PMPM
2021	60%	2.2	$25	$3	$3.08
2022	52%	2.0	$60	$28	$7.63

Some commenters expressed concern at the fluctuation in growth rates from year to year, with COVID uncertainty increasing the likelihood of fluctuation. Similar to past concerns, CMS noted in its response that growth rates estimates at different points in time are based on the latest information available, and that CMS provides sufficient detail for stakeholders to understand its projections.

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

Commenters raised several issues related to removing the pre-ACA benchmark cap, quality bonus payments for new and low enrollment, and qualifying county designation in Puerto Rico. In most of these cases, CMS indicated it did not have discretion under the Social Security Act to implement commenters' suggested changes.

Section C. Calculation of Fee-for-Service Costs

With respect to the calculation of FFS costs, key points raised by commenters included the following:

Several questions were raised related to fluctuation and uncertainty caused by COVID in future years, for example when 2020 and 2021 data are used in average geographic adjustment calculations. In its responses CMS reiterated that it is important for calculations to reflect the most current data and that averaging methods help smooth fluctuations. CMS also noted it would consider whether future adjustments are appropriate.

As with past Rate Announcements, 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. The response was also similar to past years, with CMS noting that there is no statutory requirement to exclude beneficiaries with either only Part A or only Part B coverage.

A number of comments were received regarding the disparity between payment rates in Puerto Rico and the mainland. CMS indicated it did not find evidence that FFS costs are higher than costs observed in the FFS claims data, so no changes would be made.

Section D. Kidney Acquisition Costs

Many respondents were concerned that the kidney acquisition cost (KAC) carve-out methodology needs more transparency or creates inconsistencies between plan payments and claim obligations.

CMS responded with several citations of supporting calculations on page 45 of the Notice. With respect to MA versus FFS inconsistency, CMS defended its calculations and also noted that it must comply with statutory requirements.

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 2022 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 inconsistent with Section 1853 of the Social Security Act.

Section F. MA Employer Group Waiver Plans

CMS reaffirmed the bid-to-benchmark ratios in Table 7 below, which used January 2021 enrollment data, instead of February, for weighting. In general, commenters were supportive of CMS's intent to continue using the same payment and filing requirements for EGWPs.

Table 7 – EGWP Bid-to-Benchmark Ratios

	EGWP Bid-to-Benchmark Ratio	
Quartile	2021 Payment	2022 Payment
0.950	84.2%	83.0%
1.000	85.1%	82.6%
1.075	84.9%	82.6%
1.150	85.1%	82.9%

Clarification was requested regarding the statement that CMS would "continue to waive the requirement that MA EGWPs must specify how they are allocating MA rebate dollars in CY 2022." CMS responded that they have waived the requirement for MA organizations to inform CMS how they will distribute amounts paid as rebates among the options specified in § 422.266(b).

However, the limits on using those rebates have not been waived, so Medicare Advantage Organizations (MAOs) are not permitted to use enrollee/beneficiary rebates for a different purpose.

Section G. CMS-HCC Risk Adjustment Model for CY 2022

For CY 2022, CMS will apply the full phase-in of the 2020 CMS-HCC model as proposed in the Advance Notice, ending the previous calculation that blended scores with RAPS-based models.

Commenters generally expressed support for the 2020 CMS-HCC risk adjustment model. However, there was some concern about the negative impact of the COVID-19 pandemic on risk scores. CMS does not think it possible at this time to take into account potential impacts that the COVID-19 pandemic may have on CY 2022 risk scores (which will be based on 2021 diagnoses).

Section H. ESRD Risk Adjustment Models for CY 2022

CMS will adopt the methodology as proposed in the Advance Notice. That is, for CY 2022, 100% of the risk scores for beneficiaries in ESRD status will be calculated with the 2020 ESRD models (ESRD dialysis, ESRD functioning graft, and transplant).

Section I. CMS-HCC Risk Adjustment Used for PACE Organizations in CY 2022

For CY 2022, CMS will continue 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 2022, CMS will use the frailty factors associated with the 2020 CMS-HCC model. For CY 2022, CMS recalibrated the frailty factors for FIDE SNPs to be separated out by non-dual, partial-dual, and full-dual-eligible status to better align the frailty factors with the segments of the 2020 CMS-HCC model, which was calibrated with separate segments based on the three dual-eligible statuses.

CMS will continue use the frailty factors associated with the 2017 CMS-HCC model to calculate frailty scores for PACE organizations in CY 2022. Tables 8 and 9 show the frailty factors to be used.

Table 8: Frailty Factors Associated with the 2020 CMS-HCC Model – FIDE SNPs

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

Table 9: Frailty Factors Associated with the 2017 CMS-HCC Model – PACE Organizations

Activities of Daily Living (ADL)	Non Medicaid	Medicaid
0	-0.083	-0.093
1-2	0.124	0.105
3-4	0.248	0.243
5-6	0.248	0.420

Section K. Medicare Advantage Coding Pattern Adjustment

CMS has finalized the proposed coding pattern adjustment for CY 2022 as the statutory minimum of 5.90%.

Section L. Normalization Factors

CMS is finalizing the normalization factors as proposed in the Advance Notice. Table 10 compares the normalization factors for CY 2022 to those used in CY 2021:

Table 10 – Comparison of 2022 FFS Normalization Factors with 2021

Model	2021 Payment Year	2022 Payment Year	Year-to-Year Impact
2017 CMS-HCC Model	1.106	1.128	1.99%
2020 CMS-HCC Model	1.097	1.118	1.91%
ESRD Dialysis	1.079	1.077	-0.19%
ESRD Functioning Graft	1.118	1.126	0.72%
2020/2022 RxHCC model	1.063	1.043	NA[1]

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

CMS is using the proposed methodology – a linear approach with five years of data – to estimate the applicable 2022 average risk score for Part C and ESRD models. No adjustments are being made for the impact of the COVID pandemic at this time, because the impact on 2022 risk scores is currently unknown.

CMS will calculate the 2022 RxHCC normalization factor using the linear slope methodology with four years of data (2016–2019) instead of five years (2015-2019), as previously proposed.

Section M. Encounter Data as a Diagnosis Source for CY 2022

CMS finalized its proposed move away from blending EDS and RAPS risk scores used in CY 2021 and prior. For CY2022, the risk score will be based entirely on diagnoses from MA encounter data and FFS claims. EDS Part C risk scores will be calculated with the 2020 CMS-HCC model.

For PACE organizations, CY2022 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:

- Calibrate the model on 2017 FFS claims, 2017 encounter data, and 2018 PDE records instead of 2014 FFS claims, 2014 Risk Adjustment Processing System (RAPS) submissions, and 2015 PDE records.
- Updates to the catastrophic phase benefit parameter.
- Incorporation of diagnoses identified using the same approach that is used to filter diagnoses from encounter data to calculate risk scores instead of RAPS submissions.

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

CMS received comments on the following:

- Concern that the recalibrated model does not account for the impact of POS rebates on future cost and utilization patterns. The commenters noted that this will likely affect the accuracy of the RxHCC model for several years considering the time lag in recalibration.
- Developing a hybrid prospective–concurrent RxHCC model
- Why CY 2019 PDEs are not used for recalibration
- The use of both MA-PD and FFS members in the recalibration

CMS clarified that they are not going to make any further changes or adjustments to the model to account for POS rebates. They further clarified that CMS has used both MA-PD and FFS members to recalibrate the RxHCC model since 2016, and that the 2018 PDEs were the most recent and complete source of data available prior to recalibrating the RxHCC model.

Section B. Encounter Data as a Diagnosis Source for 2022

CMS is finalizing the move to exclusively use encounter data for Part D risk scores, in the same manner as Part C scores (see Section M 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 2022, CMS proposes to continue making prospective reinsurance payments to calendar year Part D EGWPs. The CY2022 prospective reinsurance payment for EGWP sponsors will be based on the average reinsurance amount paid to CY2019 EGWPs. This amount is $65.68 PMPM (versus $48.52 PMPM in 2018).

Consistent with 2020 and 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 2022. One commenter suggested that tighter risk corridors (especially for LI populations) may be necessary if recent congressional proposals to redesign the Part D benefit become law. CMS will continue to monitor and consider whether additional adjustments may be warranted.

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

CMS provided the final Part D benefit parameters for 2022 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 CY2022 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 2020 to July 2021 divided by the per capita Part D costs from August 2019 to July 2020. Since PDE data are not yet available for 2021, the per capita costs for the latter time period are estimated using August 2020 to December 2020 PDE data. This calculation results in an estimated 5.36% 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 1.85%, primarily driven by an update to last year's API. This results in a total 2022 API of 7.31%.

The CPI increase is based on the projected September 2021 CPI divided by actual September 2020 CPI, which results in an estimated increase of 2.19%. This increase is further adjusted

based on revisions to prior years' estimates. The cumulative adjustment for prior year revisions is -1.04%. In total, this produces a 2022 CPI increase of 1.12%.

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 CY2022 total covered Part D spending at out-of-pocket threshold for applicable beneficiaries is calculated to be $10,690.20 ($10,048.39 for 2021). 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 CY2022, the retiree subsidy cost threshold is $480 (was $445 in 2021) and the cost limit is $9,850 (was $9,200 in 2021).

Attachment VI: Updates for Part C and D Star Ratings

CMS is announcing a deadline of June 30, 2021 for contracts to submit requests for review of the 2022 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.

Updates to the 2022 Star Ratings

Improvement Measures (Part C & D) and the Categorical Adjustment Index

There are no major changes to these methodologies in the 2022 Star Ratings. For reference, a list of measures and methodology can be found in the Technical Notes.[1]

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[1] https://www.cms.gov/files/document/2021technotes20201001.pdf-0

Extreme and Uncontrollable Circumstances (EUC) Policy

For the 2020 measurement period with the COVID-19 pandemic, most MA and Part D contracts qualify for the disaster adjustments finalized in the CY 2020 Final Rule. The August 25, 2020 IFR modifies the calculation of the 2022 Part C and D Star Ratings to address the application of the EUC policy.

CMS will not exclude the performance data for affected contracts with 60 percent of more of their enrollees in FEMA-designated Individual Assistance areas during the 2020 performance and measurement period from the clustering algorithms or the determination of performance summary and variance thresholds for the Reward Factor.

Under the 25 percent rule, contracts with at least 25 percent of their service area in a FEMA-designated Individual Assistance area in 2020 will receive the higher of their measure-level rating from the current and prior Star Ratings years for purposes of calculating the 2022 Star Ratings.

In addition to the nationwide waiver issued as a result of COVID-19 outbreaks, three natural disasters qualified for the EUC policy. These include the California wildfires occurring in August 2020, Hurricane Laura in August 2020, and the Oregon wildfires in September 2020.

Changes to Existing 2022 Star Ratings Measures

Non-substantive changes

- Controlling Blood Pressure (Part C) – NCQA is modifying the requirements for out-of-office readings to allow readings taken by a member with any digital device for the 2020 measurement year
- HEDIS Measures and Telehealth (Part C) – NCQA has added codes for the 2020 measurement year for the following measures:
    - Rheumatoid Arthritis Management
    - Breast Cancer Screening
    - Care for Older Adults
    - Controlling High Blood Pressure
    - Comprehensive Diabetes Care
    - Colorectal Cancer Screening
    - Osteoporosis Management in Women Who Had a Fracture
    - Plan All-Cause Readmissions

- o Statin Therapy for Patients with Cardiovascular Disease

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

Non-substantive changes

- Statin Use in Persons with Diabetes (Part D) – PQA has clarified that the index prescription start date (IPSD) for the SUPD measure should occur at least 90 days prior to the end of the measurement year. This change will be implemented in the 2021 measurement year (2023 Star Ratings)

Display measures

- Kidney Health Evaluation for Patients with Diabetes (Part C) – This NCQA measure assesses whether adults who have diabetes received an annual kidney profile evaluation. With the policy change that now allowed ESRD beneficiaries to enroll in MA plans starting in 2021, CMS believe this measure provides critical information for screening and monitoring the kidney health of persons with diabetes. This measure will be added to the display page for the 2022 Star Ratings.

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

- Plan All-Cause Readmissions (Part C) – This measure was temporarily moved to the display page for the 2021 and 2022 Star Ratings due to a substantial measure change. HEDIS data was not collected for the 2021 Star Ratings; therefore, CMS has decided to keep this measure on the display page for one additional year. This measure will remain a display measure for the 2023 Star Ratings.

- Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS) / Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH) (Part D) – These measures will use updated measure specifications in the 2023 Star Ratings display page.

Potential New Measure Concepts for Future Years

CMS received comments on two potential new measures and will consider these suggestions as they continue to explore the feasibility of a measure related to the accuracy of provider directories.

- Provider Directory Accuracy (Part C)

- COVID-19 Vaccination (Part C)

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 2022, to be 0.00%.

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

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

- Increase by 5.39% 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, the impact of the benchmark cap and the removal of kidney acquisition costs (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 3.89% 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, employer group waiver plan payment policy, nor assumed trend in MAO risk scores.

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 January 2021 MA enrollment
- Risk Model Revision

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

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

2021 to 2022	
Growth Rate	5.33%
Applicable %	0.25%
Star Rating/Quality Bonus	-0.28%
AGA	-0.02%
Benchmark Cap	0.12%
Total Benchmark Change	5.39%
FFS Normalization	-1.68%
MA Coding Pattern	0.00%
Risk Model Revision	0.25%
Total Risk Score Change	-1.43%
TOTAL	3.89%
[1] Based on January 2021 MA enrollment and Fall 2020 Star Ratings	

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

Effective Growth Rate. This is the impact of the FFS (+5.47%) 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 5.47%. There are also other factors (GME adjustment, VA and DoD adjustment, Credibility adjustment, and Kidney Acquisition Cost removal) used in the calculation on the FFS Rate which impact the effective growth rate.

Applicable %. Average nationwide change in applicable percentage, based on January 2021 enrollment by Medicare Advantage contract and county. The 2022 county quartiles are determined by the 2021 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 2021 and 2022. 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 2022.

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 2022 payment year, historical claims from years 2015 to 2019 are repriced to reflect the most current wage indices (Fiscal Year 2021).

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 National Per Capita MA Growth Percentage (NPCMGP) trend differs from the FFS trend. The 2022 MA growth rate of 6.30% is higher than the FFS growth rate of 5.47%, which contributes to a positive year-over-year impact of +0.12% (i.e. the cap applies to 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 2021 to payment year 2022

Part C Fee-for-Service (FFS) Normalization Factor. The EDS/RAPS blend for CY 2022 is 100% EDS as compared with a 75%/25% blend in 2021. The 2021 Part C FFS normalization factors were applied separately to the 2017 RAPS CMS-HCC model (1.106) and the CMS Payment Condition Count model (1.072) which were then blended 75%/25% to determine a beneficiary's risk score. For 2022, the FFS normalization factor is entirely based on the CMS Payment Condition Count model (1.118). Calculating the change between the blended 2021 factor (1.099), the impact is (1/1.118)/(1/1.099) = -1.68%.

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

Risk Model Revision. The full phase in of the EDS model for CY2022, as compared with a 25%/75% RAPS/EDS blend in CY2021, results in an estimated revenue increase of 0.25%. This estimate is from CMS.

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 2022 and 2021 bids are 83% of the benchmark (consistent with 2022 EGWP bid-to-benchmark ratios) then we estimate the change in Part C payments from 2021 to 2022 to be an increase of +3.89% (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 +3.89%. If we include estimated changes in bid and rebate levels, then the impact to Part C revenue is nearly the same at +3.71%. This estimate is based on the following assumptions:

- Plans bid at 83% of the benchmark in 2022
- Bid trend from 2021 to 2022 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 62.6% in 2021 and 61.7% for 2022.
- No consideration for sequestration or insurer fee

Table A2 shows the calculations underlying our estimates.

Table A2 – Calculations Underlying Our Estimates

Item	2021	2022	2022/2021
1.0 MA Benchmark [1]	$1,014.24	$1,068.95	5.39%
Raw Risk Adjustment Factor [2]	1.0000	1.0000	0.00%
FFS Normalization	1.0993	1.1180	-1.68%
MA Coding Pattern Adjustment	0.9410	0.9410	0.00%
Risk Model Revision [3]	1.0000	1.0025	0.25%
RAF after FFS Norm & Coding Pattern	0.8560	0.8438	-1.43%
Risk-Adjusted Benchmark	$868.23	$901.96	3.89%
Assumed Risk-Adjusted Bid [4]	$720.63	$748.63	3.89%
Savings (Benchmark less bid)	$147.60	$153.33	3.89%
Rebate (62.6% for 2021, 61.7% for 2022)	$92.38	$94.54	2.34%
Risk-Adjusted Bid + Rebate	$813.01	$843.17	3.71%
[1] Based on nationwide average MA enrollment by county as of January 2021			
[2] Assumed no trend in risk scores			
[3] Risk Model Revision Changes as displayed in the Fact Sheet published January 17, 2021			
[4] Bid set at 83% of risk-adjusted benchmark			