



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,

A handwritten signature in black ink that reads "Tim Courtney".

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](mailto:tim.courtney@wakely.com)

A handwritten signature in black ink that reads "Rachel Stewart".

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](mailto:rachel.stewart@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 .....	1
Growth Rate and Expected Average MA Payment Change for 2023 .....	1
Estimated MA Payment Change for 2023 .....	1
Average Geographic Adjustment Factors for 2023 .....	7
Part C Risk Adjustment Model for CY 2023 and Analysis of the FFS Normalization Factor .....	8
Part C FFS Normalization Factor .....	8
Commentary on Changes for ESRD Beneficiaries for 2023 .....	11
ESRD Growth Rate, Enrollment, and Financial Impact .....	12
ESRD Risk Adjustment .....	14
Cost Sharing Limits Impacted by new ESRD Entrants .....	17
Part D Risk Adjustment Model for CY2023 .....	18
RxHCC FFS Normalization .....	18
Appendix A – Method and Assumptions .....	21
CMS Part C Benchmarks .....	21
County Level AGA Variation .....	21
Risk Score Model Impact .....	21

## 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%
<b>Total Benchmark Change</b>	<b>5.46%</b>	<b>5.29%</b>
MA Coding Pattern	0.00%	0.00%
Risk Model Transition	0.00%	0.00%
FFS Normalization	-0.80%	-0.81%
<b>Total Risk Score Change</b>	<b>-0.80%</b>	<b>-0.81%</b>
<b>Total</b>	<b>4.66%</b>	<b>4.48%</b>

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<sup>1</sup>, 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

<sup>1</sup> <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<sup>2</sup>, which is unadjusted for

---

<sup>2</sup> <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<sup>3</sup>, 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%

<sup>3</sup> 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 result 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
<b>15-21 Slope</b>	<b>1.09%</b>
<b>2023 FFS Norm</b>	<b>1.090</b>

## 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<sup>4</sup> on this topic in February 2019, and provided

---

<sup>4</sup> For more background on the 21<sup>st</sup> 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<sup>5</sup>.
- 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<sup>6</sup>, 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.

---

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

<sup>6</sup> <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)**

Year	FFS	MA		
		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<sup>7</sup>, 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%

<sup>7</sup> <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	Functioning		Denominator Year
		Dialysis	Graft	
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**

Years Used	CY2023 FFS Normalization Factor			
	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 95<sup>th</sup> 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**

Year	95th Percentile of OOP Spending		Difference	% of Diff Used	Final
	Excl ESRD	Incl ESRD			
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 than 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 denominator 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
<b>Slope</b>	<b>1.22%</b>	<b>1.30%</b>

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 2023.
- 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.