601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
C 202.450.8218
ahip.org

Matthew Eyles
President & Chief Executive Officer

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Dr. Meena Seshamani, Director, Center for Medicare
Ms. Jennifer Wuggazer Lazio, F.S.A., M.A.A.A., Director, Parts C & D Actuarial Group, Office of the Actuary
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Dr. Seshamani and Ms. Lazio:

Both the MA and Part D programs are enormously successful examples of public/private partnerships that deliver tremendous value for America's seniors and people with disabilities. AHIP[1] welcomes the opportunity to comment on the Advance Notice of Methodological Changes for CY 2023 for MA and Part D (Advance Notice).

More than 28 million people choose MA—45% of those eligible for Medicare and more than double the number in MA a decade ago—because MA delivers better services, better access to care, and better value. Enrollees in MA are more racially and ethnically diverse and are more satisfied with their coverage than those in the Original Medicare program. MA also enjoys strong bipartisan support, with more than 60 Senators and 340 House Members of Congress recently writing CMS to protect MA.[2]

Similarly, Medicare Part D is a model of consumer choice and market competition that is improving access to prescription drugs and reducing out-of-pocket costs for nearly 50 million people.[3] Despite exorbitant launch prices for new drugs and out-of-control drug price increases on existing medicines, Part D premiums have remained steady over the last decade due to the efforts of Part D plans to negotiate lower costs using tested and effective cost management and negotiating tools, when available.

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[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

[2] https://www.ahip.org/news/press-releases/over-340-house-members-stand-together-to-strengthen-and-improve-medicare-advantage; https://www.ahip.org/news/press-releases/more-than-60-senators-are-clear-medicare-advantage-should-be-protected

[3] Almost 26 million receive their benefits through MA plans and more than 23 million through stand-alone Prescription Drug Plans.

In connection with the release of the Advance Notice, Administrator Brooks-LaSure said that the agency's goals for MA (and for CMS' programs as a whole) are to "advance health equity; drive comprehensive, person-centered care; and promote affordability and the sustainability of the Medicare program." MA plans strongly support—and are uniquely positioned to achieve—these goals. MA plans have a long and successful history of consistently advancing innovative, patient-centered programs that improve care, reduce consumer costs, and address the needs of seniors and people with disabilities. And health insurance providers, including those offering MA plans, have been taking decisive action to improve health equity and address social factors. Nearly all MA plans offer supplemental benefits and services, and an increasing number offer supplemental benefits to address barriers like food insecurity and poverty. They have also made substantial progress in reducing health disparities for racial and ethnic minorities and rural populations across key health measures such as annual flu vaccines, diabetic eye and kidney exams, and access to preventive services.[4] MA plans also played a leading role in efforts to improve health and vaccine equity through the Vaccine Community Connectors initiative that resulted in more than 2 million seniors living in socially-vulnerable communities receiving COVID-19 vaccines in less than 100 days as a result of the programs.[5]

Given the success and popularity of MA, we commend CMS for releasing an Advance Notice that should maintain the overall stability of the MA payment structure and facilitate continued growth, value, and innovation for consumers and taxpayers. We also support CMS' interest in exploring ways that MA plans can help further improve health equity. In particular:

- **We strongly support retaining the coding intensity adjustment at the statutory minimum for 2023.** This approach will help MA plans keep premiums low and offer the important supplemental benefits that seniors increasingly value.

- **While it is critically important for CMS to maintain longstanding adjustments for MA coverage in Puerto Rico, we urge CMS to consider additional ways to address significant payment disparities in Puerto Rico.** We strongly support continuing the methodological adjustments for Puerto Rico that determine benchmarks based on claims data for people enrolled in both Parts A and B, expand criteria for certain "double bonus" counties, and adjust for the large number of people in Puerto Rico with no Part A or B claims. These provisions help reduce the large disparity in payment rates between Puerto Rico and the mainland. However, because the adjustments do not fully account for the disparity, we urge CMS to explore other options for adjusting MA benchmarks in Puerto Rico to ensure the continued availability of comprehensive MA coverage.

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[4] RAND Health Care. "Trends in Racial, Ethnic, Sex, and Rural-Urban Inequities in Health Care in Medicare Advantage: 2009-2018." December 2021.
[5] https://www.ahip.org/news/press-releases/health-insurance-providers-commit-to-help-millions-of-seniors-in-underserved-communities-receive-covid-vaccines

- **We applaud CMS for its commitment to collaborate with plans, providers, and other stakeholders in identifying and reducing health care disparities.** As part of these efforts, we strongly support MA plans receiving confidential stratified reports regarding their performance on certain Star Ratings measures by social risk factors. In our detailed comments, we provide feedback on additional changes to the Star Ratings CMS is contemplating, including measuring plan efforts in advancing health equity and strengthening value-based care.

However, certain aspects of the Advance Notice limit future affordability, stability, and choice for consumers. In particular:

- **AHIP has several questions and concerns about how CMS is proposing to address the impacts of the pandemic, including inconsistent use of 2020 data.**

  - *FFS Normalization.* Unlike the benchmark calculations, where CMS believes 2020 data are appropriate for use in determining 2023 rates, CMS proposes to exclude 2020 data in calculating the annual adjustment known as "FFS normalization."[6] CMS typically adds a new year of data in projecting the FFS risk scores that determine the adjustment. However, CMS assumes that 2023 FFS risk scores will return to pre-pandemic trends, and therefore proposes not to update the years of data to include 2020 (a year of reduced risk scores) because it would result in lower projected risk score growth in the FFS program for 2023 and a lower normalization factor. As explained in our detailed comments and the attached Wakely Consulting Group (Wakely) analysis, we request that CMS more fully explain its assumptions about 2023 FFS risk scores, provide more information about the impact of not using 2020 in calculating the normalization factor, and describe how it will address 2020 data in calculations for future years.

  - *Provider diagnoses.* CMS does not address the extent to which delayed or foregone care during the pandemic has limited providers' ability to accurately and completely document enrollee health care conditions. We renew our prior recommendations that CMS allow plans to carry over diagnosis codes for non-curable chronic conditions documented in prior years for purposes of determining enrollee risk scores (e.g., congestive heart failure), allow diagnosis codes documented during audio-only telehealth visits to be counted for purposes of risk scores where clinically appropriate, and permit the use of prescription drug data to support diagnoses.

  - *Star Ratings.* There is continued risk and likelihood that the ongoing public health emergency (PHE) could affect patient experience survey responses and response rates. We renew our call for CMS to issue an interim final rule with comments (IFC) that maintains the weighting of patient experience/complaints and access measures at 2 for 2023 Star

[6] This adjustment, which accounts for underlying changes in FFS enrollee health status over time, generally reduces FFS risk scores and makes a corresponding reduction to MA risk scores.

Ratings. In addition, the PHE affected the 2021 measurement year. Given the potential impacts on provider and plan performance on a variety of measures across different geographies, we urge CMS to extend its COVID-19 disaster relief policy and special rules through an IFC to all applicable measures for 2023 Star Ratings.

- **AHIP has ongoing concerns with certain benchmark calculation methodologies.** We reiterate our longstanding concerns with several methodological approaches that CMS uses in calculating MA benchmarks.

  - *Parts A and B FFS costs*. CMS calculates benchmarks (other than in Puerto Rico) by including people enrolled in FFS who, by statute, are ineligible to enroll in MA plans, thereby artificially reducing rates in many counties. This approach fails to adequately determine the cost of providing a benefit to MA enrollees that is comparable to the cost of providing the benefit under Original Medicare.

  - *ESRD payment methods.* CMS does not propose any material change to how it calculates expected costs for enrollees with end stage renal disease (ESRD). Yet, various studies show that current payment methodologies do not adequately address expected costs for enrollees with ESRD. Cost-to-payment ratios for ESRD enrollees in MA are dramatically higher than those for non-ESRD enrollees, averaging 104% in 2020 according to a recent analysis from Wakely.[7] We appreciate that CMS studied the impacts of moving away from state-based rates given our prior comments that state-based rates mask large geographic variations and exacerbate payment shortfalls. However, the agency is not proposing to move forward with that approach. We urge CMS to provide more details about the study and work with stakeholders to assess alternatives.

- **Other Issues.** The Fact Sheet chart released by CMS in conjunction with the Advance Notice, which shows expected payment impacts of the policy changes in the Advance Notice, includes CMS' estimate of MA risk score trend for 2023. Other than describing the estimate as the "average increase in risk scores, not accounting for normalization and MA coding adjustments," CMS does not describe the methodology or assumptions used in developing this trend estimate, the data used for such estimate, how the estimate compares to estimated coding in the FFS program, or whether/how the estimate accounts for COVID-19's impacts. Information on the data, methods and assumptions allows stakeholders to assess the validity of the estimates and put them in the proper context in assessing the policy proposals in the Advance Notice. We urge CMS to share that information.

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[7] Wakely Consulting Group. 2023 Medicare Advantage Advance Notice. February 2022. Available at: https://www.ahip.org/resources/2023-medicare-advantage-advance-notice.

In addition, AHIP and our members have worked in close collaboration with CMS and other stakeholders to ensure enrollees have been able to access COVID-19 vaccines.[8] As plans prepare bids for 2023, we ask that the Administration share its latest information on when government-purchased stocks of COVID-19 vaccines and therapeutics (e.g., monoclonal antibodies, COVID-19 antivirals) are projected to be depleted and any plans for future product acquisitions, so that plans can develop more accurate estimates of vaccine and therapeutics costs moving forward.

Further, in our comments supporting CMS' proposed National Coverage Determination (NCD) for aducanumab and similar drugs targeting Alzheimer's Disease, we noted that MA plans will need guidance regarding the implications of a final NCD on MA plan obligations, costs, and payments for 2023. As CMS prepares the final Rate Notice announcement, we renew our request for such guidance so plans have the information they need to ensure accurate bids and stable funding for the 2023 payment year.

The Value of Medicare Advantage

Medicare Advantage delivers better services, better access to care, and better value through innovative, patient-centered programs that improve quality and reduce costs for seniors and the most vulnerable Americans with disabilities.

- **Care for diverse and vulnerable populations.** MA plans care for a growing share of Medicare beneficiaries dually eligible for Medicare and Medicaid benefits. In 2019, 44% of dual-eligible beneficiaries were enrolled in MA, up from 25% in 2013[9], and research shows dual-eligibles enrolled in MA have greater health needs than those in Original Medicare.[10] MA also serves a more racially and ethnically diverse population. In fact, 32% of MA enrollees are minorities, compared with 21% of those in Original Medicare, and that share has grown in recent years. [11] In 2019, almost half of all racial and ethnic minorities eligible for Medicare were enrolled in MA, up from 31% in 2013.[12] Minority populations are especially dependent on MA plans that combine both medical and prescription drug coverage with no monthly premium beyond the standard Part B premium.[13]

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[8] For more information about the actions AHIP members have taken to ensure access and care during the COVID-19 pandemic, see https://www.ahip.org/news/articles/health-insurance-providers-respond-to-coronavirus-covid-19.
[9] Murphy-Barron, C, Pyenson, B, Ferro, C, et. al. "Comparing the Demographics of Enrollees in Medicare Advantage and Fee-For-Service Medicare." Milliman. October 2020.
[10] NORC at the University of Chicago. "Analysis of COVID-19 Impact on Medicare Advantage and Fee-for-Service Beneficiaries." May 2021.
[11] Murphy-Barron, C, Pyenson, B, Ferro, C, et. al. "Comparing the Demographics of Enrollees in Medicare Advantage and Fee-For-Service Medicare." Milliman. October 2020.
[12] Murphy-Barron, C, Pyenson, B, Ferro, C, et. al. "Comparing the Demographics of Enrollees in Medicare Advantage and Fee-For-Service Medicare." Milliman. October 2020.
[13] NORC analysis of June 2021 CMS Medicare enrollment and demographic data, conducted for AHIP. December 2021.

- **Greater care coordination and more comprehensive benefits.** MA plans work with their members to prevent, detect, and manage chronic conditions through programs that better integrate and coordinate care compared to Original Medicare. MA plans also provide more comprehensive benefits than Original Medicare. Some of these essential benefits include integrated dental, hearing, and vision coverage, along with innovative telehealth options. In recent years MA plans began offering new types of benefits that address various social barriers to better health, such as wellness programs and nutrition, transportation, and in-home caregiver services, and the availability of these benefits has grown tremendously. In 2022, 1,034 plans offer a new type of health-related benefit designed to help support enrollees such as in-home support services, home-based palliative care, adult day services, or caregiver support, an increase of 111% since the benefits were first made available in 2020. The availability of special supplemental benefits for chronically ill patients—like nutrition support, transportation for non-medical needs, or structural home modifications to support independent living—have grown even faster, increasing by almost 400% to more than 1,200 plans in 2022.[14]

- **More financial security.** All MA plans deliver affordable coverage to members by capping annual out-of-pocket costs; individuals with Original Medicare coverage alone (without supplemental coverage) are exposed to extraordinarily high cost-sharing. MA premiums continue to decline, falling 10% from 2021 to an average of $19 a month in 2022.[15] Further, the Medicare Payment Advisory Commission (MedPAC) reports that in 2022, 98% of those eligible for Medicare have an option to enroll in an MA plan that offers drug coverage for no additional cost.[16]

- **Better health outcomes.** MA has been shown to provide better quality of care on various clinical quality measures[17,18], employ value-based payment arrangements to improve survival rates while lowering costs[19], reduce hospital admissions and readmissions as well as patient days

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[14] ATI Advisory. "New, Non-Medical Supplemental Benefits in Medicare Advantage in 2022." January 2022. Accessed at https://atiadvisory.com/wp-content/uploads/2022/01/Plan-Year-2022-Medicare-Advantage-New-Non-Medical-Supplemental-Benefits.pdf.

[15] CMS. CMS Releases 2022 Premiums and Cost-Sharing Information for Medicare Advantage and Prescription Drug Plans. September 2021. https://www.cms.gov/newsroom/press-releases/cms-releases-2022-premiums-and-cost-sharing-information-medicare-advantage-and-prescription-drug.

[16] Medicare Payment Advisory Commission. "The Medicare Advantage Program: Status report and mandated report on dual-eligible special needs plans." January 2022 Public Meeting.

[17] Timbie, Justin W., Bogart, Andy, Damberg, Cheryl et al. Medicare Advantage and fee-for-service performance on clinical quality and patient experience measures: Comparisons from three large states. *Health Services Research* 52(6), Part I: 2038-2060. December 2017.

[18] Agarwal, Rajender, Connolly, John, Gupta, Shweta, et al. Comparing Medicare Advantage And Traditional Medicare: A Systematic Review. *Health Affairs* 40(6): 937-944. June 2021.

[19] Mandal, Aloke K., Tagomori, Gene K., Felix, Randell V. et al. Value-based contracting innovated Medicare Advantage healthcare delivery and improved survival. *American Journal of Managed Care* 23(2): e41-e49. February 2017.

spent in rehabilitation facilities and nursing homes[20,21,22,23], and lower hospital use in the last days of life.[24] Peer-reviewed research has found that MA plans outperform Original Medicare across a range of metrics, including better access to preventive care and better clinical outcomes.[25] For example, MA enrollees are more likely to receive important preventive services like annual wellness exams and cognitive screenings than their counterparts in Original Medicare.[26]

Studies have also found better outcomes for patients with specific chronic diseases when they are covered by MA plans. When compared to patients with Original Medicare, MA members with ESRD have lower mortality and reduced utilization.[27] Further, MA members with diabetes and cardiac disease experienced fewer emergency room visits and hospitalizations and better quality scores compared with those covered under Original Medicare.[28] Lastly, MA members who experience a hip fracture have shorter lengths of stay and fewer hospital readmits.[29]

- **Cost efficiency for seniors and taxpayers.** For many years, average MA plan bids for delivering the basic Medicare benefit have been well below Original Medicare costs—85% of Original Medicare, based on the latest MedPAC estimates. Research provides examples of how MA plans achieve these savings: for example, through more efficient prescribing of Part B drugs and MA enrollees receiving care from more efficient providers.[30] Further, according to

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[20] Kumar, Amit, Rahman, Momotazur, Trivedi, Amal N. et al. Comparing post-acute rehabilitation use, length of stay, and outcomes experienced by Medicare fee-for-service and Medicare Advantage beneficiaries with hip fracture in the United States: A secondary analysis of administrative data. *PLoSMed* 15(6): e1002592.
[21] Huckfeldt, Peter J., Escarce, Jose J., Rabideau, Brendan, et al. Less intense post-acute care, better outcomes for enrollees in Medicare Advantage than those in fee-for-service. *Health Affairs* 36(1): 91-100. January 2017.
[22] Jung DH, DuGoff E, Smith M, Palta M, Gilmore-Bykovskyi A, Mullahy J. Likelihood of hospital readmission in Medicare Advantage and Fee-For-Service within same hospital. *Health Serv Res*. 2020;55:587–595. https://doi.org/10.1111/1475-6773.13315
[23] Schwartz, Aaron L., Slaoui, K., Foreman, R., et al. Health Care Utilization and Spending in Medicare Advantage vs. Traditional Medicare: A difference-in-difference analysis. Jama Health Forum. 2021: 2(12): e214001.
[24] Teno, Joan M., Gozalo, Pedro, Trivedi, Amal N. et al. Site of death, place of care, and health care transitions among US Medicare beneficiaries, 2000-2015. *JAMA* Published online June 25, 2018.
[25] DuGoff, Eva, Rabak, Ruth, Diduch, Tyler, et al. Quality, Health, and Spending in Medicare Advantage and Traditional Medicare. *The American Journal of Managed Care* 27(9). September 2021.
[26] Jacobson, Mireille, Thunell, Johanna, and Zissimopoulos, J. Cognitive Assessment at Medicare's Annual Wellness Visit in Fee-For-Service and Medicare Advantage Plans. *Health Affairs* 39 (11): 1935–1942. November 2020.
[27] Powers, Brian W., Yan, Jiali, Zhu, Jingsan, et al. The Beneficial Effects of Medicare Advantage Special Needs Plans for Patients with End-Stage Renal Disease. *Health Affairs* 39(9): 1486–1494. September 2020.
[28] Landon, Bruce E., Zaslavsky, Alan M., Saunders, Robert, et al. A comparison of relative resource use and quality in Medicare Advantage health plans versus traditional Medicare. *American Journal of Managed Care* 21(8): 559-566. August 2015.
[29] Kumar, Amit, Rahman, Momotazur, Trivedi, Amal N. et al. Comparing post-acute rehabilitation use, length of stay, and outcomes experienced by Medicare fee-for-service and Medicare Advantage beneficiaries with hip fracture in the United States: A secondary analysis of administrative data. *PLoSMed* 15(6): e1002592.
[30] Anderson, Kelly, Polsky, Daniel, Dy, Sydney, et. al. Prescribing of low-versus high-cost Part B drugs in Medicare Advantage and traditional Medicare. *Health Serv Res.* 2021; 1-11. doi:10.1111.1475-6773.13912.

MedPAC, average payments to MA plans in 2022 are projected to be on par with Original Medicare costs while MA offers supplemental benefits and enhanced financial security for seniors.[31] In fact, in areas where MA enrollment is higher relative to Original Medicare, additional MA enrollment leads to slower growth in Original Medicare costs as providers employ MA practice patterns and care guidelines for their remaining Original Medicare patients.[32,33,34,35]

- **High satisfaction.** A recent survey finds continued high satisfaction with the MA program, with 93% of senior voters with MA reporting satisfaction with their health care coverage, compared to 83% satisfaction among those with Original Medicare. Nearly 60% of senior voters with MA are "very satisfied" with their coverage. Moreover, 9 in 10 senior voters on MA are satisfied with their preventive services, and nearly 90% are satisfied with their prescription drug coverage. Nearly all (96%) of senior voters on MA would recommend it to their friends and family.[36]

Detailed Comments

Our attached detailed comments address specific proposals raised in the Advance Notice. Our recommended changes are aimed at maintaining a strong and stable MA program to improve American health care. The changes will ensure millions of seniors and people with disabilities continue to receive the high-quality, coordinated care they deserve—and rely on—through the MA program.

By working together, we can ensure MA continues to be a leader in delivering affordability, access, choice, and innovation. We look forward to providing any additional information you may need, and to continuing working together to improve the health and well-being of Americans.

Sincerely,

Matthew Eyles
President & Chief Executive Officer

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[31] Medicare Payment Advisory Commission. January 2022 Public Meeting Presentation. January 2022.
[32] Johnson, Garret, Figuero, Jose F., Zhou, Xiner, et al. Recent growth in Medicare Advantage enrollment associated with decreased fee-for-service spending in certain US counties. *Health Affairs* 35(9): 1707-1715. September 2016.
[33] Callison, Kevin. Medicare managed care spillovers and treatment intensity. *Health Economics* 25(7):873-887. July 2016.
[34] Baicker, Katherine, Robbins, Jacob A. Medicare payments and system-level health-care use: The spillover effects of Medicare managed care. *American Journal of Health Economics* 1(4):399-431. October 2015.
[35] Baicker, Katherine, Chernew, Michael E., Robbins, Jacob A. The spillover effects of Medicare managed care: Medicare Advantage and hospital utilization. *Journal of Health Economics* 32(6):1289-1300. December 2013.
[36] Morning Consult National Poll. December 3-6, 2021. Available online at: https://medicarechoices.org/americans-like-ma-2022/

AHIP Detailed Comments on Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage Capitation Rates and Part C and Part D Payment

Attachment I. Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for CY 2023

Section B. USPCC Estimates

CMS projects total United States per capita costs (USPCC) non-ESRD will grow by 4.25% and FFS USPCC (Non-ESRD) costs will grow by 4.84% for 2023. Both growth rate estimates presume a substantial drop in costs for 2020, with costs rebounding for 2021 through 2023.

Along with the growth rates, CMS published a comparison of its most current non-ESRD FFS cost projections with those in the January 15, 2021, final Rate Announcement (see Table 1 below). CMS' current estimates for non-ESRD FFS spending show higher spending for both 2020 and 2023 than prior projections.

Table 1. CMS Restatements of Non-ESRD FFS Cost Projections

Year	Current	Prior	Restatement
2020	$848.64	$832.18	2.0%
2021	$939.23	$929.69	1.0%
2022	$1,022.07	$1,028.38	-0.6%
2023	$1,078.12	$1,056.60	2.0%

AHIP appreciates the information CMS has provided in the Advance Notice. However, additional details regarding the estimates would further assist MA plans in developing their 2023 bids. In particular, CMS provides no specifics on the reasons for the restatements, noting only that cost projections for 2020 and subsequent years include costs associated with COVID-19, including vaccines, service utilization impacts due to COVID-19, and changes to coverage resulting from COVID-19 legislation. While the ongoing COVID-19 pandemic clearly has altered FFS utilization and spending, additional explanation about the specific drivers of the cost restatements could be particularly informative in assisting plans in ensuring accurate cost estimates. In addition, the Advance Notice does not address CMS estimates of potential costs associated with aducanumab (brand name Aduhelm), a treatment for mild Alzheimer's Disease approved by the Food and Drug Administration (FDA) in 2021. We recognize that CMS' proposed NCD for aducanumab (and similar treatments) is not expected until April, but we also note that CMS developed cost estimates for coverage when it determined Part B premiums for 2022. A clear understanding of CMS estimates regarding projected costs for this class of treatments will be important for MA plans in developing their bids and in assessing the implications of the final NCD.

Recommendation: We request that CMS provide more information about the factors contributing to the changes in non-ESRD FFS cost projections. In addition to assisting plans in bid preparation, it is important that all stakeholders understand the factors that make up cost projections and have an opportunity to provide feedback to CMS on the accuracy and reliability of CMS' cost projections.

Further, we request that CMS release additional detail about the assumptions related to COVID-19 used in the cost and growth rate estimates for 2021 and beyond. The additional detail should include information on CMS' assumptions around the number of inpatient hospitalizations subject to the 20% COVID-19 payment bump, ongoing COVID-19 testing and treatment costs, future COVID-19 vaccine costs, including projections for when the government-purchased vaccine and COVID-19 therapeutics will be exhausted, and the expected impact of COVID-19 on utilization of health care services in Medicare more broadly.

Finally, we ask that CMS explain how the potential costs of aducanumab are incorporated into projected costs for 2023 and the implications for cost estimates if a final Medicare coverage determination allows relatively broad Medicare access to aducanumab.

MA Coding Trend

While not addressed in the Advance Notice itself, in the Fact Sheet about the Advance Notice released on February 2, 2022, CMS includes an estimate of MA risk score trend for 2023, which CMS describes as the "average increase in risk scores, not accounting for normalization and MA coding adjustments". CMS includes this estimate – 3.5% for 2023 – in its chart showing the expected impact of proposed policy changes on MA plan payments for 2023.

The Advance Notice offers no additional information on the methodology or assumptions used in developing this trend estimate, the data used for such estimate, or how the estimate of MA coding trend relates to estimated coding in the FFS program. In a response to a question about the estimate on a recent stakeholder call, CMS suggested the trend was a 'raw' estimate and does not account for underlying changes in enrollee populations. However, numerous questions remain, including whether or how the estimate accounts for the impact of COVID-19 on enrollee risk scores. Prior research showed that reduced utilization of health care services due to COVID-19 led to sharp drops in enrollee risk scores for 2021[37]. CMS' own data shows utilization below prior estimates, suggesting risk scores will remain below expected levels into 2023.

Recommendation: We urge CMS to release detailed information on the data, methods, and assumptions used to estimate MA coding trend for 2023 so that stakeholders can better understand the estimate. If CMS includes a similar estimate in future announcements, the data, methods, and

[37] Avalere. COVID-19 Pandemic May Reduce MA Risk Scores and Payments. November 2020. Accessed online at: https://avalere.com/insights/covid-19-pandemic-may-reduce-ma-risk-scores-and-payments.

assumptions associated with such estimate should be included in the Advance Notice itself with an opportunity for stakeholders to review and comment on the data and methodology.

Attachment II. Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2022

Section B. Calculation of Fee for Service Cost

B2. Average Geographic Adjustment (AGA) Methodology

CMS comments on the use of 2020 FFS data to establish MA benchmarks for 2023 given the extraordinary circumstances of the COVID-19 pandemic and its impact on health care utilization in 2020 (and beyond). CMS states that the agency has reviewed trends in the 2020 FFS data and found that some specific regions experienced decreased per capita costs while other regions experienced increased per capita costs when compared to the 2019 national average per capita costs. Despite these variations, CMS proposes to make no ratebook adjustments to 2023 cost trends or benchmarks. CMS notes that adjustments have not been made for other 'select events' such as natural disasters in the past.

AHIP has expressed concerns about the impact of using 2020 experience to project future utilization both at a national level and at the local (county) level, given the dramatic variations in the way COVID-19 affected different communities over time. We note that CMS has deemed 2020 data on FFS utilization and costs to be reliable and appropriate for use in the context of the AGA methodology but has determined the same data to be inappropriate for purposes of determining the risk adjustment model normalization factors.

Recommendation: We urge CMS to explain more fully its rationale for concluding that 2020 data are suitable for determining AGA factors but not for determining normalization factors.

B3. Adjustments for Medicare Shared Savings Program and Innovation Center Models and Demonstration Programs

Consistent with prior years, CMS proposes several changes to the calculation of the AGAs used to determine the county benchmarks. CMS indicates that these changes are primarily associated with adjusting the FFS claims data for shared savings and losses of alternative payment models, including accountable care organizations, bundled payment demonstrations, and other Center for Medicare and Medicaid Innovation (Innovation Center) payment models. CMS proposes to limit the adjustment for Innovation Center models to the models listed in Table B3-1 of the Advance Notice. CMS further proposes to continue excluding from FFS costs certain payments made through Innovation Center models when those payments are not funded from the Medicare Part A or B Trust Funds.

We are concerned that CMS is limiting its adjustment of the AGAs for Innovation Center demonstrations and payment models to those listed in Table B3-1, and that CMS continues to exclude from FFS cost calculations Innovation Center payments that do not come directly from the

Medicare trust funds. We are not aware of any statutory basis for excluding these costs from the calculation of MA benchmarks. Similar to CMS' policy (discussed below) of including certain enrollees ineligible for MA in calculating benchmarks, the exclusion of these funds means CMS is not determining the cost of providing a benefit to MA enrollees that is comparable to what it would be if the benefit were provided to such enrollees under the FFS program. This should be the key test in setting MA benchmarks, not the source of FFS funding. We are also concerned that as the Innovation Center expands the scope and range of alternative payment models that diverge from traditional FFS payment methods, a growing share of FFS spending may be excluded from MA benchmarks.

Recommendation: We recommend that CMS reconsider its policy of excluding models in its adjustment of the AGAs to the extent the models involve payments such as bonuses and care management fees funded through the Innovation Center. Instead, CMS should apply the "actual spending impact" of any demonstrations and payment models in its adjustment of the AGAs, including care management fees and other spending amounts not reflected in shared savings/losses. Further, we ask that CMS publish a list of all Innovation Center models that are financed, in whole or in part, outside of the Medicare Trust Funds, including the projected annual payments made through such models that do not originate from the funds.

B4. Additional Adjustment to FFS per Capita Costs in Puerto Rico

The MA program is critically important in Puerto Rico. More than three fourths of Medicare beneficiaries in Puerto Rico are enrolled in MA plans (82% as of January 2022). A substantial number of these beneficiaries have low incomes and enroll in plans to receive more care coordination and affordable Part D coverage, which otherwise may not be affordable due to the statutory prohibition on providing Part D low-income subsidies (LIS) to beneficiaries in the territories.

We continue to be concerned about the large disparity in payment rates between Puerto Rico and the mainland. The unusually low FFS expenditures for Puerto Rico, which serve as the basis for MA benchmarks, and the significant rate cuts for Puerto Rico put into place by the Affordable Care Act (ACA), jeopardize the continued availability of the comprehensive coverage provided by MA plans operating on the island to the low-income populations they serve.

The Secretary has previously directed the Office of the Actuary (OACT) to account for the fact that a higher proportion of beneficiaries in Puerto Rico did not have claims than beneficiaries outside of Puerto Rico. The agency has determined that from 2015 through 2019, an average of 15% of Puerto Rico beneficiaries enrolled in both Medicare Parts A and B had no claims reimbursements in a given year, compared to 6.1% of beneficiaries nationwide during the same period. To account for the large share of beneficiaries in Puerto Rico who have no claim reimbursements in a year, OACT applied an adjustment of 4.6% to the standardized per capita FFS costs in Puerto Rico for 2015 through 2019 and the resulting 2022 rates, and OACT is considering whether to make this adjustment for the 2023

rates. For an adjustment in 2023, CMS would perform a similar analysis to the one used to determine the 2022 adjustment, but with an updated five years of data: 2016 – 2020.

CMS also notes that it will continue to adjust the FFS calculation for Puerto Rico to include only those beneficiaries enrolled in both Parts A and B. In addition, in the CY 2018 Final Notice CMS expanded the criteria used to determine which counties qualify for a double quality bonus payment to include certain counties in Puerto Rico.

Recommendation: AHIP supports CMS continuing to adjust the calculation of benchmarks for Puerto Rico using only claims data for beneficiaries enrolled in both Parts A and B. We also support continuation of the expanded criteria for double bonus counties.

In addition, we strongly urge CMS to apply an adjustment to account for the large number of Puerto Rico beneficiaries with no Part A or B claims. Such an adjustment remains necessary to ensure that plans in Puerto Rico can maintain benefits for the low-income populations they serve. We are concerned, however, about the potential impacts on the adjustment if CMS includes 2020 data due to the effects of the COVID-19 pandemic and its impact on health care utilization. Given the unique situation in Puerto Rico, we recommend CMS consider excluding the 2020 data year from the analysis if including 2020 would result in a smaller adjustment to the MA benchmark rates for Puerto Rico in 2023 than prior years.

We also renew calls for CMS to explore additional options for increasing MA benchmark rates for Puerto Rico to achieve greater parity with FFS rates on the mainland. Even with the adjustments discussed above, payment disparities remain and can limit the availability of the comprehensive MA coverage that is critical to Puerto Rico residents.

Calculating FFS Costs Using Enrollees Enrolled in Medicare Part A and Part B

For several years we have raised concerns that CMS is not appropriately calculating all MA benchmarks from an actuarial perspective, as the current methodology includes beneficiaries who are not eligible to enroll in MA. A Medicare beneficiary must have both Part A and Part B to be eligible for MA plan enrollment, yet CMS calculates rates based on enrollees with either Part A or Part B. Actuarial principles require that an estimate of the benchmark must represent what that enrollee would cost in Original Medicare. By using claims experience from Original Medicare beneficiaries who are not eligible to enroll in MA, CMS is calculating benchmarks that include beneficiaries with only Part A and only Part B, and therefore does not appropriately estimate what would have been paid for the same beneficiary had they remained in Original Medicare. CMS has made this adjustment to the benchmark rates for Puerto Rico since 2012.

While CMS has recognized the need to count historical claims and enrollment of those beneficiaries with both Part A and Part B enrollment in calculating MA rates for Puerto Rico, we are disappointed that CMS continues to not make this adjustment to the calculation of MA rates nationwide. In announcing the release of Part II of the 2022 Advance Notice, CMS indicated the agency was

considering revising MA rates based on data from beneficiaries with both Parts A and B. The press release also said the agency intended to issue a request for information on the topic, though no such request has been made public.

AHIP believes the current methodology is inappropriate from an actuarial perspective because it includes beneficiaries who are not eligible to enroll in MA. We also continue to believe the Social Security Act requires that the Agency exclude Part A-only enrollees from the calculation of county benchmarks, to ensure the estimate best represents what that enrollee would cost in Original Medicare.

Recommendation: We urge CMS to revise the way all MA benchmarks are determined to include only individuals enrolled in Parts A and B in calculating FFS costs. We also encourage CMS to issue a request for information on this issue so that stakeholders can provide input.

Section C2. Organ Acquisition Costs for Kidney Transplants

As required by the 21st Century Cures Act, CMS describes a methodology for excluding costs related to kidney acquisitions from MA benchmarks. For 2023, CMS is proposing a new approach for the development of the exclusion amounts for kidney acquisition costs to incorporate variations in the way provider payments are calculated by Medicare Administrative Contractors (MACs). The impact of the revised carve-out method would be to increase overall MA non-ESRD and ESRD county rates by about $1 per member per month (PMPM), on average. However, CMS notes the impact varies dramatically by jurisdiction, from a negative impact of -$11 PMPM to a positive impact of $33 PMPM.

The removal of kidney acquisition costs from MA benchmarks is still relatively new payment policy, having begun in 2021. As such, plans are still gaining experience with the impact of the carve-out on ESRD payment rates. We are concerned that the changes proposed for the kidney acquisition carve-out, combined with the proposed changes to the direct graduate medical education (DGME) exclusion, county rebasing, and varying impacts of the COVID-19 pandemic on growth rates could lead to very large changes in MA benchmarks for some counties in 2023. While any one of these changes is unlikely to result in a destabilized payment environment, the combined effects of these changes could lead to large shifts in benchmarks for some counties.

Recommendation: We urge CMS to closely monitor the net impact of proposed payment changes and take steps to limit large drops in county benchmarks that may result from such changes.

Section D. MA ESRD Rates

CMS proposes to maintain the current method for calculating the 2023 MA ESRD rates, while describing the results of an analysis of the impact of moving from current state-based ESRD rates to Core-Based Statistical Area (CBSA)-based rates. In response to concerns raised by stakeholders, including AHIP, regarding ESRD payment adequacy and accuracy, CMS compared ESRD dialysis

rates at the state level, as currently determined, with CBSA-based ESRD dialysis rates. CMS found that, on average, the MA ESRD rates for rural CBSAs declined by 2.6% and increased for urban CBSAs by 0.5%. The analysis also found that MA ESRD rates would fall in medically underserved urban areas under CBSA-based benchmarks. Based on the findings, CMS proposes no changes to the current state-based ESRD rate methodology but asks for feedback reading the impact of sub-state rates on rural and underserved populations.

AHIP has previously expressed serious concerns that MA ESRD benchmark rates are too low generally. An important contributing factor remains the highly concentrated dialysis provider market, which leverages network adequacy requirements to demand favorable contracting terms from MA plans for dialysis services.[38] The lack of competition is compounded by outdated conditions of participation for dialysis providers that hamper increased use of home dialysis. In addition, maximum out-of-pocket (MOOP) limits apply to ESRD costs for Medicare Advantage organizations (MAOs) but not to such costs in the FFS program. This has resulted in many MA plans incurring costs for dialysis services well above Original Medicare rates and medical loss ratios (MLRs) in excess of 1 for these enrollees (well above average MLRs for other enrollees).[39]

The problem of inadequate ESRD payment rates grows as the number of ESRD enrollees in MA increases. CMS originally projected that about 41,500 beneficiaries with ESRD would enroll in MA for the first time in 2021; by 2023, CMS estimates that almost 1% of all MA enrollees will have an ESRD diagnosis, a 48% increase from 2020. A 2019 analysis by Wakely found that for every increase of 0.5% in the share of MA enrollees with ESRD, the total MLR would increase by 0.8%.[40] More recently, Wakely found average MLRs for ESRD enrollees were substantially higher than MLRs for non-ESRD enrollees; in 2020, for example, the average MLR for ESRD enrollees was 104%.[41]

We have also raised concerns that the payment shortfalls are exacerbated by state-based ESRD benchmarks that mask large variations in ESRD costs. A study from HMA found that in 2017 average Original Medicare costs in Oakland, CA were 113% of the state average while costs in San Diego were 89% of the state average.[42] Similar results were found across metropolitan areas in

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[38] Two companies own over 70% of all dialysis centers. See: Milliman. Medicare Advantage: Eight critical considerations for every organization as ESRD eligibility expands in 2021. December 2019. Available online at: https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/medicare-advantage-eight-critical-considerations.ashx.
[39] See: https://www.ahip.org/documents/AHIP-2021-Advance-Notice-Comment-Letter_WakelyReport.pdf
[40] Wakely Consulting Group. Increased ESRD Beneficiary Enrollment Flexibility Presents a Potential Financial Challenge for Medicare Advantage Plans in 2021. February 2019. Available online at: https://www.wakely.com/sites/default/files/files/content/increased-esrd-beneficiary-enrollment-flex-presents-potential-financial-challenge.pdf.
[41] Wakely Consulting Group. 2023 Medicare Advantage Advance Notice. March 2022. Available online at: https://www.ahip.org/resources/2023-medicare-advantage-advance-notice.
[42] Health Management Associates. End-stage renal disease and Medicare Advantage. February 2020. Available online at: https://www.healthmanagement.com/wp-content/uploads/Health-Management-Associates-ESRD-and-Medicare-Advantage-White-Paper.pdf

Florida, Ohio, and Texas, suggesting the state ESRD benchmarks do not adequately reflect the costs of serving beneficiaries with ESRD in many areas. The 2019 Wakely study found that 11 of the top 15 counties by MA enrollment had a cost to payment ratio over 100% for beneficiaries with ESRD. This ratio was as high as 136.5% in Kings County, NY (i.e., Brooklyn), meaning that FFS Medicare costs for ESRD beneficiaries living in Brooklyn were 36.5% higher than the New York state ESRD benchmark rate that an MA plan serving this population would be paid (see Table 2).[43]

Table 2. ESRD Payment Ratios for Top 15 Counties by MA Enrollment

State	County	January 2020 MA Enrollment	January 2020 MA Penetration Rate	2018 ESRD Dialysis Cost/Payment
CA	Los Angeles	1,603,769	48.3%	114.4%
FL	Miami-Dade	503,439	66.7%	114.9%
AZ	Maricopa	762,339	42.0%	101.9%
TX	Harris	599,681	46.2%	118.4%
CA	Orange	549,680	48.7%	92.6%
CA	San Diego	575,361	46.0%	93.4%
IL	Cook	882,163	29.9%	121.9%
CA	Riverside	421,808	53.3%	93.5%
FL	Broward	363,232	52.7%	123.6%
CA	San Bernardino	333,539	55.7%	123.5%
NY	Queens	398,172	45.9%	127.0%
NY	Kings	407,537	43.0%	136.5%
PA	Allegheny	279,175	60.0%	110.2%

[43] Wakely Consulting Group. 2021 Medicare Advantage Advance Notice. March 2020. Available online at: https://www.ahip.org/documents/CY2021-Advance-Notice-Summary-and-Analysis-03-04-2020.pdf.

State	County	January 2020 MA Enrollment	January 2020 MA Penetration Rate	2018 ESRD Dialysis Cost/Payment
NV	Clark	398,628	41.4%	97.2%
MI	Wayne	354,164	45.9%	114.5%

Moving from state-based ESRD benchmarks to CBSA-based ESRD benchmarks would help address the large disparities in ESRD costs that exacerbate the overall problem of inadequate payments to MA plans for the costs of enrollees with ESRD. Accordingly, we very much appreciate CMS responding to the concerns about geographic variation by studying the potential impacts of a CBSA-based approach. While the results do confirm that metropolitan areas are underpaid under the current approach, it would be helpful if CMS provided more details about the study so researchers can replicate the analysis and assess the implications for specific areas.

We also recognize that moving to smaller geographic areas for payment could result in some areas seeing a reduction in payment rate. We appreciate CMS' concerns about the distributional effects of a change for rural and medically underserved areas. Rather than disregarding a CBSA-based approach, however, we urge CMS to consider an approach that would protect rural and medically underserved areas from payment reductions while also helping to address the continued inadequate payment rates at the state level that result in higher premiums and reduced access to extra benefits for all MA enrollees.

Recommendation: Given the large within-state variations in ESRD costs, AHIP supports the use of CBSAs or another sub-state geographic unit as the basis for calculating MA ESRD benchmarks. To address the impact of sub-state rating areas, CMS should apply an adjustment to the rates in rural and underserved areas to ensure access to care for enrollees. Similar to the use of rate adjustments in rural areas in many Medicare FFS payment systems, such an adjustment here would reflect the higher costs of providing care and building adequate networks in areas with fewer providers. We also request that CMS provide more details about its study to allow for additional research and analysis.

In addition to moving from state-based to more refined geographic areas for ESRD rates, we urge CMS to take additional steps to address the inadequacy of payments for ESRD enrollees overall. On a related note, we encourage CMS to update conditions of coverage for dialysis providers to encourage expansion of home dialysis and increase the tools plans have available to reduce costs.

ESRD Costs and MOOP Limits

One factor contributing to underpayment for ESRD enrollees is that limits on enrollee cost sharing transfer a greater share of costs for these enrollees onto MA plans. In setting the MOOP cost sharing limit in 2021, CMS incorporated 40% of the expected additional beneficiary costs for ESRD enrollees and suggested the share of added costs would be increased over time until MOOP limits fully incorporated beneficiary costs for ESRD enrollees. However, for the 2022 payment year CMS made no changes to the MOOP limits and CMS has yet to release information on cost sharing limits for 2023. In a separate proposed rule for the 2023 payment year, CMS would make other changes to the way enrollee cost sharing paid by third parties and certain unpaid amounts are counted toward the MOOP.

Wakely's analysis of expected costs for ESRD suggests that the current mandatory MOOP limit of $7,550 is significantly below what the MOOP would be if it fully reflected costs for enrollees with ESRD; Wakely estimates the 2023 MOOP would be between $8,150 and $9,350 if it included 100% of ESRD enrollee costs. [44] Failing to fully account for these costs – or account for a larger share than CMS currently does – results in higher costs for MA plans, higher premiums for all enrollees, and fewer added benefits.

Recommendation: We urge CMS to revise the MOOP limits for 2023 to more fully account for the added costs of ESRD enrollees, and to establish a transition to inclusion of 100% of expected ESRD enrollee costs in the MOOP.

Section F. MA Employer Group Waiver Plans (EGWPs)

CMS proposes to maintain the current payment methodology for EGWPs in 2023. Under that approach, CMS waives the bidding requirements that apply to non-EGWP plans and instead determines EGWP rates based on average bid-to-benchmark ratios using 2022 bids. In response to requests from stakeholders, CMS provides preliminary bid-to-benchmark ratios for EGWPs in the Advance Notice, noting that the ratios are not final and could differ from final ratios used to determine EGWP rates for 2023.

Recommendation: AHIP appreciates CMS publishing preliminary bid-to-benchmark ratios for 2023, which facilitates MAO engagement with employers as they develop EGWP offerings and bids. We are concerned that the published preliminary bid-to-benchmark ratios are lower than expected, and request that CMS provide additional detail about how the ratios were calculated.

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

CMS is proposing to continue use of the 2020 Part C HCC model without modification for 2023. However, CMS is soliciting input on potential future enhancements to the model to address the

[44] Wakely Consulting Group. 2023 Medicare Advantage Advance Notice. March 2022. Available online at: https://www.ahip.org/resources/2023-medicare-advantage-advance-notice.

impacts of social determinants of health (SDOH) on beneficiary health status by incorporating additional factors that predict the relative costs of MA enrollees.

AHIP's members are committed to improving health equity and addressing the impacts of SDOH on enrollees' health outcomes. Recognizing the role that social and economic need plays in an individual's health status, health behaviors, and health outcomes is important for efforts to achieve better overall health for individuals and communities. To this end, AHIP supports CMS' efforts to address SDOH in payment and quality measurement systems, including in MA payment and performance measures.

To appropriately account for SDOH in the risk adjustment model, CMS must be able to identify and measure social risk factors fairly and accurately for all beneficiaries. There are still many challenges with collecting and acting on SDOH data, including: (1) Standards are still being developed for standardized SDOH data collection and interoperable data sharing; (2) the infrastructure to collect, store, and share SDOH data is still being built; and (3) health care, social services, and community-based organizations still have limited readiness and capacity to collect and share data and mitigate socioeconomic barriers to health. For example, ICD-10 Z-codes have potential to better document SDOH, but provider use of Z-codes is low for several reasons, including lack of provider awareness and concerns about how the code information is used. Information sharing barriers also contribute to low utilization of Z-codes. Electronic health records (EHR) do not provide easy pathways for documenting Z-codes associated with specific problems or diagnostics.

Recommendation: To ensure that any risk adjustment for SDOH is fairly and consistently applied, CMS should identify approaches most likely to generate comparable information for all enrollees. One way to do that may be to use data available for all Medicare beneficiaries at the time of enrollment or captured through CMS' administrative processes rather than relying on information collected through provider claims, surveys, or other data collection instruments that are not universal or standardized. For example, a beneficiary's zip code could be used as a proxy for certain social risk factors and is readily available from administrative data. As noted above, there are significant barriers to provider collection of SDOH data. And even if physicians and other providers could overcome those barriers, asking them to collect and code social risk factors for all patients will add significant burden to providers already overworked by non-clinical tasks. Further, relying on information collected through providers could exacerbate disparities if adjustments depend on access to providers with sufficient resources to collect, document, and report the information.

Should CMS move forward on accounting for social risk factors in the risk adjustment model, it will be important to engage with MAOs and other stakeholders throughout the process. Elsewhere in this letter, we discuss the need for allowing at least 60 days for notice and comment on changes to the risk adjustment model, to ensure MAOs have time to analyze the impact of proposed changes and offer meaningful feedback to the agency. Given the importance of getting health equity and risk adjusted payments right, we also urge CMS to discuss potential approaches to accounting for SDOH

in the risk adjustment through a white paper or similar report, with an opportunity for comment and stakeholder input, similar to the approach CMS has taken for risk adjustment for Exchange plans.

Impact of COVID-19 on MA Risk Scores

AHIP remains concerned that CMS has not done more to address the impact of the COVID-19 PHE on plans' ability to accurately and completely assess enrollees' health care conditions and needs. As discussed in Section M. below, CMS' own data demonstrate a significant drop in risk scores for Medicare beneficiaries as a result of the PHE. Artificially decoupling actual health from risk scores can undermine the high-quality care and benefits seniors and people with disabilities deserve. The impact of CMS' failure to recognize and respond to incomplete risk score reporting is likely to carry into 2023. As the PHE continues without any clear end date, we will likely see continued adverse impacts on the use of primary care and other providers who are critical in documenting diagnoses for purposes of determining risk adjusted payments in 2023.

Recommendation: We urge CMS to take additional steps to address the impact of the COVID-19 PHE on MA enrollee risk scores by 1) allowing plans to carry over diagnosis codes for chronic conditions for purposes of determining enrollee risk scores, and 2) allowing diagnosis codes documented during audio-only telehealth visits to be counted for purposes of risk scores in all payment years since the start of the PHE. These steps would ensure stability in access and payment for enrollees and the plans that serve them.

Finally, we ask that CMS provide stakeholders a minimum of 60 days to comment on any and all future proposed changes to the risk adjustment models for Parts C, D, and ESRD. When Congress specifically required a 60-day comment period for the changes mandated by the 21st Century Cures Act, it recognized the importance of giving stakeholders sufficient time to carefully analyze and consider the proposed changes and develop meaningful feedback for the agency. Given the critical role the risk adjustment model plays in ensuring fair and adequate payment to plans and access to services for enrollees, we urge CMS to adopt a similar approach for other changes.

Section H. ESRD Risk Adjustment Models for CY 2023

CMS proposes several updates to the ESRD risk adjustment model for 2023, including implementing an updated clinical version of the ESRD model, updating the data years used for model calibration, and accounting for differences in cost patterns for dual-eligible enrollees by creating separate model segments for the single functioning graft community model based on an enrollee's disabled status and eligibility for full or partial Medicaid benefits.

Wakely's analysis of the Advance Notice finds that the proposed recalibration of the ESRD risk adjustment model will result in a lower average ESRD risk score for the new (2023) ESRD risk models (average risk score, 1.600) than the average ESRD risk score for the prior (2020) ESRD risk

models (average risk score, 1.621).[45] The lower average risk score, together with the change in FFS normalization factor for the models, will result in a 1.32% decrease in MA payments for ESRD enrollees in 2023. CMS' own analysis of impact shows $470 million in payment reductions in 2023 as a result of the ESRD risk adjustment model changes. Wakely also finds the net impact will vary considerably across models and populations, with the post-graft model leading to a risk score reduction of 2.27% compared with a .55% reduction for the dialysis model, and a larger risk score reduction for non-dual-eligible population (-4.43%) than for dual-eligible ESRD enrollees (-1.32%). These reductions are especially concerning given the evidence that ESRD payment rates are already inadequate; implementation of the new ESRD risk adjustment model will only serve to exacerbate the payment shortfall.

Recommendation: As previously stated, AHIP asks that CMS provide additional advance notice of changes to the ESRD risk adjustment models, similar to the notice provided for changes to the Part C model required by the 21st Century Cures Act. Providing at least 60 days for notice and comment would allow stakeholders time to carefully analyze and provide more meaningful feedback on the models, which are an essential component of payment for plans and enrollees.

Section K. Medicare Advantage Coding Pattern Adjustment

The Advance Notice announces that for CY 2023 CMS is proposing to apply the statutory minimum MA coding adjustment factor of 5.90%.

Recommendation: AHIP supports the agency's decision to maintain and not exceed the statutory minimum adjustment.

Section L. Normalization Factors

L1. Normalization for the Part C CMS-HCC Models

CMS proposes a normalization factor of 1.127 for the 2020 CMS-HCC model, which would result in an estimated 0.81% reduction to MA plan payments for 2023 compared with 2022. In a change from past practice, CMS proposes to continue using the same five years of FFS utilization data as last year – 2015 through 2019 – to estimate the normalization factor, rather than updating the five years of data – as CMS has done in past years – to include 2020. CMS' rationale for the proposal is that 2020 data reflect lower-than-expected utilization due to the pandemic and using the 2020 data would result in a lower FFS risk score trend that CMS believes is below what the actual average FFS risk score is likely to be in 2023.

Analysis of risk score trends and normalization factors shows that CMS' proposal to exclude 2020 FFS utilization data from the 2023 calculation results in a significantly higher normalization factor than would result from use of 2020 data. Using information provided in the Advance Notice, Wakely

[45] Wakely Consulting Group. 2023 Medicare Advantage Advance Notice. March 2022. Available at: https://www.ahip.org/resources/2023-medicare-advantage-advance-notice.

estimates that calculating the 2023 normalization factor based on 2016 – 2020 utilization data would result in a factor of 1.059 as opposed to the 1.127 normalization factor calculated based on 2015 – 2019 utilization data and would result in a positive adjustment to MA risk scores for 2023.[46]

AHIP has several concerns with CMS' proposal to exclude the 2020 utilization data entirely for purposes of calculating the 2023 normalization factor:

- In justifying the proposal to exclude the 2020 data, CMS describes 2020 as an anomalous year, with an expectation that risk scores will immediately rebound to be consistent with prior years. However, the COVID-19 pandemic has continued to affect health care utilization and spending throughout 2021 and into 2022. As CMS' own FFS cost projections demonstrate, FFS costs for 2021 are now estimated to be significantly below prior projections, suggesting FFS risk scores will continue to be suppressed beyond 2020. CMS provides no rationale in the Advance Notice for why the projected 2023 FFS risk score is likely to be unaffected by the continued low utilization.
- CMS does not explain how it intends to address 2020 in future years. If, as discussed earlier, 2021 utilization follows the same pattern of 2020, will CMS continue to rely on 2015 – 2019 data to calculate the normalization factor in 2024 and beyond? How will CMS determine that FFS risk scores have returned to a 'normal' state?
- We note that earlier in the Advance Notice, in discussing calculation of FFS growth rates, CMS found that using 2020 data on FFS costs was appropriate and proposed no adjustments or changes to account for 2020. It remains unclear why CMS believes 2020 data are inappropriate for purposes of calculating the normalization factor but suitable for calculating FFS growth rates and geographic adjustments.

Recommendation: We acknowledge the uniqueness of the pandemic and the complexities in determining how best to appropriately account for its impacts in projecting future costs. Accordingly, we recommend CMS outline exactly how 2020 utilization data will be used in calculating the normalization factor for 2023 and all future years in which 2020 utilization data would be included in the FFS risk score trend. We also ask that CMS explain how it will evaluate and incorporate 2021 utilization data into the normalization factor for 2024 and future years given the clear evidence of ongoing effects of COVID-19 on utilization in 2021. We further request that CMS explain its analysis of the impacts of reduced utilization and mortality changes on future FFS risk scores and share its analysis of any alternatives that may have been considered.

In addition, CMS continues to rely on a Part C risk adjustment model calibrated on utilization data from 2014, reflecting ICD-9 codes that have not been used since 2015. In this Advance Notice, CMS proposes to recalibrate and update the RxHCC and ESRD risk adjustment models to reflect more

[46] Wakely Consulting Group. 2023 Medicare Advantage Advance Notice. March 2022. Available online at: https://www.ahip.org/resources/2023-medicare-advantage-advance-notice.

recent utilization and cost data. As discussed elsewhere in this letter, both updates result in significant changes in payment to plans generally and may have even greater impacts on individual plans depending on the underlying populations they serve. Recalibration of the Part C risk adjustment model would also likely lead to overall changes in plan payments and considerable variation in impact across counties, enrollee subgroups, and plans. It is important that plans have time to evaluate the impacts of any model recalibration and have an opportunity to share those impacts with CMS to inform the process and ensure stability in payments and access.

Recommendation: We encourage CMS to release information on the impact of recalibrating the Part C risk adjustment model using only years of data in which ICD-10 has been fully implemented (i.e., 2016 and later). Further, we believe this information should be published (e.g., through a white paper issued separately from the rate notice process) with an opportunity for stakeholders to submit comments on the assumptions and methods used, and with sufficient time for stakeholders to analyze the information and develop meaningful comments to improve MA payment policy. Recalibration of the risk model using ICD-10 data could lead to material changes in the risk adjustment model and the industry will need significant lead time to understand the impact and provide comments to the agency.

We also recommend that CMS establish a Technical Expert Panel (TEP) on the MA risk adjustment model, which would address issues such as FFS normalization and any model recalibration activities. This TEP would be an excellent approach for considering alternative methodologies to developing the FFS normalization factor or how recalibration of the risk adjustment model using ICD-10 data should be undertaken. Such a collaboration would also allow for substantive analysis and discussion of changes to the risk adjustment model outside of the annual Advance Notice process, which only provides 30 days for analysis and comment (and 60 days for changes implemented per the 21st Century Cures Act). AHIP and its members would welcome the opportunity to participate in such a TEP.

There are many examples of TEPs and other Federal Advisory Committees across the FFS Medicare payment systems, including for the Medicare Physician Fee Schedule as well as for hospital outpatient payment, clinical diagnostic laboratory tests, and the ESRD prospective payment system.[47] We urge CMS to consider taking a more collaborative approach to the risk adjustment model and look forward to working with the agency to improve the MA program.

[47] For the Medicare Physician Fee Schedule, see: https://www.ama-assn.org/about/rvs-update-committee-ruc/rvs-update-committee-ruc. For other Federal Advisory Committees serving CMS, see: https://www.cms.gov/Regulations-and-Guidance/Guidance/FACA.

L2/L3. Normalization for the CMS-HCC ESRD Models

As with the CMS-HCC risk adjustment model, CMS is proposing to also continue using utilization data from 2015 through 2019 to estimate the change in FFS risk scores and calculate normalization factors for the CMS-HCC ESRD dialysis model and the CMS-HCC ESRD functioning graft model for 2023.

Recommendation: AHIP has the same questions and concerns with CMS' proposal to disregard 2020 FFS utilization in calculating normalization factors for the ESRD models as we have with the Part C model. We urge CMS to provide the same information for the ESRD risk models as requested above regarding the CMS-HCC model, including how 2020 FFS utilization data will be used for determining future normalization factors.

Attachment III. Benefit Parameters for the Defined Standard Benefit and Changes in the Payment Methodology for Medicare Part D for CY 2023

Section A. RxHCC Risk Adjustment Model

For 2023 CMS proposes to recalibrate the Part D risk adjustment (RxHCC) model to incorporate a revised clinical classification system based on ICD-10-CM diagnosis codes. The revised 2023 RxHCC model would have 84 payment RxHCCs, compared with 76 payment RxHCCs in the current model. Unlike the Part C and ESRD risk models, 2020 utilization data is not a factor in the RxHCC normalization for 2023, as risk scores are lagged by an additional year in the Part D model due to the inclusion of MA Part C risk scores.

Wakely's analysis suggests that the updated RxHCC model will result in an overall decrease in Part D risk scores of 1.10%, with the impact being greatest for continuing enrollees and non-low-income enrollees.[48]

Recommendation: AHIP supports the proposed update to the RxHCC model, though we believe this is an example of a methodological change that should be made with at least a 60-day comment period for plans and other stakeholders. The updated model will have a significant impact on average risk scores across all plans, with some plans seeing substantial shifts in risk-adjusted payments. To fully evaluate the changes and offer meaningful input, CMS should propose risk model changes and allow at least 60 days for feedback.

[48] Wakely Consulting Group. 2023 Medicare Advantage Advance Notice. March 2022. Available online at: https://www.ahip.org/resources/2023-medicare-advantage-advance-notice.

Attachment IV. Updates for Part C and D Star Ratings

Reminders for 2023 Star Ratings

In the Advance Notice, CMS reminds plans about the increase in the weight of patient experience/complaints and access measures from 2 to 4 for the 2023 Star Ratings.

We understand that plans may have experienced reductions in patient experience survey response rates throughout the pandemic. Lower response rates could adversely affect plan and provider performance on patient experience survey measures. Increased virtual visits may also have an impact on CAHPS survey results, as beneficiaries completing CAHPS surveys may not consider telephone and video services with clinicians when answering the survey questions. Although the initial instructions for the CAHPS survey do ask beneficiaries responding to consider health care services received through a variety of methods, including by video or telephone, these instructions are fairly new. We are concerned that unlike other CAHPS surveys, not all questions for the MA survey have been updated to align with the initial instructions on virtual visits. This new instruction and method for receiving care combined with the lack of consistency in language about virtual visits throughout the survey could be confusing or misleading to Medicare beneficiaries and impact the reliability of their survey responses. While we appreciate CMS adding in telehealth as a modality, we have concerns about interpretation and alignment across CAHPS survey versions.

We also remain concerned about the impact of COVID-19 on patient experiences as well as other aspects of the CAHPS methodology such as the impact of the tight clustering of CAHPS measure cut points. MA contracts with marginally different performance can receive measure scores that are several star levels apart.[49]

Recommendation: Because of concerns about lower response rates, other methodological issues and negative impacts of the pandemic, we urge CMS to issue an interim final rule with comments (IFC) to maintain the weighting of patient experience/complaints and access measures at 2 (including for the improvement measure calculation) for 2023 Star Ratings. We also ask CMS to review the comments submitted by AHIP members on the impact of COVID-19 on CAHPS measures for 2023 Star Ratings.

Measure Updates for 2023 Star Ratings

In the Advance Notice, CMS provides information and updates for the upcoming Star Ratings year. We appreciate the inclusion of these updates in the notice.

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[49] For example, the difference between a 1 Star rating and a 5 Star rating for the CAHPS customer service measure in the 2022 Star Ratings was only 5 percentage points (a score of less than 88 percent for 1 Star and greater than or equal to 92 percent for 5 Stars). Medicare 2022 Part C & D Star Ratings Technical Notes, https://www.cms.gov/files/document/2022-star-ratings-technical-notes-oct-4-2022.pdf.

Recommendation: When releasing future Advance Notices, we request that CMS consider posting on CMS' MA Star Ratings webpage a complete measure set for both the upcoming Star Ratings year and the following year. The availability of this information would promote clarity and common understanding, and assist plans with their efforts to provide meaningful comments in response to future Star Ratings proposals. We also ask CMS to consider holding an annual user group call with plans to discuss key changes for the upcoming Star Ratings year. Annual calls that CMS held previously on Star Ratings were extremely informative.

Extreme and Uncontrollable Circumstances Policy

The Advance Notice describes the current extreme and uncontrollable circumstances policy ("disaster relief policy"). It also provides a list of states and counties that are Federal Emergency Management Agency (FEMA) designated Individual Assistance areas subject to the disaster relief policy for 2023 Star Ratings. Under the disaster relief policy, eligible MA plans with at least 25 percent of their service area in the FEMA designated areas in 2021 will receive the higher of their measure-level ratings from 2022 or 2023 for applicable Star Ratings measures.

HOS Measures

CMS notes that due to the impact of COVID-19, the agency has proposed through the MA and Part D proposed rule for CY 2023[50] to extend the disaster relief policy's "higher of" methodology to only the three Health Outcomes Survey (HOS) measures: Monitoring Physical Activity, Reducing the Risk of Falling, and Improving Bladder Control. This change would enable the agency to calculate these measures for the 2023 Star Ratings and include them in the 2023 reward factor calculation.

As indicated in our comments in response to the proposed rule, we support CMS' proposed change to the Star Ratings disaster relief methodology for the three HOS measures to enable the agency to calculate these measures for the 2023 Star Ratings and include them in the 2023 reward factor calculation. We note, however, that on August 5, 2021, CMS decided to move two HOS outcome measures, Improving or Maintaining Physical Health and Improving or Maintaining Mental Health, to the display page for 2022 and 2023 Star Ratings due to data integrity issues related to COVID-19. We remain concerned about the impact of COVID-19 on all of the Star Ratings measures, including the three HOS measures addressed in the Advance Notice and proposed rule**.**

Recommendation: We urge CMS to closely review potential data anomalies for these three HOS measures, and if any are uncovered, we recommend these measures also be removed from the 2023 Star Ratings.

[50] 87 Fed. Reg.1842 (January 12, 2022).

Other Measures

We appreciate CMS' statement in the proposed rule that the agency intends to pursue additional rulemaking in response to comments submitted to the March and September 2020 IFCs. We believe such guidance is critically important given some of the key issues we and others raised in our comments. For example, the COVID-19 PHE has still not ended. During the 2021 measurement year the country experienced the spread of the Delta variant and the surge of the Omicron variant, both of which impacted patients' desire to seek care and/or access to care. This has affected provider and plan performance on a variety of measures including those focused on health care delivery, utilization, patient experience, and outcomes. And these impacts vary by geography due to factors such as differences in COVID-19 infection rates; stay-at-home recommendations and other restrictions; provider and staff shortages leading to office closures, rescheduling or delays of services, and suspensions of elective procedures; and supply chain issues.

Recommendation: We continue to urge CMS to extend its COVID-19 disaster relief policy and special rules through an IFC to all applicable measures for 2023 Star Ratings. This policy extension would provide needed stability to ensure plans, their network providers, and the affordable benefit offerings and options they provide to their enrollees are not adversely affected.

Changes to Existing Star Ratings Measures in 2023 and Future Years

Statin Use in Persons with Diabetes (SUPD) and Medication Adherence for Diabetes Medications Measures (Part D)

CMS indicates the Pharmacy Quality Alliance (PQA) has modified several exclusions for the SUPD measure.

Recommendation: We support this change and request the agency work with PQA to evaluate and apply the same exclusions, as appropriate, to the Part D Medication Adherence for Diabetes Medications measure for consistency purposes. We also ask that CMS work with PQA to evaluate and apply to both these measures the exclusion for enrollees who cannot tolerate statins but are receiving treatment with PCSK9 inhibitors, which NCQA is considering for its statin measure.

Medication Adherence for Diabetes Medication/Medication Adherence for Hypertension (RAS Antagonists)/ Medication Adherence for Cholesterol (Statins) Measures (Part D)

In the Advance Notice, CMS indicates that the agency is currently testing the risk adjustment for socioeconomic status (SES) or sociodemographic status (SDS) of the three Part D medication adherence measures according to the PQA measure specifications which were endorsed by the National Quality Forum (NQF). When applying the SDS risk adjustment for the medication adherence measures, CMS is considering to no longer use member-years of enrollment. Instead, CMS would align with PQA measure specifications of continuous enrollment as defined by the treatment period and exclude beneficiaries with more than a 1-day gap in enrollment during the

treatment period. CMS would also remove adjustments for inpatient and skilled nursing facilities (SNF) stays. CMS solicits initial feedback on the implementation of the SDS risk adjustment for the medication adherence measures for consideration in developing future policy and rulemaking.

Recommendation: Appropriate risk adjustment in quality measurement promotes accurate and fair comparison of health care outcomes. AHIP supports CMS' plans to continue testing and evaluating risk adjustment for social risk factors and its impact on the Star Ratings program and health disparities. We encourage CMS to provide more details about its testing approach and testing results with plans to ensure meaningful engagement and input early on to help inform future policy and rulemaking. We also believe that inpatient and SNF stays would affect medication adherence results since enrollees would still be enrolled in the plan while hospitalized or staying in the SNF. We ask that CMS examine whether the removal of adjustments for inpatient and SNF stays would adversely impact plan performance and publicize its findings for additional public input.

Medicare Plan Finder (MPF) Price Accuracy (Part D)

In the Advance Notice, CMS indicates it plans to modify the MPF Price Accuracy measure's specifications to increase the allowable threshold to $0.02 to address concerns raised by plans that the current rounding approach may negatively impact measure scores. CMS plans to implement this change for the 2022 measurement year (2024 Star Ratings).

Recommendation: We support this change to the MPF Price Accuracy measure specifications and would also appreciate if CMS could provide more details about the rounding calculations.

Complaints about the Health/Drug Plan (Part C and D)

CMS solicits feedback on its proposal to include the complaints category 1.30 (CMS Lead Marketing Misrepresentation: Allegation of inappropriate marketing by plan, plan representative, or agent/broker) in the measure specifications for the Part C and D Complaints measures through future rulemaking. Complaints in category 2.30 (Plan Lead Marketing Misrepresentation: Allegation of inappropriate marketing by plan, plan representative, or agent/broker) are currently included in the measure specifications.

Recommendation: We are concerned about the impact on plan performance for the complaints measures in cases where a complaint is included under either category 1.30 or 2.30 that may have been misclassified, is unfounded, or not the result of plan action/inaction. We recommend that CMS develop a process that ensures complaints are properly included under these categories prior to proposing this change.

Adult Immunization Status (Part C)

CMS notes that it may consider changing the data source used to capture influenza vaccination. CMS would use the HEDIS results for the influenza indicator of adult immunization status instead of

the CAHPS survey. CMS also welcomes feedback on the completeness of influenza and pneumococcal vaccination information in health plan records.

Recommendation: We understand that health plans continue to face challenges having complete and accurate flu vaccine information for their enrollees given the variety of options enrollees have for receiving the flu vaccine, including options that do not involve the submission of a claim to the health plan or easy access to vaccine information. Plans also may have challenges with determining the pneumococcal vaccine history if a patient was vaccinated before they joined the plan. We recommend CMS ensure the data collection challenges are fully addressed and resolved prior to consideration of a comprehensive immunization measure for Star Ratings.

COVID-19 Vaccination Measure

CMS solicits feedback on the utility and feasibility of adding a COVID-19 vaccination measure to the Star Ratings measure set.

Recommendation: We remain concerned about the addition of a COVID-19 vaccine measure to Star Ratings. Challenges still exist for health plans to access accurate and complete vaccination data on all of their enrollees and regional differences in vaccination rates and guidelines remain. It is also unclear whether the vaccine measure specifications would require data from periodic boosters. These and other issues that impact vaccination rates make it difficult to design a measure that could fairly evaluate and compare plan performance across the country. Until these challenges are addressed, we recommend CMS refrain from adding a COVID-19 vaccination measure to the Star Ratings system.

Colorectal Cancer Screening and Breast Cancer Screening (Part C)

For the Colorectal and Breast Cancer Screening measures, CMS indicates the National Committee for Quality Assurance (NCQA) plans to remove the administrative reporting method and transition these measures to electronic clinical data systems (ECDS) reporting only. Additionally, if NCQA changes the data source for these measures, CMS states the agency plans to make this same change to the specifications for these two measures in Star Ratings.

We believe it is premature for NCQA and CMS to limit the data source to ECDS for these and other measures. While AHIP supports moving to end-to-end digital measurement, we continue to have concerns with the pace at which NCQA proposes to implement ECDS measures in HEDIS, especially given these measures are also ones that will be newly stratified for race and ethnicity. Even if the number of health plans reporting ECDS measures is increasing, it continues to be low overall and significant barriers to ECDS implementation remain. Interoperability between plans and providers continues to be a significant hindrance. There is still a significant gap in Electronic Medical Records (EMRs) use by clinicians and an even bigger gap in their ability to exchange data with plans. CMS risks missing key data from individual providers and small group practices with minimal or no EHR use by ECDS reporting only. The impact of removing hybrid data could vary between urban and rural settings. Furthermore, plans have expressed difficulty getting provider buy-

in on ECDS measure reporting. Clinicians who are meaningfully using EMRs may be reluctant or unwilling to share information contained in those records with health plans. Given these concerns, we also believe that this change would be substantive, especially for the Colorectal Cancer Screening measure due to gaps in data.

Recommendation: We urge CMS to not remove the administrative data collection option for the Breast Cancer Screening and Colorectal Cancer Screening measures and require ECDS reporting only. Given the challenges plans have experienced implementing ECDS and continued clinician hesitancy, we ask CMS to maintain an administrative option for all ECDS specified measures. We appreciate the potential of ECDS to reduce the burden of measurement but plans and clinicians must be able to equally participate to ensure acceptance of this new system. We look forward to working closely with CMS to meaningfully advance electronic quality measure reporting.

Potential New Measure Concepts and Methodological Enhancements for Future Years

Stratified Reporting (Part C and D)

In the Advance Notice, CMS indicates it intends to provide feedback reports to MA plans that illustrate differences in contract performance on certain Star Ratings measures stratified by disability, Low Income Subsidy (LIS) status, and dual eligibility (DE) status. CMS further indicates the reports will be provided confidentially to MAOs and Part D sponsors. CMS also notes the agency is considering including stratified data on the display page and Medicare.gov Plan Finder tool in the future.

We applaud CMS for the agency's ongoing efforts to collaborate with plans, providers, and other stakeholders to drive efforts to identify and reduce health care disparities. The confidential reports could facilitate these efforts by providing plans with time to understand, review, and assess the data; inform recommended and necessary changes to ensure the accuracy, reliability, and utility of the reports; and help plans develop strategies to best target the areas of concern.

Recommendation: AHIP strongly supports CMS' plans to provide confidential stratified reports to MAOs and Part D sponsors. However, we request that CMS provide more details about the reports, including the format and complete measure set the agency is contemplating. These details would help inform additional feedback from AHIP and our members.

We also recommend CMS consider aligning stratification of conceptually similar measures across public and private quality incentive programs including for Original Medicare and NCQA.

As for possible future posting of plan results on the display page or Medicare.gov, we believe that both CMS and plans should fully evaluate and ensure the plan data to be publicly reported are accurate and understandable. CMS should also establish a preview period as part of the process, so plans have an opportunity to review and provide feedback on the accuracy of the plan results before they are posted on the display page or Medicare.gov. Finally, we recommend that public posting of

plan data only be done in conjunction with the posting of Original Medicare data; otherwise, it could give a misleading picture of the MA program given the widespread impact of disparities that also affect Original Medicare. AHIP and our members look forward to engaging with CMS on this important initiative.

Health Equity Index (Part C and D)

CMS indicates the agency is developing a health equity index as a methodological enhancement to the Star Ratings that summarizes contract performance among those with social risk factors (SRFs) across multiple measures into a single score. CMS also notes data are available to include for disability and LIS/DE status. CMS welcomes feedback on development of a health equity index and possibly replacing the current reward factor with the health equity index at some point in the future.

Recommendation: We appreciate CMS' request for initial feedback on development and use of a health equity index for MA Star Ratings. We agree with the importance of promoting health equity and applaud CMS' efforts to understand how best to reduce disparities and advance equity. We have the following related questions, comments, and recommendations.

- **Consideration of a health equity strategy that aligns with efforts already underway.** We recommend CMS look to the work of NCQA and other consensus-based organizations when developing a strategy on health equity, including considering the use of a health equity index in MA Star Ratings.
- **Index specifications.** As CMS continues with its plans to develop its own health equity index, we recommend CMS provide more details regarding specifications for the index. We also believe the health equity index should be designed to incentivize and reward both attainment and improvement. CMS notes data are available to include for disability and LIS/DE status. We agree that as an initial step, CMS should consider data that is accessible in order to test and validate the concept. We look forward to engaging with CMS on consideration of additional sociodemographic data. We would also recommend CMS identify and consider proposing ways to address geographic variation and the potential influence of a plan's location, access to organizations and resources that can address social needs, and patient population; and consider potential appropriate risk adjustment to ensure plans that serve more complex populations are not unfairly penalized.
- **Measures.** We support the consideration of a subset of Part C and D Star Ratings measures included in the Categorical Adjustment Index (CAI) and certain CAHPS measures for the health equity index. We further suggest that CMS consider taking an incremental approach and start with a small number of measures in order to test and validate the concept. We recommend the agency provide the complete set of measures it is contemplating, develop and propose specific criteria for inclusion of additional measures, and allow for a public comment opportunity prior to the addition or removal of measures.

- **Pilot testing and confidential feedback.** Once CMS has developed and provided more details regarding the construct of the health equity index, the agency should pilot test the health equity index and provide plans with confidential feedback reports, and then seek additional public comments prior to adding it to the Star Ratings system. This approach would ensure plans have an opportunity to understand, assess and provide feedback to CMS to promote accuracy, reliability, and utility of the health equity index and its results.
- **Reward factor.** CMS also welcomes feedback on whether the agency should ultimately consider and propose the replacement of the reward factor with the health equity index. We believe it is premature for us to comment on this initial proposal. However, we note the reward factor incentivizes high performance and is therefore an important aspect of the Star Ratings program. We caution against removal of an adjustment that incentivizes consistent high performance from plans. We recommend that CMS perform simulations to examine the impact of replacing the reward factor with the health equity index, and share the simulation details and results to enable AHIP and our members to provide meaningful comments.

AHIP has convened a Health Equity Measures for Value-Based Care workgroup to identify the measurement domains that should be addressed to promote health equity. This workgroup (constituting of member health plans) is using an evidence-based and stakeholder-driven process to review currently available measures that directly promote actions to address equity. The group is also determining measures that should be prioritized for stratification, and identifying concepts where measure development is needed. We would be happy to share the results of this work with CMS.

Measure of Contracts' Assessment of Beneficiary Needs and Screening and Referral to Services for Social Needs (Part C)

In the Advance Notice, CMS indicates the agency is considering developing a performance measure that assesses whether a plan's enrollees have had their health-related social needs assessed, using a standardized screening tool. CMS also notes NCQA is developing a screening measure that would assess plan's enrollees for unmet food, housing, and transportation needs; and referral to intervention for those who screened positive. CMS welcomes feedback on both these measures as potential future measures for the display page and Star Ratings.

Recommendation: We appreciate CMS' request for initial feedback on these screening measures. We understand that the goal would be to measure plans' assessment of beneficiary health-related needs to help better serve at-risk beneficiaries and improve quality of care and outcomes for them. However, we ask CMS to consider the following issues prior to proceeding with the development or adoption of this type of measure.

- **Leverage existing data, infrastructure, and systems**. CMS should consider leveraging existing data infrastructure and systems. Health plans and health care providers recognize the

value of identifying and addressing SDOH in order to improve patients' health. They are already integrating SDOH screening into practice workflows, patient care, and data systems. Rather than require health plans to specify whether they themselves are screening for social needs, we would instead encourage CMS to focus on whether health plans have the appropriate data on social needs to improve quality of care and outcomes. Data on social needs could come from a health plan's own screening efforts, from their provider networks' screening efforts, or from their community-based partner organizations' screening efforts. This way, CMS could leverage existing data systems and infrastructure and focus on interoperability of SDOH data rather than create duplicative SDOH screening efforts that could result in inefficiencies and place burdens on patients. To do this, CMS could work with plans and providers to identify the specific interoperable codes on social needs that could be reported to CMS for analysis and comparison. We recommend CMS look to the Gravity Project[51] for standardized value sets, interoperable codes, and HL7 technical standards to document standardized data on social needs. Interoperable codes could include ICD-10 Z-codes, LOINC codes, SNOMED codes, among others.

- **Consideration of SDOH measures from consensus-based organizations**. CMS' guiding principles for the Star Ratings system[52] support new measures for Star Ratings developed by consensus-based organizations. We agree and recommend that CMS engage relevant stakeholders, including health plans, SDOH screening tool and measure developers, consumers, and consensus-based organizations such as NCQA when considering SDOH measures. We also recommend that the measure contemplated for Star Ratings focus on understanding the SDOH need or domain (e.g., food insecurity, housing insecurity, transportation insecurity) through data and interoperable, standardized codes (whether LOINC, SNOMED, or ICD-10 Z-codes) versus the actual question that was used to determine the need.
- **Alignment between Original Medicare and MA.** To ease burdens for providers and enable the comparing of performance on measures between Original Medicare and MA, CMS should also ensure alignment of screening measures under Original Medicare and MA.

Value-based Care (Part C)

CMS welcomes feedback on a possible future measure that focuses on how MAOs contract with providers and, in particular, what percentage of their providers have value-based contracts and what types of arrangements these contracts entail.

AHIP and our members are committed to supporting efforts that strengthen value-based care and ensure high quality, lower cost care for Medicare enrollees. Every year, AHIP partners with CMS and other stakeholders through the Health Care Payment Learning & Action Network (LAN), a

[51] https://thegravityproject.net/.
[52] 83 Fed. Reg. 16440 at 16521 (April 16, 2018).

private-public partnership, to conduct an annual national assessment of the adoption of Alternative Payment Models (APMs) over time. Results released in 2021 on payment years 2020 and 2019 show MA plans continue to be ahead of the curve on adoption of APMs compared to other lines of business. In fact, more than half (58%) of health care payments from MA plans were tied to APMs in 2020, compared to 42.8% in Original Medicare.[53]

However, we are concerned about the potential limits of developing a Star Ratings measure based on APM adoption. There are often barriers to increasing adoption of value-based contracts with providers due to circumstances beyond a plan's control. For example, health systems or providers in certain regions, such as highly concentrated markets or rural geographic areas, may have dominant negotiating power. Such providers may be less willing to enter into a value-based contract.[54] Granular reporting also risks disclosure of confidential and sensitive contract terms.

Recommendation: Given the positive performance of MA plans and the limits of developing a fair performance measure on APM adoption, we question the utility of developing a Star Ratings measure.

However, if CMS were to move forward with the development of such a measure, we recommend the agency leverage existing MA plan data and reporting on value-based care arrangements to promote efficiencies. CMS already collects data from MA organizations on payments to providers[55] based on four categories of value-based payment arrangements, which are aligned to the classification system used by the LAN.[56] One of the missions of the LAN is to standardize APM classification efforts and promote use of a common vocabulary and pathway for measuring successful payment models. If CMS used an alternative framework for measuring value-based payment contracting in Star Ratings, it would risk undermining these important standardization efforts. Any differences could also increase reporting burdens, potentially deterring voluntary reporting to the LAN on APM adoption.

Lastly, while AHIP supports efforts by CMS to encourage adoption of value-based care initiatives and recognizes the need to develop metrics for assessing their use and effectiveness, it is important to note the inconsistency between these efforts and the proposed revisions to use of direct and indirect remuneration (DIR) as a means for achieving these goals as proposed in the MA and Part D proposed rule for 2023. Although we will provide more detailed comments on that proposal separately, the changes to "negotiated price" as proposed will severely undermine the use of value-based/pay-for-performance tools in the pharmacy provider space. We urge CMS to weigh the impact

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[53] https://www.ahip.org/news/articles/new-hcp-lan-survey-results-show-increase-in-adoption-of-alternative-payment-models.

[54] See, e.g., Hoangmai H. Pham, Amol S. Navathe, "Why Aren't Value-Based Payment Models More Successful? A Failure To Confront Market Dynamics," Health Affairs (Jan. 27, 2022), available at: https://www.healthaffairs.org/do/10.1377/forefront.20220125.362333/full/

[55] https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.

[56] https://hcp-lan.org/apm-framework/.

of those proposals on potentially limiting the scope of these future measures on such an important segment of patient care.

Kidney Health (Part C)

CMS welcomes feedback on potential kidney health measures for the display page or Star Ratings in the future.

We appreciate CMS' request for stakeholder input. AHIP recently joined Innovative Kidney Care (IKC),[57] an advocacy campaign to improve patient options for home dialysis training and support. Kidney failure affects more than 500,000 Medicare enrollees, with more than 150,000 receiving coverage through MA. These patients deserve high-quality and convenient care that empowers them to enjoy their best life outside of a health care setting.

Recommendation: We look forward to our continued engagement with CMS to ensure Medicare policies and guidance support kidney health, including better patient outcomes, improved patient experiences, improved clinician experiences, and lower costs of care.

We also ask CMS to review AHIP members' comments on potential kidney health measures. In addition, we ask CMS to provide an update on the HEDIS measure, Kidney Health Evaluation for Patients With Diabetes, which is currently on the display page. We also recommend that kidney care measures considered for Star Ratings be developed by consensus-based organizations such as NCQA.

Beneficiary Access and Performance Problems (Part C and D)

CMS solicits feedback regarding re-introduction of the Beneficiary Access and Performance Problems (BAPP) measure as a Star Ratings measure through rulemaking. This measure is based on CMS's Compliance Activity Module (CAM) data, which includes notices of non-compliance, warning letters (with or without business plan), and ad-hoc corrective action plans (CAP) and the CAP severity.

We continue to have strong concerns with proposals that link compliance and audit activities to Star Ratings. CMS has the flexibility to enforce compliance violations through a broad range of significant financial and regulatory penalties, including civil money penalties, sanctions, and enrollment suspensions. Incorporating compliance and audit findings into the Star Ratings system through the BAPP measure would effectively levy penalties that duplicate compliance actions for the same violation. Furthermore, audit and compliance actions can impact Star Ratings and payment long after a plan has resolved an issue, due to the lag in how Star Ratings affect payment. We are

[57] https://www.innovatekidneycare.com/.

also concerned about and do not support the higher weighting that the BAPP measure would receive in comparison to evidence-based quality measures (e.g., HEDIS) under the Star Ratings program.

Lower Star Ratings due to compliance and audit findings can also impact Medicare enrollees by reducing additional benefits offered by plans or increasing cost-sharing requirements. The Star Ratings system should be focused on improving customer experience and quality of care, instead of incorporating penalties on plans that may have little or no connection to the broad experience of a plan's enrollees.

Recommendation: AHIP does not support the return of the BAPP measure to Star Ratings. We continue to urge CMS to eliminate the link between audit and compliance actions and Star Ratings.

CAHPS (Part C and D)

In the Advance Notice, CMS indicates that it is field testing whether using a web-based CAHPS survey could increase response rates. CMS is also field testing additional questions on topics covering: patient-provider communication, getting test results, communication between providers, management of different health services, language spoken at home, experience with video or phone visits, and perceived discrimination. CMS also requests feedback on adding more questions to the survey on sexual orientation and gender identity, and asks whether this information is currently available through plan administrative data.

We very much appreciate CMS' interest in improving the CAHPS survey. We look forward to learning the results of its field test of a web-based tool. We would also welcome the opportunity to work with CMS to make improvements to the survey to increase response rates and ensure the reliability of survey responses.

We are concerned, however, if CMS were to consider additional questions for the survey without comprehensively assessing the current length of the survey and the impact of adding more questions, and without determining which questions (current and additional) would be most relevant to a customer's experience with their MA and Part D plans.

Recommendation: CMS should consider a comprehensive evaluation and field testing of the CAHPS survey as a whole and potential improvements. It could be done through an Innovation Center demonstration. The Innovation Center could pursue a more comprehensive study and test methods for improved capturing of customer experience that also ensure the reliability of survey responses. While the demonstration is underway, CMS could also adopt a series of limited and interim improvements to the MA and PDP CAHPS surveys. These improvements, and lessons from the proposed CMMI demonstration, should be adopted prior to any contemplated increases to the weighting of the current set of MA and PDP CAHPS-based patient experience measures. Areas that CMS should consider improving include: length of the survey, including more questions focused on a customer's experience with their plan, aligning all questions with the initial instructions on virtual visits, and producing meaningful differences between the cut points. We also recommend CMS

closely review recommendations provided by AHIP members on improvements to the CAHPS survey.

As indicated earlier in our comment letter, we again highlight our concern about the increased weighting of the CAHPS measures for 2023 Star Ratings as well as other aspects of the CAHPS methodology that could adversely impact plan performance in Star Ratings. As such, we urge CMS to retain the weighting of the CAHPS measures to 2 for 2023 Star Ratings.

Future Measures for Star Ratings

AHIP and our members recognize the value of the Star Ratings system for ensuring that millions of diverse individuals continue to have access to high-quality, coordinated care, affordable benefit offerings, and options they deserve and rely on. We would appreciate more collaborative opportunities with CMS to assess all aspects of the Star Ratings system, including those related to the consideration of the volume and types of measures included in Star Ratings and on the display page. We look forward to working with CMS to support and improve this important program for Medicare consumers.

March 2, 2022

Lynn Nonnemaker
Vice President, Medicare Policy
America's Health Insurance Plans

RE: CY 2023 ADVANCE NOTICE, ESRD ANALYSIS, AND FFS NORMALIZATION

Dear Lynn:

America's Health Insurance Plans (AHIP) has retained Wakely Consulting Group LLC. (Wakely) to provide a financial impact summary report of the information presented in the February 2, 2022 CY2023 Advance Notice published by the Centers for Medicare and Medicaid Services (CMS). Specifically, we were asked to analyze changes to Medicare Advantage (MA) revenue, risk adjustment models, Employer Group Waiver Programs (EGWP), Star Rating, and Part D specific parameters and rules.

The attached report contains the results, assumptions, and methods used in our analysis, and satisfies reporting requirements in Actuarial Standards of Practice (ASOP) 41. Reliance on this report is at AHIP's discretion. This information has been prepared for the sole use of the management of AHIP and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. This information is confidential and proprietary.

Sincerely,

Tim Courtney, F.S.A., M.A.A.A.
7650 W. Courtney Campbell Causeway
Suite 1250
Tampa, FL 33607
727-259-7480
tim.courtney@wakely.com

Rachel Stewart, A.S.A, M.A.A.A.
7650 W. Courtney Campbell Causeway
Suite 1250
Tampa, FL 33607
727-259-7478
rachel.stewart@wakely.com

www.wakely.com

2023 Medicare Advantage Advance Notice

Summary and Analysis

March 2, 2022

Prepared by:
Wakely Consulting Group

Tim Courtney, FSA, MAAA
Director and Senior Consulting Actuary

Rachel Stewart, ASA, MAAA
Consulting Actuary

Table of Contents

Executive Summary

On February 2, 2022 the Centers for Medicare & Medicaid Services (CMS) released the contract year (CY) 2023 Advance Notice with an accompanying Fact Sheet.

AHIP has retained Wakely Consulting Group LLC. (Wakely) to provide a financial impact summary report of the information presented in the Notice as well as changes to the risk adjustment models and the impact of COVID on CMS projections.

Key highlights of our analysis are:

- The CY2023 fee-for-service (FFS) growth rate is higher than projections from the 2022 Final Announcement. CMS did not provide an explanation for the restatements.
- The Part C FFS normalization factor continues to trend upward, which reduces payment to plans. Notably, CMS is proposing to ignore 2021 risk scores in the calculation of the CY2023 Part C FFS normalization factor due to low utilization caused by the COVID-19 pandemic. While CMS provides justification for this decision, we raise several questions with entirely ignoring 2021.
- New risk models are proposed for both the RxHCC, ESRD Dialysis, and Functioning Graft models. Based on Wakely client experience, we estimate risk scores from these updated models will result in 1.0% to 1.3% reductions in 2023 risk scores.

The sections below provide additional detail and discussion of these issues.

Growth Rate and Expected Average MA Payment Change for 2023

Estimated MA Payment Change for 2023

The CY 2023 FFS growth rate, which is the major driver of Part C benchmark rates, is 4.84%. The total (FFS and MA) growth rate is 4.25%. The FFS growth rate is 63 basis points (bps) lower than the final 2022 growth rate.

Table 1 compares these growth rate estimates.

Table 1 – CMS Projected 2023 Growth Rate

Component	2023 Advance Notice	2022 Final Notice
Non-ESRD FFS	4.84%	2.74%
Non-ESRD Total	4.25%	2.81%

CMS published a comparison of its most current non-ESRD FFS cost projections with those in the January 15, 2021 Final Announcement. Table 2 below shows the restatement in CMS estimates for selected years.

Table 2 - Restatements in CMS Non-ESRD FFS Cost Projection

Year	Current	Prior	Restatement
2020	$848.64	$832.18	2.0%
2021	$939.23	$929.69	1.0%
2022	$1,022.07	$1,028.38	-0.6%
2023	$1,078.12	$1,056.60	2.0%
2023/2020	1.270	1.270	

CMS has not yet provided specifics on the causes of the restatements. Given the size of the restatements, we believe it will be important for CMS to provide additional explanation. For example, if the restatements are related to updated estimates of the impact of COVID, then that would have a different implication on future trend assumptions made by Medicare Advantage Organizations than, for example, a change in CMS's assumptions regarding FFS claims completion.

It is important to note that CMS described the following COVID-related costs as being considered in the projection of costs for 2020 and subsequent years:

- COVID vaccine with no cost sharing allowed
- Utilization of services due to COVID
- Changes to MA coverage created by COVID-related legislation
    - Prohibition on charging cost sharing in excess of Medicare FFS for COVID testing services during the public health emergency and vaccine cost and administration.

- Prohibition on utilization management requirements related to COVID lab testing and testing-related services.

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 5.46%. We further estimate that the nationwide average change in the risk-adjusted MA Payment will be 4.66%. We conclude the Wakely estimates are consistent with the estimates published in the CMS fact sheet.

Table 3 presents the components of these changes.

Table 3 – Estimated Change in MA Payment – 2022 to 2023

Component	Wakely Estimated Annual Change	CMS Estimated Annual Change
Effective Growth Rate	4.98%	4.75%
Rebasing/Re-pricing (AGA)	0.00%	0.00%
Change in Star Ratings	0.49%	0.54%
Total Benchmark Change	**5.46%**	**5.29%**
MA Coding Pattern	0.00%	0.00%
Risk Model Transition	0.00%	0.00%
FFS Normalization	-0.80%	-0.81%
Total Risk Score Change	**-0.80%**	**-0.81%**
Total	**4.66%**	**4.48%**

Below is a brief definition of each of the elements in Table 3.

Effective Growth Rate. This is the combined impact of the FFS growth rate (4.84%), changes to Kidney Acquisition Cost (KAC) and Direct Graduate Medical Equipment (DGME) cost development, applicable percentage, and the benchmark cap.

Kidney Acquisition Costs (KAC)/Direct Graduate Medical Education (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. We assume CMS is factoring this change into their estimate of the effective growth rate.

Applicable Percentage

We estimated the average nationwide change in applicable percentage, based on the enrollment by Medicare Advantage contract and county to be 0.16%. The applicable percentage varies according to a county's quartile ranking. The 2023 county quartiles are determined by the 2022 FFS rates. The 0.16% increase is driven by increased enrollment in MA plans with higher than average applicable percentages.

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 change year-to-year as plans Star Ratings change, and as the Total growth rate – formally referred to as the National Per Capita Medicare Growth Percentage (NPCMGP) – varies from the FFS trend. The 2023 Total growth rate of 4.25% is lower than the FFS growth rate of 4.84%, which contributes to a negative year-over-year impact of 0.23 % (i.e. the cap applies for more 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 2022 to payment year 2023.

Star Rating/Quality Bonus. This is the difference in quality bonus impact on benchmarks due to star rating changes between 2022 and 2023. This is based on a static enrollment mix, so it only reflects changes in average Star Ratings by contract, and not a shift in enrollment toward plans with higher or lower Star Ratings. We assume that the CMS estimated impact of Star Rating changes includes both changes in the ratings as well as change in enrollment by plan, although CMS does not provide a description of its method in the Fact Sheet.

Change in Coding Pattern Adjustment. The PY2023 coding pattern adjustment is -5.90%, which is the minimum adjustment required by the Affordable Care Act. This is the same adjustment used in PY2022.

Risk Model Transition. CMS has proposed a new risk score model for Part D and for ESRD. Although these proposed changes are described in the Fact Sheet, we assume CMS has not reflected the impact of the new risk models in the year-to-year percentage change in payment. We've presented Wakely's estimated impact of the proposed risk models in the sections below.

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%. Note, the proposed 2023 normalization factor excludes the 2021 risk score (i.e. from 2020 diagnosis data). That is, the data years for the 2023 proposed normalization factor are the same as the 2022 normalization factor. More on this is explained below.

In addition to the amounts included in Table 3, CMS also published an expected MA risk score trend of 3.5% in the Fact Sheet[1], making the total expected average change in revenue 7.98%. Table 4 displays the coding trend amounts CMS has included in past year's Fact Sheets.

Table 4 – Historical Coding Trend Presented in CMS Fact Sheet

Advance Notice Year	Expected Annual Coding Trend	Reflected in Total Expected Avg Change in Revenue
2023	3.50%	included in total
2022	N/A	N/A
2021	3.56%	not included in total
2020	3.30%	not included in total
2019	3.31%	not included in total

During the February 4, 2022 CMS Stakeholder call, CMS explained that the coding trend presented in the fact sheet was developed by reviewing several years of estimated MA risk scores on the current payment year model. While the estimate does remove the impact of normalization and MA coding pattern adjustments, it does not remove the impact of population changes. Population changes that should be considered in the estimate include the relative impact of deaths by year, new entrants to Medicare, and the mix of members by duration since joining a

[1] https://www.cms.gov/newsroom/fact-sheets/2023-medicare-advantage-and-part-d-advance-notice-fact-sheet

Medicare Advantage plan. It is unclear whether CMS includes any of these items in their analysis. It is also unclear how CMS considered the impact of COVID in the development of the 3.5%.

As has been the case in past years, the change in benchmarks can vary significantly depending on geographic area and plan Star Rating.

As noted above, CMS is proposing a change to the way they develop KAC and DGME carve out factors in the development of the Part C benchmark rates.

- For KAC, CMS states the impact of revising the carve-out varies by county, and the FFS enrollment weighted average impact is about $1 PMPM for the MA non-ESRD rates. They also state the largest positive impact is about $14 PNMPM and the largest negative impact is about $5 PMPM.
- For DGME, CMS states the impact of revising the carve-out varies by county, and the FFS enrollment weighted average impact is about $2 PMPM for the MA non-ESRD rates. They also state the largest positive impact is about $47 PNMPM and the largest negative impact is about $26 PMPM.
- Wakely reflected the impact of the carve-out changes in the estimated benchmark change.
    - About 74% of counties with more than 5,000 MA enrollees have a positive impact of about 0.4%. About 26% of counties with more than 5,000 MA enrollees have a negative impact of about -0.3%.
    - Likewise, about 65% of counties with less than 5,000 MA enrollees have a positive impact of about 0.2%. About 35% of counties with less than 5,000 MA enrollees have a negative impact of about -0.1%.
    - While the adjustments impacts do vary by county, there does not appear to be more or less of an impact based on population size. (i.e. rural vs metro).

Table 5 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 KAC/DGME), as estimated by Wakely.

Table 5 – States with Highest and Lowest Expected Benchmark Change

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%

Table 5 is based on the January 2022 county level enrollment file and fall 2021 Star Rating information published by CMS. Please note the estimated benchmark changes do not include any changes due to repricing or county rebasing.

Average Geographic Adjustment Factors for 2023

CMS intends to rebase county FFS rates for 2023 using FFS claims data from 2016 through 2020. In the Notice, CMS addressed concerns regarding the 2020 FFS data used to establish the MA benchmarks, with regard to the impact of COVID. They acknowledge that there are some regions that experienced decreased per-capita costs and other regions that experienced increased per-capita costs, relative to 2019. However, given the average geographic adjustment (AGA) is developed based on a five-year average, they believe annual fluctuations and anomalies are mitigated. They also note that historically there have not been adjustments made for local or regional events such as natural or weather-related disasters and various impacts from nationwide events.

Although we do not have access to the FFS data CMS will ultimately use for the 2023 AGA development, CMS has released the 2020 FFS cost data by county[2], which is unadjusted for

[2] https://www.cms.gov/files/zip/ffs-data-2020.zip

Innovation Center Models and Demonstration Programs and the Medicare Shared Savings Program, and do not reflect adjustments for claim repricing.

Using FFS data for 2017 through 2020,, we calculated proxy county level geographic indices, by taking county level per capita costs relative to nationwide per capita costs. For each of the years, 2017-2020, we assigned a county level quartile based on the proxy geographic index ranking. To assess whether there is increased variability from 2019 to 2020, we reviewed quartile shifts over a few years. Table 6 displays the number of counties that have moved quartiles from one year to the next.

Table 6 – Number of Counties with Significant Per Capita Cost Variation

	Shift in Quartile > 1	Shift in Quartile > 2
2017 to 2018	84	13
2018 to 2019	110	15
2019 to 2020	119	25

There is a slight increase in the number of counties which shifted more than two quartiles in 2020, however, all these counties have fewer than 1,800 MA enrollees in 2020 and are rural areas. The shift in quartiles for low enrollment/rural counties is consistent with prior years. Similarly, the counties that shifted more than one quartile are relatively small, with a max 2020 MA enrollee count of about 8,000.

In summary, the 2020 FFS data does not show a significant increase in year-over-year county level variation. Therefore, it seems reasonable to include 2020 data year in the 2023 AGA calculation.

Part C Risk Adjustment Model for CY 2023 and Analysis of the FFS Normalization Factor

For CY2023 Part C risk adjustment, CMS proposes to continue use of the 2020 CMS-HCC model based on encounter data submission (EDS) model. This is the same model used for CY2022.

Looking ahead, CMS is soliciting comments on potential enhancements to the HCC model that would take social determinants of health (SDOH) into account. More specifically, CMS is interested in which factors should be incorporated and the data needed to support such factors.

Part C FFS Normalization Factor

The proposed Part C FFS normalization factor for the 2020 CMS-HCC Model for CY 2023 is 1.127.

Traditionally, CMS has used a five-year rolling average of normalization factor risk scores to set the trend to calculate the contract year FFS normalization factor. Table 7 shows the updated risk scores by year.

Table 7 – Part C Normalization Factor Risk Scores

Year	CY2023 FFS Normalization Factor [1]
2016	1.019
2017	1.030
2018	1.048
2019	1.063
2020	1.078
2021	1.051

[1] Based on 2020 CMS-HCC model

Normally, CMS would calculate the slope over 2017 through 2021 to calculate the CY2023 FFS normalization factor; however, CMS is proposing to continue using 2016 through 2020 in order to "calculate a normalization factor that better projects CY 2023 risk scores". They further indicated that they believe the lower score in 2021 is driven by reduced utilization in 2020 due to the pandemic. Note that 2020 diagnoses are used to calculate the payment year 2021 risk score.

Further, CMS said it believes "CMS believes that the inclusion of the 2021 risk score in the slope calculation will 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.

There is a significant difference in the FFS normalization factor depending on which years are used, as shown in Table 8.

Table 8 – Comparison of CY2023 Part C Normalization Factors by Years Used

Years Used	CY2023 FFS Normalization Factor
2016-2020	1.127
2017-2021	1.059
17-'21/'16-'20	-6.1%

The impact to plan payments if 2017-2021 data were used would be an increase of 6.4%, relative to payment year 2022.

The exclusion of the 2021 risk score from the calculation raises several concerns:

- 2020 costs are used in the calculation of average geographic adjustment (AGA) factors underlying the FFS benchmarks. Given the varying impact of COVID and state government response by different regions of the country, it seems inconsistent to ignore 2020 data for risk scores and use it for AGA factor calculations.

- CMS provides no rationale as to why the projected 2023 risk score is likely to be in line with 2020 and prior year risk scores, with no lingering impact of COVID.

- The 2022 FFS normalization factor was set at a time when it could have been reasonably projected that risk scores could be lower; however, no such adjustment was contemplated.

- No consideration is given for the potential change in demographics caused by increased deaths in 2020[3], and the potential for increased deaths again in 2021. If deaths are higher, then the demographic mix of the FFS population will be affected for several years, possibly dampening past trends in normalization factors.

  Based on Wakely client data, we observe that deaths increased in 2020 and 2021 as compared with 2019, as shown in Table 9.

Table 9 – Mortality Rate 2019 through 2021, Wakely Clients

Year	Mortality Rate
2019	1.44%
2020	1.87%
2021	1.90%

These increased deaths in turn produced a bigger negative impact on risk scores in 2020 and 2021 versus 2019, as shown in Table 10.

Table 10 – Risk Score of Survivors Relative to Total, Wakely Clients

	Part C Risk Score		
Year	Total	Survivors	Survivors/Total
2019	1.209	1.191	-1.52%
2020	1.166	1.145	-1.84%
2021	1.099	1.079	-1.82%

[3] See, for example, https://www.cdc.gov/nchs/data/databriefs/db427.pdf

- CMS provides no indication of how it will evaluate the calculation for 2024 and future years. It seems quite possible that the 2022 risk score will also follow the pre-2021 slope given the continued impact of COVID in 2021. If so, then would CMS continue to use 2016 through 2020 for the FFS normalization factor in payment year 2024? A blended approach would allow for increased flexibility if 2022 or other subsequent years appear to be out of sync with previous trends.

One alternative method CMS could consider would be to take a blend of normalization factors from the two five-year periods. For example, a 50%/50% blend of using 2016-2020 and 2017-2021 periods would results in a CY2023 Part C FFS Normalization factor of 1.093.

Another alternative would be to use six years of risk score data, or 2015 through 2021. Adopting this approach would result in an average slope of 1.09% and a CY2023 Part C FFS Normalization factor of 1.090. Table 11 shows the calculation.

Table 11 – CY2023 Part C Normalization Factor Risk Scores using Six Years

Year	Norm Fx
2015	1.000
2016	1.019
2017	1.030
2018	1.048
2019	1.063
2020	1.078
2021	1.051
15-21 Slope	**1.09%**
2023 FFS Norm	**1.090**

Commentary on Changes for ESRD Beneficiaries for 2023

As of CY2021, ESRD beneficiaries could select an MA plan during open enrollment regardless of previous coverage. Wakely published a White Paper[4] on this topic in February 2019, and provided

[4] For more background on the 21st Cures Act (Act) and details on ESRD payment methodology please refer to https://www.wakely.com/sites/default/files/files/content/increased-esrd-beneficiary-enrollment-flex-presents-potential-financial-challenge.pdf.

a quantitative analysis in our March 4, 2020 report to AHIP highlighting the potential financial challenges MA plans may encounter with this eligibility change.

Since our previous reports to AHIP, the following updates for ESRD beneficiaries have occurred:

- OACT noted in a February 25, 2021 user group call that new ESRD entrants for 2021 were approximately 40,000. This is slightly lower than their original projection of 41,500 published in the June 2, 2020 CY2021 Policy and Technical Changes Rule[5].
- For CY2022, CMS elected to maintain voluntary and mandatory maximum out-of-pocket (MOOP) levels at the same levels used for CY2021. The MOOP thresholds in CY2021 were increased compared with CY2020 levels, with the rationale that additional ESRD beneficiaries joining MA plans justified the increase.
- CMS is proposing updates to the CY2023 ESRD risk adjustment model for non-PACE MA organizations that more closely aligns with the Part C risk adjustment model.

In the 2023 Advance Notice, CMS addresses commenters' concerns that dialysis payment rates should be calculated at a more granular level than state-wide. Based on CMS "preliminary analysis", CMS is proposing to maintain the ESRD rate methodology for 2023 in a manner consistent with previous years.

Below we discuss ESRD financial impact, risk adjustment, and impact on cost sharing limits.

ESRD Growth Rate, Enrollment, and Financial Impact

As we have noted in previous reports, the higher percentage of ESRD enrollees in MA plans could create additional financial stresses for some MA plans. In the June 2, 2020 CY2021 Policy and Technical Changes Rule[6], CMS projected the number of ESRD beneficiaries in FFS and the number in MA plans due to open enrollment versus all other causes. Table 12 shows these projections.

[5] https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/FR-2020-06-02.pdf, pp. 33796-33911

[6] https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/FR-2020-06-02.pdf, pp. 33796-33911

Table 12 – CMS Projected ESRD Enrollment by Source (June 2, 2020 CY2021 Policy and Technical Changes Rule)

		MA		
Year	FFS	Open Enrollment	Existing/Non-Specific Growth	MA ESRD/ All MA
2020	399,000	0	140,000	0.65%
2021	373,000	41,500	144,500	0.83%
2022	358,000	62,250	150,750	0.91%
2023	353,000	73,317	157,683	0.96%

According to the CMS projections in Table 12, the percentage of ESRD beneficiaries enrolled is expected to increase from 0.65% in CY2020 to nearly 1% by CY2022. The 2021 open enrollment projection of 41,500 compares with actual enrollment of about 40,000 reported in a February 25, 2021 OACT User Group call. As such, it appears that the OACT projections are accurate thus far.

In a November 12, 2020 agenda for an OACT user group call[7], CMS also reported on analysis estimating that the impact of incremental ESRD enrollees on MA plan profits would be -$0.78 PMPM, or -0.08% of required revenue. In addition, we expect plans will incur additional administrative costs for managing a larger ESRD population.

Table 13 displays the average MLR for ESRD and Non-ESRD beneficiaries as reported in worksheet 1 of the bid pricing tool (BPT) for Wakely clients.

Table 13 – Wakely BPT Experience MLR

Year	Non-ESRD MLR	ESRD MLR
2016	84.5%	116.2%
2017	86.1%	111.7%
2018	84.9%	103.7%
2019	86.4%	100.1%
2020	80.8%	103.6%

[7] https://www.cms.gov/files/document/user-group-call-agenda-2020-11-12.pdf

The 2020 worksheet 1 data indicates if the ESRD enrollment as a percentage of all MA increases to 1%, that profit would decrease by -0.23%.

While the proportion of ESRD beneficiaries in MA is low, the health expenditures are very high relative to the population size (approximately six to seven times). In addition, Dialysis-Only ESRD benchmark growth rates have been very volatile over the last several years. Table 14 shows Dialysis-Only ESRD growth rates from 2017 through 2023.

Table 14 – Dialysis-Only ESRD Growth Rates

Year	Growth Rate
2023 (proposed)	5.58%
2022	5.00%
2021	4.04%
2020	-0.48%
2019	9.81%
2018	1.57%
2017	-1.84%

ESRD Risk Adjustment

CY2023 Model Update

CMS is proposing a significant update to the ESRD-Dialysis and ESRD-Functioning Graft models for CY2023. Highlights of the updates are as follows:

- Updating the clinical version of the ESRD model from version 21 to version 24.
- Update the data years used for model calibration from 2014 diagnoses to predict 2015 costs to 2018 diagnoses to predict 2019 costs.
- Accounting for differences in cost patterns for dual eligible beneficiaries by breaking out the single functioning graft community model into four separate model segments:
- Non-Dual/Partial Dual Aged
- Non-dual / partial benefit dual non-aged
- Full benefit dual aged
- Full benefit dual non-aged

The FFS normalization factors for the new ESRD Dialysis and Functioning Graft risk models reflect four years of trend from 2019 to 2023, and are proposed to be 1.034 and 1.048, respectively. Table 15 displays the recent history of ESRD normalization factors.

Table 15 – FFS Normalization Factors for ESRD Risk Adjustment

Year	Model	Dialysis	Functioning Graft	Denominator Year
2023	2023 ESRD	1.034	1.048	2019
2022	2019 and 2020 ESRD	1.077	1.126	2015
2021		1.079	1.118	2015
2020		1.059	1.084	2015
2019	2019 ESRD	1.033	1.048	2015

It is important to note that the impact on ESRD payment from the 2023 factors relative to 2022 will be a function of the model's impact in addition to the new normalization factor.

Shortly after the release of the Advance Notice, CMS released plan-specific ESRD risk scores based on both the current and proposed risk models. Based on Wakely clients, we observe that the impact of the new models, together with the change in FFS normalization is -1.32%.

Table 16 – Wakely Average Impact of Proposed ESRD Risk Model

	Wakely Average ESRD Risk Score
2020 ESRD Model (14/15 calibration) Encounter Data and FFS	1.621
2023 ESRD Model (18/19 calibration) Encounter Data and FFS	1.600
Difference	-1.32%

CMS also released ESRD risk scores by model segment. We found the Post-Graft model to have a more significant impact than the Dialysis model (-2.27% vs. -0.55%). Likewise, risk scores for the non-dual population had a more significant impact than dual (-4.43% vs -1.32%). Therefore, plan specific impact will depend on distribution of duals/non-duals and dialysis/functioning graft ESRD beneficiaries. Please note, dialysis members are usually the majority of all ESRD members. Prior studies using FFS data indicate about 85% of ESRD beneficiaries are on dialysis.

FFS Normalization Calculation

The calculation of the CY2023 FFS normalization for the ESRD Dialysis and Functioning Graft risk models is affected not only by a new model, but also the impact of the COVID-19 pandemic that began in early 2020.

For ESRD normalization, CMS follows the same five-year rolling average approach used for Part C risk scores. Table 17 shows the updated risk scores by year.

Table 17 - ESRD Normalization Factor Risk Scores

Year	2023 ESRD Dialysis	2019-2020 ESRD Dialysis [1]	2023 ESRD Func Graft	2019-2020 ESRD Func Graft [1]
2016	0.974	1.014	0.966	1.023
2017	0.983	1.029	0.974	1.038
2018	0.991	1.040	0.988	1.058
2019	1.000	1.051	1.000	1.073
2020	1.007	1.056	1.012	1.087
2021	0.999	1.048	0.980	1.057

Normally, CMS would calculate the slope over 2017 through 2021 to calculate the CY2023 FFS normalization factor; however, CMS is proposing to continue using 2016 through 2020, as is the case with Part C risk scores.

There is a significant difference in the FFS normalization factor depending on which years are used, as shown in Table 18.

Table 18 – Comparison of FFS Normalization Factors by Years Used

	CY2023 FFS Normalization Factor			
Years Used	2023 ESRD Dialysis	2023 ESRD Functioning Graft	2019-2020 ESRD Dialysis	2019-2020 ESRD Functioning Graft
2016-2020	1.034	1.048	1.088	1.138
2017-2021	1.019	1.014	1.044	1.055
17-'21/'16-'20	-1.4%	-3.2%	-4.0%	-7.3%

No specific reasoning for maintaining 2016 through 2020 as the base period is provided for the ESRD model, so we assume CMS makes follows the same rationale for ESRD as they do for the non-ESRD Part C normalization calculation.

The same concerns we raised with ignoring 2021 risk score in the normalization calculation for Part C generally apply to the ESRD model as well.

Cost Sharing Limits Impacted by new ESRD Entrants

For CY2021, CMS made changes intended to give plans more flexibility in setting cost sharing by reflecting the impact of additional ESRD MA beneficiaries by increasing both the mandatory Maximum Out-of-Pocket (MOOP) limit and Beneficiary Cost (TBC) threshold.

CMS derived the CY2021 a mandatory MOOP limit of $7,550 by estimating the 95th percentile of FFS beneficiary costs excluding and including ESRD enrollees, and then adding in 40% of the difference between the two estimates. The selection of the 40% factor was justified as producing a change in MOOP that was not too steep, and that was consistent with CMS's estimated number of ESRD beneficiaries joining MA plans for 2021.

For CY2022, CMS did not update this methodology and held the MOOP and TBC levels the same as CY2021. This was despite the available information that the number of ESRD beneficiaries voluntarily enrolling in MA plans was in line with the original CMS projections in the June 2, 2020 CY2021 Policy and Technical Changes Rule.

No proposed updates have yet been provided for CY2023 for either the MOOP limit or TBC threshold in the Notice, and no Part C Bid Review Memorandum has not yet been released addressing these issues, as was the case during the CY2021 process.

If we assume that CMS returns to the methodology used in deriving the CY2021 MOOP, we estimate the CY2023 mandatory MOOP limit would be between $7,950 and $8,950, depending on the share of the difference between beneficiary costs with and without ESRD enrollees used for the 2023 MOOP calculation. If no phase-in calculation were used (i.e. 100% of expected costs for ESRD enrollees included), then the mandatory MOOP limit would be between $8,150 and $9,350.

Table 19 shows the 2021 calculation and estimates for 2023.

Table 19 – Estimated CY2023 Mandatory MOOP Limit

	95th Percentile of OOP Spending				
Year	Excl ESRD	Incl ESRD	Difference	% of Diff Used	Final
2021/2022	$7,175	$8,174	$999	40%	$7,550
2023 Low Estimate	$7,175	$8,174	$999	80%	$7,950
2023 High Estimate	$8,228	$9,374	$1,146	65%	$8,950

Part D Risk Adjustment Model for CY2023

CMS is proposing an updated RxHCC model for CY2023 that reflects these changes:

- Clinical update to the model that includes a transition from ICD-9 to ICD-10 diagnosis definitions of categories.
- Addition of several new RxHCCs and revisions to existing RxHCCs.

The proposed model exclusively uses encounter-based filtering for diagnoses, as was the case with the CY2022 model.

As with the updated ESRD model, CMS released RxHCC risk scores for a July 2020 population cohort under the proposed model as well as the existing CY2022 model. Table 20 displays the impact of the proposed model based on Wakely clients.

Table 20 - Wakely Average Impact of Proposed Part D Risk Model

	Wakely Average Part D Risk Score
2022 RxHCC Model (17/18 calibration) Encounter Data and FFS	1.211
2023 RxHCC Model (18/19 calibration) Encounter Data and FFS	1.198
Difference	-1.10%

It is important to note that the results above are based on a comparison of raw scores under both models. The raw score comparison is valid without adjustment, however, because both models have a denominator year of 2019 and a negligible difference in the FFS normalization factor (see the section below).

We also reviewed the impact by model segment and found that while the continuing enrollee model is impacted negatively, the new enrollee model has a positive impact of about 2.3%. In addition, the impact for low-income beneficiaries is less impactful then for non-low income beneficiaries (-0.41% vs. -2.03%).

RxHCC FFS Normalization

As with any change in risk adjustment model, the FFS normalization factors need to be updated. The proposed RxHCC FFS normalization factor for 2023 is 1.050. The calculation is based on two steps:

1. Calculate the observed trend of over five years of historical scores using the RxHCC model.

2. Project the growth in risk scores to the contract year based on the number of years between the denominator year and contract year. For the 2023 RxHCC model, the enominator year is 2019, so four years of trend are needed.

Table 21 shows these calculations for both the 2023 RxHCC and 2022 RxHCC models.

Table 21 – Observed Trend in Part D Risk Scores

Year	2023 RxHCC	2022 RxHCC
2016	0.962	0.958
2017	0.972	0.972
2018	0.986	0.986
2019	1.000	1.000
2020	1.009	1.009
Slope	**1.22%**	**1.30%**

The 1.050 factor for 2023 is then calculated as (1+1.22%)^4.

It is important to note that the Part D risk scores in Table 21 are based on both MA and FFS risk scores. The inclusion of MA risk scores causes a one year lag of available data as compared with Part C scores based only on FFS risk scores. As a result, it was not necessary for CMS to address any potential impact of the COVID-19 pandemic.

The calculations used by CMS to derive the 2023 and 2022 factors are based on risk scores calculated with EDS filtering. We believe RAPS filtering was used in prior years; although, CMS did not specify this in previous Notice publications.

The updated slope calculations for the 2023 and 2022 RxHCC models produce materially lower five-year slope values than last year.

Table 22 compares the observed slope as published in the 2021 through 2023 Notice.

Table 22 – RxHCC Observed Slope

Notice Year	2023 RxHCC	2022 RxHCC	2020 RxHCC	Filtering	Averaging Period Used
2023	1.22%	1.30%	NA	EDS	2016-2020
2022	NA	1.84%	1.52%	EDS	2015-2019
2021	NA	NA	1.02%	RAPS	2014-2018

Please note that CMS did not finalize the CY2022 normalization factor using a five-year trend (i.e. 1.84%). Instead, a four-year trend over 2016-2019 was used, which produced a slope of 1.40%. This appears to be wise judgment considering the revised 2022 RxHCC slope is 1.30%.

Appendix A – Method and Assumptions

CMS Part C Benchmarks

The Part C benchmark analysis uses publicly available data published by CMS.

- The 2023 benchmark projections use the information and methodology presented in file *CalculationData2022.xlsx* trended forward by the growth rates provided in the Notice.
- We summarized nationwide data using the January 2022 MA county level enrollment file and published Star Rating data to be used for payments years 2022 and 223.
- Please note the estimated benchmark changes do not include any changes due to repricing or county rebasing for 2023.

County Level AGA Variation

The comparison of the 2020 FFS data to prior years considered the following:

- Nationwide per-capita were calculated based on the enrollment weighted average of county level Parts A & B per-capita costs for each year.
- Proxy geographic indices were calculated by the county level per-capita costs divided by the calculated nationwide average for each year.
- The data was not adjusted for repricing. That is the five year sample reflect actual costs and are not on a consistent fee schedule basis.

Risk Score Model Impact

On February 9, CMS posted plan-level risk scores on HPMS. These risk scores are calculated with the current risk adjustment model and the models discussed in the 2023 Advance Notice. Wakely aggregated client data and calculated the enrollment weighted average for our overall impact mentioned in this report. Note, the ESRD risk scores were adjusted for the proposed difference in FFS normalization as discussed in the ESRD tech notes.