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Summary of Advance Notice of Methodological Changes

Calendar Year 2023

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

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Prepared by:
Wakely Consulting Group, LLC, an HMA Company

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Executive Summary

On February 2, 2022, CMS released the 2023 Advance Notice,[1] which details planned changes in the Part C and Part D capitation and risk adjustment methodology for calendar year (CY) 2023. The comment period for the Advance Notice will be open for 30 days with the final rating provisions announced no later than April 4, 2022.

The CY2023 fee-for-service (FFS) growth rate, which is the major driver of Part C benchmark rates, is estimated at 4.84%. CMS has not proposed any change to the non-ESRD Part C risk model, but has proposed an update to the RxHCC model.

CMS is projecting an increase in Part C FFS risk scores despite the 2021 FFS risk score dropping. The proposed CY2023 FFS normalization factor is 1.127, which compares with 1.118 for CY2022. The proposed coding intensity adjustment factor remains flat at 5.9%.

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

Racial Equity and Underserved Markets

CMS announced it is exploring ways to advance equity through a variety of methods including:

1) collection of more data on race, ethnicity, and social determinates of health,
2) developing quality measures related to health disparities, and
3) programmatic changes that are aimed at closing health equity gaps.

This initiative is evident in the proposed updates to the Star rating measures.

Part C Growth Rates

The non-ESRD FFS growth rate percentage for CY2022 is 4.84%. The Total UPSCC non-ESRD growth rate percentage is 4.25%. The FFS Dialysis-only ESRD USPCC growth rate is 5.58%.

[1] https://www.cms.gov/files/document/2023-advance-notice.pdf

Risk Scores

No changes are expected to the Part C risk models used for payment in CY2023 for non-ESRD and PACE populations. For ESRD (non-PACE), the Part C risk model is proposed to be updated for:

- more recent calibration data,
- a more recent clinical model version,
- updates on expected costs for duals on dialysis (proposed to have four separate model segments like the non-ESRD population)
- updates for continuing enrollees on dialysis, and
- updates to the functioning graft model for LTI and beneficiaries who are in 4-9 and 10+ months post-transplant.

The FFS normalization factor for CY2023 for non-ESRD Part C models[2] is estimated to be 1.127 (up from 1.118) and now reflects eight years of trend. The ESRD Dialysis Model normalization factor is proposed to be reset based on the new model updates and now reflects five years of trend (last year's normalization reflected seven years of trend). It is important to note that the CY2021 data point was excluded as a source of projecting these factors. Including the CY2021 would have reduced the FFS Normalization factors substantially from the published estimates.

The coding pattern adjustment is set at the statutory minimum of 5.90%, which represents no change compared with CY2022.

CMS is proposing a newly calibrated non-PACE RxHCC model for CY2023 to reflect a clinical update based on ICD-10-CM diagnosis and updated data. The RxHCC FFS normalization factor is proposed to be 1.050. If CMS chooses to continue using the 2022 RxHCC model, then, the proposed normalization factor is 1.053, which compares with 1.043 for payment year 2022.

For PACE organizations, the 2020 RxHCC model is proposed to continue with no changes. This would be accompanied by a 2023 normalization factor of 1.073 (up from 1.056 and now reflecting eight years of trend).

[2] For community, institutional, new enrollee, and C-SNP new enrollee models.

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 not yet published requirements for MA and PD benefits related to the Total Beneficiary Cost (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 5.48% 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 4.64%. 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 October 2021 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.

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

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

Section A. Data and Assumptions Supporting USPCC's

CMS provided additional details and descriptions regarding the development of the USPCC's, in response for previous requests for such information. Some highlights include:

- Historical Enrollment — Historical total Medicare enrollment is developed from CMS' administrative records. Historical MA enrollment is tabulated from the Monthly Membership Report (MMR) data files.
- Projected Enrollment — Projected total Medicare enrollment is generally based on certain percentages of the Social Security Administration's population projections. Whereas, MA projected enrollment is based on an enrollment model which incorporates historical growth in penetration rates to estimate the MA enrollment growth rates for future years.
- Historical Benefit Expenditures — The primary source for historical FFS claims is the National Claims History (NCH) file. Additional sources of FFS expenditures include payments to providers based on cost reports, payments for pass through costs, and payment adjustments authorized by law or in connection with participation in innovation model programs. These claims are grossed up for claims incurred but not paid based on completion factors developed based on recent program experience. Historical MA expenditures are tabulated from the MMR data files.
- Projected Benefit Expenditures — Projected FFS costs are developed separately by service category as reflected in the NCH file, cost report settlements, pass through costs

and innovation model bonuses, and penalties. The projections take into account various trends including the following:

- Unit cost changes tied to market baskets and productivity adjustments, fee schedule updates, or the consumer price index (CPI).
- Utilization and intensity of services.
- Impact of changes in population mix.
- Changes in Medicare Coverage due to legislation, regulation, and national coverage decisions.

Medicare Advantage cost projections are developed from historical bids, rebates, and benchmarks.

Section B. 2023 Growth Percentage Estimates

The preliminary estimate of the MA growth rate is +4.25% (last year the rate was +6.30%).

The non-ESRD fee-for-service growth rate is estimated at +4.84% (last year rate was +5.47%).

Section C. USPCC Estimates

In the Notice, CMS noted that the growth rate includes consideration for the impact of COVID in 2020 and beyond. Specifically, CMS noted that estimated for the following COVID-related costs were considered:

- COVID-19 vaccine.
- Utilization of services (presumably both deferred services and pent-up demand).
- Changes to MA coverage created by COVID-related legislation.
- Cost sharing in excess of Medicare FFS cost sharing.
- Specified testing-related services.
- Prohibition on utilization management requirements related to COVID lab testing and testing-related services.

The restatements in CMS's FFS USPCC estimates from the prior estimates in the January 15, 2021 CY2022 Final Announcement are summarized in the table below. Note that all years 2020 through 2024 are restating upward by 1%-2%, except 2022.

Table 1: FFS USPCC Estimate Restatement Impact

Year	Current/Prior
2024	1.97%
2023	2.04%
2022	-0.61%
2021	1.03%
2020	1.98%

CMS has not yet provided specifics on the causes of the restatement.

During the February 4, 2022 CMS Stakeholder call, an estimate of the 2023 cost of COVID Vaccine was provided in the following components:

- 52% of beneficiaries are expected to use the vaccine.
- Each user will need an average of 1.4 doses.
- The cost per dosage is $104.

This translates to about $6.31 PMPM, which is lower than the $7.63 estimate included in the 2022 growth rate.

Wakely estimates that the nationwide average change in blended standardized (non-risk adjusted) MA Benchmarks from 2022 to 2023 will be 5.48% and the nationwide average change in the blended risk adjusted benchmark will be 4.64%. See Appendix A at the end of this summary for additional detail.

As it has been the case in past years, the change in benchmarks can vary significantly depending on geographic area, plan star rating, and applicable percentage. While CMS will not publish the final geographic relativities (aka Average Geographic Adjustment, or AGA, factors) until the Final Announcement, we can still estimate the impact of changing county quartiles, average star ratings, and a minor change in how CMS will develop the costs exclusions for kidney acquisition costs and direct graduate medical equipment.

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

Table 2: States with Highest and Lowest Benchmark Change (Before Rebasing)

Rank	State	Change
1	MI	7.5%
2	DC	7.5%
3	KS	7.2%
4	AZ	7.0%
5	NY	7.0%
46	MT	4.3%
47	VT	4.3%
48	NH	4.1%
49	SD	4.0%
50	CO	3.8%

Section D. Loading for Claims Processing Costs

This section is new this year and explains the USPCC is adjusted to include administrative costs incurred by the Medicare Administration Contractors (MAC's) as described in the ACA. For PY 2023, the adjustment is based on FY 2021 expenses. MAC expenses for FY2021 totaled about $575,000 for an adjustment factor of 0.001399.

Attachment II: Changes in the Part C Payment Methodology for Medicare Advantage and PACE for CY2023

Section A. MA Benchmark, Quality Bonus Payments and Rebate

CMS intends to rebase county FFS rates in 2023 (which is the basis of the "Specified Amount").

County benchmark rates are capped at the Applicable Amount (defined below). CMS interprets that the comparison occurs after the Quality Bonus Payment Percentage ("QBP") has been included. CMS acknowledged stakeholders' concerns that the benchmark cap may diminish incentives for MA plans to continuously improve care; however, CMS believes that "section 1853(n)(4) of the Act prevents elimination of the rate cap or excluding the bonus payment from the cap calculation."

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

- 2023 "Applicable Amount" (pre-ACA amount): The greater of a county's 2023 FFS cost and the 2022 Applicable Amount increased by the 2023 National Per Capita MA Growth Percentage of 4.25%.

- 2023 “Specified Amount” (FFS benchmark): 2023 FFS Cost less IME phase-out less kidney acquisition costs multiplied by the “Applicable Percentage” plus the QBP.
- “Applicable Percentage” varies by county and is based on the county’s rank of 2022 per capita FFS rate, assigned by quartiles, as shown in Table 3.

Table 3: FFS Quartile Assignment

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

If a county’s quartile changed from last year, the Applicable Percentage is the average of the current and prior year’s applicable percentage. Note that applicable percentages for 2023 county rates will use 2022 rankings, which will include the revised calculation of kidney acquisition costs.

- Quality Bonus Percentage (QBP), or “applicable % quality increase”: The QBP is 5% for 4, 4.5 and 5 star MAOs, and is 0% for plans with a star rating below 4. For new plans under a new parent and low enrollment plans, a 3.5% QBP applies.

For consolidations of two or more contracts of the same plan type and legal entity approved on or after January 1, 2019, the QBP rating for the first year following consolidation is determined by the enrollment weighted average of what would have been the QBPs of both contracts using November enrollment from the year the Star Ratings were released. *Example:* for two contracts consolidating for January 2023, the 2022 QBP rating is based on 2022 Star Ratings released in 2021, using November 2020 enrollment of the two contracts.

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

1) Have a population of over 250,000 (as of 2004).
2) Have at least 25% of MA-eligible beneficiaries enrolled in MA plans (as of December 2009).
3) Have 2023 per capita FFS spending lower than the national average.

The final 2023 rate notice will contain a list of all double bonus counties, as the third criterion above is not yet known.

- Cap on Benchmarks. The QBP-adjusted benchmark for a county cannot exceed the applicable amount.
- Rebates. Rebate levels are based on plan Star Ratings as follows in Table 4:

Table 4: MA Rebate Percentages

Star Rating	2023
4.5+ Stars	70%
3.5 to < 4.5 Stars	65%
< 3.5 Stars	50%

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

Section B. Calculation of Fee for Service Cost

2023 FFS COUNTY COST

The FFS county cost for CY2023 is calculated as the USPCC x AGA, where:

- USPCC = the National Average FFS Cost, called the U.S. Per Capita Cost.
- AGA = County-level Geographic Index, called the Average Geographic Index.
- With the Advance Notice, CMS is releasing county-level 2020 FFS cost data used to develop 2023 rates:

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

AGA DEVELOPMENT OVERVIEW:

- A five-year average of FFS costs from 2016 to 2020 is initially calculated (last year was 2015 to 2019), and is then adjusted.
- Costs for hospice are excluded.
- CMS will re-price 2016 to 2020 to the most current (FY2022) wage and geographic practice cost indices and adjust historical FFS claims for legislative changes.
- This includes the repricing of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims to reflect updated methodologies in

accordance with the final rule which appeared on the Federal Register on 12/28/2021. https://www.federalregister.gov/d/2021-27763/

- Adjustments are made for shared savings and losses from programs like the MSSP, Pioneer and NextGen ACO programs, or other Innovation Center models and demonstration programs.

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

- GME and IME costs are removed.
- Counties with less than 1,000 members are blended with other counties in the market area for credibility.
- Adjustments are made for beneficiaries in Veteran Affairs and/or the Department of Defense health programs.
- Puerto Rico data only includes beneficiaries with Part A & B for all five years of the base period. (Puerto Ricans are not auto-enrolled into Part B, they must opt in). CMS is considering whether to apply an adjustment to Puerto Rico FFS costs to reflect Puerto Rico's high proportion of zero-claimant members versus the national average. Such an adjustment has been applied in prior years.
- VA and DoD adjustments for those dually enrolled in VA and/or the DoD health programs.
- Organ acquisition costs for kidney transplants. This adjustment was new for CY2021 benchmarks and is continuing for CY2023. The adjustment was prompted by the 21st Century Cures Act. It does not apply to PACE organizations. A carve-out ratio is applied to FFS costs by taking estimated "pass-through" kidney acquisition costs divided by the five-year average Parts A and B FFS costs in the county (or state for ESRD rates).

AGA Development COVID-19 Commentary:

- CMS acknowledged concerns regarding the 2020 FFS data used to establish the MA benchmarks nationally, with particular regard to the impact of the COVID-19 pandemic.
- In its review of trends in the 2020 FFS data, CMS found that some specific regions experienced decreased per-capital costs while other experienced increased per-capita costs when compared to the 2019 national average per-capita costs.
- The ratebook development uses an average of five years of FFS experience for each county, which mitigates annual fluctuations and anomalies in the data. This methodology provides stability in the rates despite local or regional events, such as natural or weather-related disasters, and varying impacts from nationwide events, such as pandemics.

- CMS noted that it has not made ratebook adjustments in prior years for select events in specific areas, such as for other natural disasters which may have impacted FFS experience.

Section C1. Direct Graduate Medical Education

Direct Graduate Medical Education (DGME or GME) costs must be excluded from FFS per capita costs used to develop MA capitation rates. Prior to 2023, these costs have been carved out by tabulating estimated "pass-through" payments to hospitals, which are inclusive of DGME costs, and using DGME estimates from these reports to reduce FFS payments. For 2023, CMS is proposing to instead use the provider specific file (PSF) as the source for the development of the DGME exclusion. This change would align reporting of DGME amounts across Medicare Administrative Contractors (MACs). The impact of this change to MA county rates varies by geography, ranging from -$26 to $47 PMPM, with a FFS enrollment weighted average change of $2 PMPM. The new DGME carve-out factors will be published with the 2023 rate announcement.

Section C2. Organ Acquisition Costs for Kidney Transplants

Kidney acquisition costs (KAC), first removed in 2021, will continue to be carved out for non-PACE plans in 2023. Similar to the proposed DGME exclusion, CMS is also proposing a change to KAC calculation methodology. Like the DGME adjustment, CMS is proposing that the PSF be used as the source for carve-out percentage development. The impact of this change to MA county rates varies by geography, ranging from -$5 to $16 PMPM, with a FFS enrollment weighted average change of $1 PMPM. These impacts will be adjusted to account for associated living donor expenses, estimated to be worth less than -$0.01 PMPM. The KAC adjustment will be applied subsequent to the IME adjustment, as was done in 2022. The new KAC carve-out factors will be published with the 2023 rate announcement.

Section C3. IME Phase Out

Indirect Medical Education (IME) costs are being phased out of MA capitation rates. For 2023, CMS will first calculate FFS rates including IME. The maximum reduction for any county in 2023 is 8.4% of the FFS rate. As in prior years, CMS will publish rates with and without the 2023 IME reduction. In the Economic Information section of the Notice, CMS notes that in 2023 only two counties are affected by more than the 2022 maximum of 7.8%.

Section D. ESRD Rates

ESRD Rates = [2016-2020 FFS ESRD dialysis USPCC] x [trend to 2023] x [State AGA] x [GME and IME removal factor] x [kidney acquisition cost removal factor].

- State AGA is the weighted average of state ESRD FFS dialysis costs for 2016 to 2020 divided by the national average for the same timeframe normalized for risk score.
- CMS intends to reprice historical inpatient, outpatient, SNF, and ESRD PPS claims for 2016 to 2020 to reflect the most recent wage indices (in this case FY2022), and reprice physician claims with the most recent Geographic Practice Cost Indices (CY2022). This is a continuation of an enhancement introduced last year.
- ESRD state rates for PACE plans will include kidney acquisition costs.

CMS also notes that they are aware of MAO concerns regarding ESRD payment adequacy in light of the 21st Century Cures Act, which allows ESRD beneficiaries to enroll in MA plans. One suggestion, which was analyzed, was to develop ESRD rates at a geographic level smaller than state. Preliminary analysis suggested that rural and underserved urban areas would see rate decreases relative to the current state level. Further analysis will continue, but CMS is not proposing any further change to ESRD rate methodology for 2023.

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

Non-employer MA PFFS plans offered in a network area must meet certain access standards. Network area is defined as an area that the Secretary identifies as having at least two network-based plans. CMS will include the list of network areas for plan year 2024 with the CY2023 Rate Announcement.

Section F. Employer Group Waiver Plans

For 2023, CMS intends to continue to waive bid pricing tool requirements.

CMS is also proposing to continue to generally use the payment methodology implemented for MA EGWPs finalized in the 2022 Rate Announcement, with one change. For 2023, CMS proposes to use bid-to-benchmark ratios based on 2022 bids and February 2022 enrollment. While this is a change from 2022 when rates were released early, it is consistent with methodology in years prior to 2022.

New for 2023, CMS has published preliminary bid-to-benchmark ratios for EGWPs. These preliminary ratios are not final and are based on January 2022 enrollment, not the intended February 2022 enrollment.

Table 5: EGWP Bid to Benchmark Ratios

Applicable Percentage	2022 Bid to Benchmark Ratio	2023 Bid to Benchmark Ratio	Difference
0.95	83.0%	80.8%	-2.2%
1	82.6%	79.9%	-2.7%
1.075	82.6%	79.9%	-2.7%
1.15	82.9%	79.9%	-3.0%

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

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

CMS will continue to calculate non-ESRD/non-PACE MA risk score using 100% of the EDS based risk score as described in Part I of the CY2020 advance notice. This is consistent with the source of diagnosis codes used for the CY2022 non-ESRD/non-PACE MA risk score. For PACE organizations, CMS proposes to continue using the 2017 CMS-HCC model to calculate risk score, consistent with CY2022 risk scores.

CMS indicated that they are soliciting public comments on potential enhancements to the CMS-HCC risk adjustment model to address social determinants of health (SDOH). These comments would address what additional data CMS should collect and what additional factors could be incorporated into the risk adjustment model.

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

CMS is proposing to implement a revised model for MA organizations that more closely aligns with the Part C risk adjustment model. PACE plans would not be impacted by this updated ESRD risk adjustment model and is proposed to continue to use the 2019 ESRD dialysis and functioning graft models for risk adjustment. CMS is proposing the following updates to the previously used 2020 ESRD model for non-PACE organizations:

- Model Recalibration.
- CMS is proposing to update the clinical version table used for ESRD risk scoring to version 24 (V24). This is the same version used in the currently used CMS-HCC model. The ESRD

model will exclude HCCs for kidney conditions. There are various differences between the previously used V21 and V24 diagnosis.

- Model Specifications.
- CMS recalibrated the model using 2018 diagnosis to predict 2019 expenditures using CMS EDS filtering criteria.
- Dialysis Continuing Enrollee Model Updates.
- Two new add-on variables for institutional (LTI) members to better differentiate LTI costs: LTI Aged and LTI NonAged.
- Eight new Medicaid interaction variables for full and partial dual members.
- Continued use of the V21 ESRD model non-aged interaction terms except for HCC54 and HCC55 interaction, which will be replaced by a stand-alone Substance Use Disorder and Psych interaction.
- Dialysis New Enrollee Model Updates.
- Since CY2020, an adjustment has been made to all new enrollee dialysis members to address the over-prediction of this population. CMS is proposing to continue to apply an adjustment for the over-prediction of this group and to differentiate the factor further. The updated over-prediction factors are to be applied based on the age of the members (0.827 for non-aged and 0.900 for non-aged).
- There will be four distinct models that reflect the differences in cost patterns for dual eligible dialysis members. Non-duals and partial duals are proposed to be grouped together. Previously, the Medicaid status was based on whether the member ever had Medicaid coverage. This will change to be an annual assessment based on the highest dual eligibility status.
- Functioning Graft Continuing Enrollee.
- CMS proposes using four V24 CMS-HCC model segments to differentiate cost patterns between duals and non-duals. Each model will be further differentiated by the number of months since transplant (4-9 months and 10+ months), consistent with the prior ESRD functioning graft ESRD model. An add-on factor will be applied for partial benefit dual members.
- Kidney disease HCC and renal interactions will continue to be set to 0 while HCC186 will also be set to zero because the costs for this condition will be captured in the functioning graft factors.

- Functioning Graft Institutional (LTI) enrollee.
- Similar to the dialysis add-on factor for LTI enrollees, CMS proposes adding a coefficient to LTI enrollees based on their age: LTI Aged and LTI NonAged.
- There will be ten different groups of dual status variables, using the V24 institutional model as the underlying basis for the groups. The groups are based on dual status, months since transplant, and age.
- Functioning Graft New Enrollee.
- The new enrollee model will have the same number of models and factors as the community model.
- Similar to prior years, an adjustment will be made to reflect that new enrollees are under-predicted compared to actual expenditures. CMS analyzed the under-prediction and proposes dividing all relative factors by 0.905 for the 4-9 months post-transplant enrollees and by 0.698 for the 10+ months post-transplant enrollees.

Section I. Medicare Secondary Payer (MSP)

CMS is proposing to update the underlying data used to calculate the MSP factor (ratio of actual Medicare spending to model-predicted Medicare spending). The methodology to calculate the factor is not changing and continues to be calculated by taking the actual Fee for Service (FFS) costs and dividing it by the CMS-HCC model predicted FFS costs. The updated MSP factor will use 2014 diagnosis data as the source for the CMS-HCC predicted total Fee-For-Service (FFS) costs and 2015 expenditure data as the source for the actual FFS costs. The proposed MSP factor will decrease revenue for MA plans' MSP members. The table below summarizes the proposed changes.

Table 6: Medicare Secondary Payer Factors

Payment Year	Actual FFS expenditures year / Prediction diagnosis year	Working Aged/Disabled & ESRD Functioning Graft	ESRD dialysis
CY2022	2009/2008	0.173	0.215
CY2023	2015/2014	0.136	0.135

Section J. Frailty Adjustment for PACE Organizations and FIDE SNPs

For FIDE SNPs in CY 2023, CMS will continue to use the CY 2022 frailty factors for the 2020 CMS-HCC model. For PACE organizations, CMS is proposing to continue use of the 2017 CMS-HCC model to calculate risk scores used to pay for Part A and B services in CY 2023. CMS will

use the frailty factors associated with the 2017 CMS-HCC model to calculate frailty scores for PACE organizations in CY 2023.

Table 7: 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 8: 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 is proposing the coding pattern adjustment for CY2023 is the statutory minimum of 5.90%. This is the same adjustment used for CY2022.

Section L. Normalization Factors

CMS is proposing the following normalization factors for CY2023:

Table 9: Normalization Factors

Model	2022 Payment Year	Proposed 2023 Payment Year	Year-to-Year Impact
2020 CMS-HCC Model	1.118	1.127	-0.80%
2017 CMS-HCC Model (PACE)	1.128	1.140	-1.05%
ESRD Dialysis [1]	N/A	1.034	N/A
ESRD Functioning Graft [1]	N/A	1.048	N/A
2023 RxHCC model [2]	1.056	1.050	0.57%

[1] Due to model change proposed in CY 2023, the 2022 normalization factors are associated with different models

[2] Model recalibration in CY 2023

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

For CY2023, CMS is proposing to maintain the same linear slope projection method as was used in CY2022 to calculate the normalization factors. CMS is also proposing to use the same five years of historical risk scores used to calculate the slope for developing the CY2022 normalization factor and would exclude the 2021 FFS risk scores from the calculation of the slope used to project the normalization factors for the CMS-HCC risk adjustment models for CY 2023. CMS noted that the 2021 risk score, which is based on diagnoses from 2020 dates of service, is lower than the 2020 risk score, which is based on 2019 dates of service, believed to be driven by reduced utilization in 2020 due to the pandemic.

CMS noted that including the 2021 risk score would result in a reduction in the CY 2023 normalization factor and that the inclusion of the 2021 risk score in the slope calculation would result in a projected risk score (i.e., normalization factor), that is significantly below what the actual average FFS risk score is likely to be in 2023.

CMS noted that due to the inclusion of MA risk scores in determining the normalization factor for the RxHCC model, the risk score data is lagged one year for Part D and that the typical process of removing the earliest year and adding the most recent year (2020 for Part D) produced a reasonable estimate. Therefore, CMS is proposing to continue with its typical methodology for the Part D normalization factor for CY2023.

CMS is proposing to update the ESRD dialysis and ESRD functioning graft risk adjustment models for CY 2023, as well as recalibrating the RxHCC model.

Section M. Sources of Diagnoses for Risk Score Calculation for CY2023

For non-PACE organizations, CMS proposes to continue to use risk-adjustment eligible diagnoses only from encounter data and FFS claims.

For PACE organizations for CY 2021, CMS proposes to continue using the CMS-HCC and ESRD models that have been used since CY2015 to calculate risk scores. CMS proposes to continue calculating risk scores by pooling risk adjustment-eligible diagnoses from encounter data, RAPS data, and FFS claims to calculate a single risk score (with no weighting).

Attachment III: Changes in the Payment Methodology for Medicare Part D for CY2023

Section A. RxHCC Model

CMS is proposing to update the RxHCC model for CY2023. The new model will incorporate the following changes:

- A clinical update to the RxHCC model, with the recalibration based on a revised clinical classification system using ICD-10 codes (versus recent prior RxHCC models that used ICD-9 codes in the clinical classification system).
- As a result of the clinical revision, the count of RxHCCs has increased from 76 RxHCCs to 84 RxHCCs. Several categories, such as the neoplasm set of condition categories, have added RxHCCs to the category's disease hierarchy. Many other RxHCCs have been revised to include different disease groups. A few other RxHCCs were simply added to the model.
- The updated model used 2018 Medicare Fee-For-Service (FFS) and MA encounter data for diagnostic data, and 2019 Prescription Drug Event (PDE) data for expenditures.
- The updated RxHCC model's relative factor coefficients were recalibrated using 2019 for the denominator year.
- The 2023 RxHCC model revision includes renumbering of several RxHCCs. The model still includes gaps within the numbering system to allow for future changes in condition category classifications without the need for a complete revision of the numbering system.

As of the publication date of this paper, the model software has not been released by CMS, so the quantitative impact of the model change on demographic or condition cohorts cannot be assessed.

Section B. Source of Diagnoses for Part D Risk Score for CY2023

CMS will continue calculation of CY2023 risk score based on diagnoses from encounter data (EDS) and fee for service (FFS) claims exclusively. This methodology was introduced for last year's CY2022 model, when it represented a change from prior iterations of the model that used a blended percentage of risk adjustment processing system diagnoses in conjunction with EDS data-derived diagnoses to calculate risk scores. For PACE, CMS proposes to continue the same method for CY2023 that has been in place since CY2015.

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

For CY2023, the annual percentage increase (API) applied to the CMS Defined Standard Part D parameters is 5.08%, reflecting a 5.8% increase in the CY 2022 annual percentage trend and a multiplicative adjustment of -0.68% for prior year revisions. The Part D Defined Standard benefit changes are:

- $505 deductible ($480 in 2022).
- $4,660 ICL ($4,430 in 2022).
- $7,400 TrOOP ($7,050 in 2022).
- $1.45/$4.15 copays for full subsidy full benefit duals ($1.35/$3.95 in 2022).

Table 10 - Part D Benefit Parameters

Part D Benefit Parameters	2022	2023
Standard Benefit		
Deductible	$480	$505
Initial Coverage Limit	$4,430	$4,660
Out-of-Pocket Threshold	$7,050	$7,400
Total Covered Part D Spending at Out-of-Pocket Threshold for Non-Applicable Beneficiaries	$10,012.50	$10,516.25
Estimated Total Covered Part D Spending for Applicable Beneficiaries	$10,690.20	$11,206.28
Minimum Cost-Sharing in Catastrophic Coverage Portion of the Benefit		
Generic/Preferred Multi-Source Drug	$3.95	$4.15
Other	$9.85	$10.35
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	$1.35	$1.45
Other	$4.00	$4.30
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	$3.95	$4.15
Other	$9.85	$10.35
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 ≤ $9,900 (individuals) or ≤ $15,600 (couples) [category code 1]		
Deductible	$0.00	$0.00
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.95	$4.15
Other	$9.85	$10.35
Maximum Copayments above Out-of-Pocket Threshold	$0.00	$0.00
Partial Subsidy		
Applied and income below 150% FPL and resources below $15,510 (individual) or $30,950 (couples) [category code 4]		
Deductible	$99.00	$104
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		

Generic/Preferred Multi-Source Drug	$3.95	$4.15
Other	$9.85	$10.35
Retiree Drug Subsidy Amounts		
Cost Threshold	$480	$505
Cost Limit	$9,850	$10,350

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

The Medicare coverage gap for non-LIS members was effectively closed for applicable (mainly brand) drugs in CY 2019 and for non-applicable (mainly generic) drugs in CY2020; no change is proposed for CY 2023.

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

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

Section F. Part D Calendar Year Employer Group Waiver Plans

CMS makes prospective payments for Part D federal reinsurance for calendar year Employer Group Waiver Plans (EGWPs) offering Part D. Consistent with Part D non-EGWPs, the prospective payment will be reconciled with actual expenses several months after the conclusion of the plan year. The payment will be based on the average reinsurance amount paid to CY2020 EGWPs. This amount is $67.56 PMPM (versus $65.68 PMPM, based on 2019).

Section G. Part D Risk Sharing

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

Attachment IV: Updates for Part C and D Star Ratings

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 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 no longer a measure in 2023.

Existing Star Rating Measures with Changes for 2023

- Patient Experience/Complaints and Access Measures - Weights changed from 2 to 4.
- Statin Use in Persons with Diabetes (Part D) - Category changed 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.

- 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 soliciting feedback on the implementation of the sociodemographic status (SDS) risk adjustment for these Star Ratings measures.
- Colorectal Cancer Screening (Part C) – NCQA is considering adding ages 45-49 to the denominator in 2024. The current measure would remain in the Star Rating until the updated measure has been on the display page for at least two years, then the updated measure would 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).
    - Statin Therapy for Patients with Cardiovascular Conditions (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 is requesting feedback.

- Driving Health Equity (Part C and D).
- Stratified Reporting (Part C and D) – applying stratified reporting by disability, LIS status, and DE status for more measures wherever able.
- Health Equity Index (Part C and D) - would summarize contract performance among those with Social Risk Factors across multiple measures into one single score. This health equity Index could also replace the current reward factor.
- Measure of Contracts' Assessment of Beneficiary Needs (Part C).
- Screening and Referral to Services for Social Need (Part C).
- Value-based Care (Part C).
- Kidney Health (Part C).
- Persistence to Basil Insulin (PST-INS) Measure (Part D).
- Beneficiary Access and Performance Problems (Part C and D).
- CAHPS (Part C and D) – CMS is testing a web-based survey in an effort to increase CAHPS response rates.

Attachment V: Economic Information for the CY 2023 Advance Notice

Attachment V provides estimates of the net impact to the Medicare Trust Funds of changes to the Medicare Advantage and PACE plans for CY 2023.

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 – 4.75%.
        - Net impact $17.2 billion cost to Medicare Trust Funds.

- MA growth percentage used to calculate the 2023 PACE non-ESRD is estimated to be 4.25%.
  - Net Impact $60 million cost to Medicare Trust Funds.
- Continue the adjustment to the calculation of county benchmarks in Puerto Rico for the number of beneficiaries with zero claims.
  - Net impact $320 million cost to Medicare Trust Funds.
- The impact of excluding standardized costs for kidney acquisitions from MA benchmarks varies by jurisdiction.
  - KAC carve-out factors will be published with the CY2023 Rate Announcement.

- Indirect Medical Education (IME) Phase Out.

  Background: MIPPA (2008) requires CMS to phase out IME from pre-ACA MA capitation rates which are used to set the cap on MA benchmarks and are used as the basis for PACE non-ESRD capitation rates.

  The maximum incremental IME phase-out is 0.60% of the FFS rate per year. The maximum IME reduction in 2022 – 7.8% and in 2023 – 8.4%.

  - Only two counties in payment year 2023 have IME amounts greater than 7.8% of the FFS. All others are not impacted by the change in the IME phase-out percentage in 2023.
    - The impact is considered a net savings of $10 million to the Medicare Trust Funds.

- Medicare Advantage and PACE ESRD Ratebooks.
  - FFS growth percentage for the 2023 MA ESRD rates is estimated to be 5.58%.
    - Net impact $1.3 billion cost to Medicare Trust Funds.

- 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 $470 million.

- No changes are proposed to the PACE ESRD risk model.

- MSP (Medicare Secondary Payer).
  - CMS is proposing to update the MSP factors for working aged/disabled and ESRD beneficiaries.
    - The estimated impact to the Medicare Trust Funds in 2023 is $70 million.

- MA Coding Pattern Adjustment.
  - Since the statutory minimum coding intensity adjustment is applied – 5.9% - there is no change from CY 2022.
    - The year-over-year impact is $0.

- Normalization

  Purpose – to offset the trend in risk scores and maintain a 1.0 average FFS risk score. Five years of historical risk scores are used however, for CY 2023 CMS is proposing to not update the years of historical risk scores (2016-2020) but projected one more year for updated normalization. The impact of normalization is $0.

  - The impact of normalization is $0.

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

- Part D Risk Adjustment Model.
  - For CY 2023 –CMS is proposing an updated version of the RxHCC risk adjustment model. 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.

- Annual Percentage Increase for Part D Parameters.

- The methodology for updating other Part D parameters remains unchanged from CY 2022. The impact to the Medicare Trust Fund is dependent in the behavior and bid assumptions of Part D plan sponsors.

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

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

- Increase by 5.48 % on a standardized (i.e. 1.00) risk score basis. This incorporates the FFS growth rate, changes in applicable percentage by county, average change in star ratings and quality bonus, the impact of benchmark cap and the proposed methodology change to kidney acquisition cost (KAC) removal and direct graduate medical equipment (DGME) cost removal. It does not include changes to GME adjustment factor, VA and DoD adjustment factor, credibility factors, or county rebasing and repricing.
- Increase by 4.64% on a risk-adjusted basis. The risk-adjusted increase incorporates the year-over-year impact of FFS normalization factors, and change in MA Coding Pattern adjustment.

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 January 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	4.83%
Applicable %	0.16%
Star Rating/Quality Bonus	0.49%
KAC/DGME	0.21%
Benchmark Cap	-0.23%
Total Benchmark Change	5.48%
FFS Normalization	-0.80%
MA Coding Pattern	0.00%
Total Risk Score Change	-0.80%
TOTAL	4.64%
[1] Based on January 2022 MA enrollment and Fall 2021 Star Ratings	

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

Growth Rate. This is the impact of the FFS (+4.84%) growth rate.

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

Star Rating/Quality Bonus. Difference in quality bonus impact on benchmarks due to star rating changes between 2022 and 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 total United States per capita cost (USPCC) trend differs from the FFS trend.

KAC/DGME. The 21st Century Cures Act requires that Medicare covers 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. In addition, the ACA requires the exclusion of costs attributable to payments for DGME from the calculation of Part C benchmark rates.

For 2023, CMS is revising the methodology for how they develop the KAC and DGME amounts to be excluded from the ratebook. We estimate the change to be about 0.21 % based on the published impact from CMS.

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 2022 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 (which is consistent with EGWP ratios in Table 5) 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 65.8% in 2022 and 67.4% 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]	$1,069.61	$1,128.26	5.48%
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	$900.28	$942.05	4.64%
Assumed Risk-Adjusted Bid [3]	**$720.22**	**$753.64**	4.64%
Savings (Benchmark less bid)	$180.06	$188.41	4.64%
Rebate [4]	**$118.48**	**$127.04**	7.22%
Risk-Adjusted Bid + Rebate	**$838.70**	**$880.68**	**5.01%**
[1] Based on nationwide average MA enrollment by county as of January 2022			
[2] Assumed no trend in risk scores			
[3] Bid set at 80% of risk-adjusted benchmark			
[4] 65.8% for 2022 and 67.4% for 2023			

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