



2022 Medicare Advantage Advance Notice

Summary and Analysis

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Executive Summary

On September 14, 2020 and October 30, 2020, the Centers for Medicare & Medicaid Services (CMS) released the contract year (CY) 2022 Advance Notice Part I and Advance Notice Part II with the accompanying fact sheet (Notice), respectively.

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 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 CY2022 fee-for-service (FFS) growth rate is in line with CMS projections released prior to COVID, indicating that CMS believes most of the impact of deferred care, forgone services, and pent-up demand will not affect 2022 costs.
- The encounter data submission (EDS) risk models are proposed to be fully phased in for CY2022, and diagnoses from inpatient RAPS submissions would be removed as a supplemental source of diagnoses. Wakely estimates that the removal of inpatient RAPS submissions would result in a 0.23% drop in Part C risk scores, and 0.12% decrease for Part D.
- CMS acknowledged that the allowance of end-stage renal disease (ESRD) beneficiaries to proactively enroll in Medicare Advantage Organizations (MAOs) will negatively impact plans financially by estimating a -\$0.78 PMPM impact to gain/loss margin for 2021 due to ESRD beneficiaries joining via open enrollment. This is consistent with previous Wakely analysis that ESRD benchmark rates currently do not cover the costs of Medicare beneficiaries with ESRD on average. In addition, CMS updated its estimate of the number of new ESRD entrants joining via open enrollment for 2021 and found a much higher number of enrollees than its previous estimates published in the June 2, 2020 CY2021 Policy and Technical Rule.
- The Part C FFS normalization factor continues to trend upward, which reduces payment to plans. The calculation CMS uses to derive the normalization factors was updated to include 2016 through 2020 scores, but these scores are unaffected by potential impact of COVID on 2022 scores, and CMS made no adjustment for such a potential impact.
- The proposed RxHCC FFS normalization factor that is tied to the proposed 2022 RxHCC risk adjustment model reflects a significantly higher observed growth trend as compared with recent years. This factor could serve to decrease Part D scores for 2022, depending on the impact of the new model on each plan's score.

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

Growth Rate and Expected Average MA Payment Change for 2022

Estimated MA Payment Change for 2022

The CY 2022 FFS growth rate, which is the major driver of Part C benchmark rates, is 4.52%. The total (FFS and MA) growth rate is 4.82%. The FFS growth rate is 88 basis points (bps) higher than the final 2021 growth rate.

Table 1 compares these growth rate estimates.

Table 1 – CMS Projected 2022 Growth Rate

Component	2022 Advance Notice, Part II	2021 Final Notice
Non-ESRD FFS	4.52%	3.64%
Non-ESRD Total	4.82%	5.62%

CMS published a comparison of its most current non-ESRD FFS cost projections with those in the April 6, 2020 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
2019	\$892.90	\$886.51	0.7%
2020	\$819.64	\$932.34	-12.1%
2021	\$996.90	\$975.06	2.2%
2022	\$1,019.09	\$1,015.84	0.3%
2022/2019	1.141	1.146	

During a November 12, 2020 user group call hosted by the Office of the Actuary (OACT), CMS actuaries noted the following with respect to the restatements:

- Most of the 12.1% reduction for 2020 is due to care that is projected to be forgone or deferred due to COVID.

- Most of the 2.2% upward restatement for 2021 is due to projected increases in spending related to care deferred in CY2020.
- A key driver of the 0.3% upward restatement for 2022 is the inclusion of the estimated cost of COVID vaccine. Based on information provided by OACT, the projected vaccine cost for 2022 is \$7.63 PMPM.

In the Advance Notice, CMS noted that the following COVID-related costs were 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.

Taking into account other component changes to the benchmark rates, Wakely estimates that the nationwide average change in blended standardized (non-risk adjusted) MA Benchmarks from 2021 to 2022 will be 4.46%. We further estimate that the nationwide average change in the risk-adjusted MA Payment will be 2.8%.

Table 3 presents the components of these changes.

Table 3 – Estimated Change in MA Payment – 2021 to 2022

Component	Wakely Estimated Annual Change	CMS Estimated Annual Change
Effective Growth Rate	4.79%	4.55%
Rebasing/Re-pricing (AGA)	0.00%	0.00%
Change in Star Ratings	-0.33%	-0.34%
Kidney Acquisition Cost Removal	-0.01%	0.00%
Total Benchmark Change	4.46%	4.21%
MA Coding Pattern	0.00%	0.00%
Risk Model Transition	0.25%	0.25%
Removal of RAPS IP	-0.23%	0.00%
FFS Normalization	-1.68%	-1.64%
Total Risk Score Change	-1.66%	-1.39%
Total	2.80%	2.82%

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 (4.52%), applicable percentage, and the benchmark cap.

We estimated the average nationwide change in applicable percentage, based on the enrollment by Medicare Advantage contract and county to be 0.26%. The applicable percentage varies according to a county’s quartile ranking. The 2022 county quartiles are determined by the 2021 FFS rates. The 0.26% increase is driven by increased enrollment in MA plans with higher than average applicable percentages.

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 MA growth rate – formally referred to as the National Per Capita Medicare Growth Percentage (NPCMGP) – varies from the FFS trend. The 2022 MA growth rate of 4.82% is higher than the FFS growth rate of 4.52%, which contributes to a positive year-over-year impact of +0.02% (i.e. the cap applies for fewer contracts than before). The impact of benchmark caps by county vary depending on a contract’s Star Rating. Note that our measure does not include consideration for changes in Star Rating from payment year 2021 to payment year 2022.

Star Rating/Quality Bonus. Changes in Star Ratings for the 2022 rating year will impact quality bonus payments and benchmarks for 2022. This is based on a static

enrollment mix, so it only reflects changes in average Star Ratings by contract, and not a shift in enrollment toward plans with higher or lower Star Ratings. Note that the calculations are based on October 2020 enrollment; therefore, plans that are new in 2021 and 2022 are excluded from the analysis. 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.

Kidney Acquisition Costs (KAC). The 21st Century Cures Act requires that Medicare cover organ acquisition costs for kidney transplants for MA beneficiaries. The Act also stipulated that these costs be removed from the calculation of Part C benchmark rates.

For 2022, CMS is proposing to revise the order in which they remove these costs. The 2021 KAC carve-out was applied prior to accounting for the cost of Veterans Affairs (VA) and Department of Defense (DoD) dual-eligibles. CMS is proposing to apply the KAC adjustment at a later step in the process, subsequent to the application of the IME adjustment.

In the 2021 Rate Announcement, the KAC dollar amount was defined as the 2021 USPPC multiplied by the county Average Geographic Adjustment (AGA) factor multiplied by the county level KAC factor. CMS states the change in the formula would affect 2021 rates by a range of \$0.94 to \$0.51 PMPM, with a nationwide average change of \$0.04. Wakely calculated this formulaic change on the 2021 FFS rates. While we see the same average change of \$0.04 across all counties, we calculate a wider range by county from -\$1.54 to \$4.15 PMPM, suggesting the county level variation could be more volatile.

Using October 2020 MA enrollment and the KAC factors published in the 2021 Rate Announcement, Wakely estimates the average impact nationwide to the 2022 rates due to the formulaic change to be -0.01%.

Part C Fee-for-Service (FFS) Normalization Factor and Transition in Weights. Part I of the Notice does not propose any changes to the 2017 CMS-HCC RAPS or 2020 CMS-HCC EDS risk models. The RAPS/EDS blend for CY 2022 is proposed to be 100% EDS as compared with 25%/75% for CY 2021. In the Fact Sheet, CMS estimates that the change in blend would have a +0.25% impact on MA risk scores.

The 2021 Part C FFS normalization factors were applied separately to the 2017 RAPS CMS-HCC model (1.106) and the CMS Payment Condition Count model (1.097), which were then blended 25%/75% to determine a beneficiary's risk score. For 2022, risk scores are proposed to be entirely based on the CMS-HCC Payment Condition Count

model (1.118). Calculating the change between the blended 2021 factor (1.099), the impact is $(1/1.118)/(1/1.099) = -1.68\%$.

We believe this estimate differs slightly from the -1.64% estimate in the CMS fact sheet because CMS likely calculates the impact using actual RAPS and EDS risk scores, which impact the weighting.

Removal of RAPS Inpatient. PY2022 Risk scores will be based solely on the 2020 CMS-HCC EDS risk model. In addition, the EDS based risk score will no longer supplement using RAPS inpatient diagnoses and will be based fully on encounter data. We estimate this will have a -0.23% impact on MA plans. More detail on this analysis is presented below.

Change in Coding Pattern Adjustment. The PY2020 coding pattern adjustment is -5.90%, which is the minimum adjustment required by the Affordable Care Act. This is the same adjustment used in CY 2020.

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

CMS intends to rebase county FFS rates in 2022 (which is the basis of the “Specified Amount”); although, the rebasing will not be published until the Final Announcement. Table 4 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 removal), as estimated by Wakely.

Table 4 is based on the October 2020 county level enrollment file and Star Rating information published by CMS. Please note the estimated benchmark changes do not include any changes due to repricing or county rebasing.

Table 4 – States with Highest and Lowest Expected Benchmark Change

Rank	State	Change
1	CT	6.3%
2	OK	5.9%
3	NH	5.8%
4	PA	5.8%
5	MS	5.3%
47	NY	3.6%
48	GA	3.5%
49	WA	3.3%
50	ID	2.9%
51	HI	2.8%

COVID Data Implications for Future Years

While CMS has reflected a projected cost impact due to COVID in the USPPC amounts, the 2020 data year is not yet reflected in adjustment factors like AGA, VA and DoD, and KAC. For 2022 rates, these adjustment factors are based on a rolling average from 2015-2019. For 2023 rates, the rolling average will shift forward to include 2020 data, which could have a significant impact to these adjustments. CMS has not yet stated if and how they will adjust the development of these factors to account for the anomaly year.

AGA factors are calculated by taking a risk adjusted rolling average of Geographic Indices (GI). For 2023, the five year average will be based on 2016 through 2020 GIs. A GI is calculated at a county level, and is intended to reflect a county’s per capita FFS costs relative to the nationwide average. That is, lower cost counties will have a GI less than 1 and higher cost counties will have a GI greater than 1. We anticipate county level AGA factors could see dramatic shifts beginning in CY2023 if the 2020 Geographic Index (GI) is significantly different than the average of GI’s from 2016 to 2019. For example, if a high cost county, like Miami-Dade, had a 2020 GI factor less than 1.0, when the average of the 2016 through 2019 GIs are well above 1.0, it would decrease the average, which could decrease the AGA factor and the resulting benchmark.

Commentary on the Continuation of ESRD Beneficiary Eligibility

Beginning in 2021, ESRD beneficiaries can select an MA plan during open enrollment regardless of previous coverage. Wakely published a White Paper¹ on this topic in February 2019, and provided a quantitative analysis in our March 4, 2020 report to AHIP highlighting the potential financial challenges MA plans may encounter with this eligibility change.

Due to the early release of the CY2022 Advance Notice, plans do not fully know the number of ESRD beneficiaries who voluntarily joined MA plans for 2021 since the open enrollment period has not ended. CMS limited its commentary on this topic in the CY2022 Advance Notice; however, some updated estimates of new ESRD enrollees in MA plans and the financial impact were provided in the appendices of a November 12, 2020 agenda for an Office of the Actuary (OACT) user group call²

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

ESRD Growth Rate, Enrollment, and Financial Impact

Given that ESRD members will have the opportunity to actively enroll in general enrollment MA plans, these members will almost certainly be a higher percentage of the total MA population. In the June 2, 2020 CY2021 Policy and Technical Changes Rule³, CMS projected the number of ESRD beneficiaries in FFS and the number in MA plans due to open enrollment versus all other causes. Table 5 shows these projections.

¹ 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>.

² <https://www.cms.gov/files/document/user-group-call-agenda-2020-11-12.pdf>

³ <https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/FR-2020-06-02.pdf>, pp. 33796-33911

Table 5 – CMS Projected ESRD Enrollment by Source

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 5, the percentage of ESRD beneficiaries enrolled is expected to increase from 0.65% in CY2020 to nearly 1% by CY2022.

In a November 12, 2020 agenda for an OACT user group call⁴, CMS provided two meaningful updates on the impact of ESRD beneficiaries voluntarily enrolling in MA plans.

First, CMS is expecting that the number of new ESRD enrollees in MA plans for 2021 due to the open enrollment provision is about 83,700. This estimate is double the 41,500 new ESRD enrollees from the June 2, 2020 Rule in Table 5. This could push ESRD MA enrollment as a percent of total well over 1% for CY2022.

Second, CMS estimated that the impact of these incremental ESRD enrollees on MA plan profits would be -\$0.78 PMPM, or -0.08% of required revenue. This is consistent with prior Wakely analyses estimating that CMS ESRD payments are inadequate nationwide.

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 6 shows Dialysis-Only ESRD growth rates from 2017 through 2021.

⁴ <https://www.cms.gov/files/document/user-group-call-agenda-2020-11-12.pdf>

Table 6 – Dialysis-Only ESRD Growth Rates

Year	Growth Rate
2022 (Proposed)	1.77%
2021	4.04%
2020	-0.48%
2019	9.81%
2018	1.57%
2017	-1.84%

In past analyses, Wakely has found that the historical Medical Loss Ratio (MLR) for the ESRD population is much higher than the general enrollment population. In addition, we expect plans will incur additional administrative costs for managing a larger ESRD population.

ESRD Risk Adjustment

CMS is proposing to fully phase in the 2020 ESRD-Dialysis and ESRD-Functioning Graft models for CY2022. In addition, CMS is proposing to eliminate diagnoses sourced from inpatient RAPS records for both models, similar to the non-ESRD risk models. In contrast, CY2021 risk scores will be calculated as a 75%/25% blend of the 2020 models and 2019 models using a combination of diagnoses from EDS, FFS, and RAPS.

Table 7 summarizes the blend, models, and diagnosis sources.

Table 7 – CY2021-2022 ESRD Dialysis and Functioning Graft Risk Adjustment Models

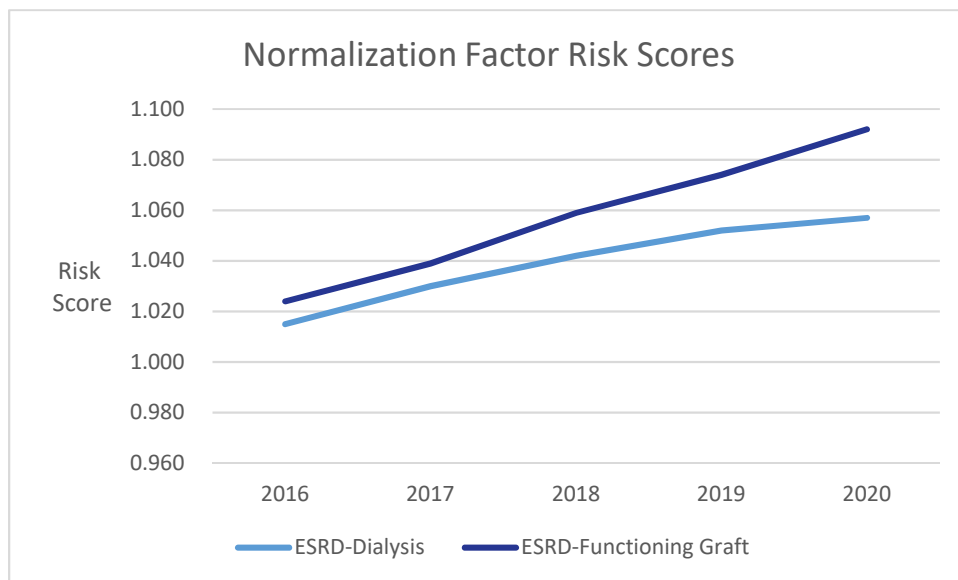
Year	Blend %	Model	Source of Diagnoses
2021	25%	2019 ESRD	RAPS and FFS
2021	75%	2020 ESRD	EDS, IP RAPS, and FFS
2022	100%	2020 ESRD	EDS and FFS

The FFS normalization factors for the ESRD Dialysis and Functioning Graft risk models reflect seven years of trend from 2015 to 2022, and are proposed to be 1.077 and 1.126, respectively. The impact to payment of these factors for 2022 will be +0.02% for Dialysis and -0.7% for Functioning Graft. Table 8 shows the recent FFS normalization factors for both models.

Table 8 – FFS Normalization Factors for ESRD Risk Adjustment

Year	Dialysis	Functioning Graft	Denominator Year
2022 (Proposed)	1.077	1.126	2015
2021	1.079	1.118	2015
2020	1.059	1.084	2015
2019	1.033	1.048	2015

The underlying historical scores that CMS uses to establish an average annual trend (aka slope) are shown in the graph below.



The functioning graft scores are exhibiting a trend similar to the non-ESRD model; however, the dialysis scores are exhibiting a decreasing trend.

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.

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

Based on the CMS and OACT projections in the CY2021 Policy and Technical Rule as well as the April 8, 2020 “Final Contract Year 2021 Part C Benefits Review and Evaluation” memorandum, we estimated the potential mandatory MOOP level for CY2022.

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.

Applying the same process to CY2022, we estimate the mandatory MOOP limit would be between \$7,800 and \$8,500, depending on the share of the difference between beneficiary costs with and without ESRD enrollees used for the 2022 MOOP calculation.

Table 9 shows the 2021 calculation and estimates for 2022.

Table 9 – Estimated CY2022 Mandatory MOOP Limit

Year	95th Percentile of OOP Spending		Difference	% of Diff Used	Final
	Excl ESRD	Incl ESRD			
2021	\$7,175	\$8,174	\$999	40%	\$7,550
2022 Low Estimate	\$7,175	\$8,174	\$999	65%	\$7,800
2022 High Estimate	\$7,684	\$8,754	\$1,070	75%	\$8,500

Part C Risk Adjustment Model for CY 2021 and Analysis of the FFS Normalization Factor

Part I of the Advance Notice, released September 14, 2020, proposed that the 2020 CMS-HCC (EDS) model should be fully phased in for 2022. The 2017 CMS-HCC (RAPS) model would no longer be used for non-ESRD risk scores.

In the Fact Sheet published with Part II, CMS estimated that the impact of fully phasing in the EDS model (in 2021, scores used a 75%/25% EDS/RAPS blend) would be to increase scores by 0.25%.

In addition to the transition to the EDS model, CMS also proposed to discontinue the use of RAPS inpatient diagnoses to supplement the encounter data.

Removal of IP RAPS

To ease the operational burden on MA plans when switching to encounter data records, CMS allowed the inclusion of diagnoses from RAPS inpatient records in the encounter data-based risk scores as a temporary approach to minimize the potential impact on risk scores due to incomplete data. For CY2022, CMS proposed to transition to using 100% EDS based risk scores and would also remove the RAPS inpatient supplementation.

Wakely analyzed the impact of calculating EDS based risk scores with and without the inclusion of RAPS inpatient submissions. Using MA data from payment year 2019, specifically RAPS and MAO-004 files, we estimate the impact to MA risk scores would be -0.23% and the impact to Part D scores would be -0.12%.

Table 10 – Impact of Excluding RAPS-Inpatient Diagnoses

Model	EDS Score		Impact
	Including RAPS-IP	Excluding RAPS-IP	
MA	1.1059	1.1033	-0.23%
PD	1.0794	1.0780	-0.12%

Wakely also tested this transition on FFS data from the 5% sample Limited Data Set (LDS). Given there are not RAPS and MAO-004 files in the FFS world, we calculated dummy data sets by processing the LDS diagnosis data through both sets of filtering logic. Doing the same comparison as in Table 10, we found no material difference in the two risk scores. This implies the results in Table 10 demonstrate that for MA plans, inpatient RAPS diagnoses are still supplementing diagnoses and producing a higher score than if only encounter and FFS data are used. That is, the impact is due to gaps in coding, rather than an impact on the filtering logic.

Part C FFS Normalization Factor

The proposed Part C FFS normalization factor for the 2020 CMS-HCC Model for CY 2022 is 1.118. Recall, risks scores would be based entirely on the EDS model, therefore only one factor is used. This compares with CY 2021 factors of 1.106/1.097 for the RAPS/EDS models respectively.

Table 11 shows the impact of changes to FFS normalization factors on plan payments over the last few years (assuming no change in plan risk scores).

Table 11 – Change in Part C FFS Normalization Factors

Contract Year	FFS Normalization		Year over Year Payment Impact	
	2017 CMS-HCC	2020 CMS-HCC	2017 CMS-HCC	2020 CMS-HCC
2018	1.017			
2019	1.041		-2.30%	
2020	1.075	1.069	-3.20%	
2021	1.106	1.097	-2.80%	-2.60%
2022	1.128	1.118	-1.99%	-1.91%

Although CMS did not provide quantitative analysis in support of the normalization factor, it did say it believes that the increase in the FFS normalization factor may be driven by the following:

- Changes in demographics,
- Change in reported health status in the FFS population,
- Implementation of ICD-10 diagnoses,
- An incentive to report diagnosis codes more completely in alternative payment models, and
- A changing case mix in the FFS population.

Mathematically, the year-over-year change in FFS normalization factors are driven by two things:

1. The restated and updated trend amounts which are derived from a five-year rolling average. For CY 2021, the average trend on the 2020 CMS-HCC model was 1.55% calculated from risk scores for years 2015 through 2019. For CY 2022, the average trend published by CMS in the Advance Notice was 1.61% and uses risk scores for years 2016 through 2020.
2. The years of trend between the denominator year and the payment year. For both payment years, the denominator year is 2015; therefore, there are 6 years of trend for CY 2021 and 7 years of trend for CY 2022.

The year over year change in the underlying risk scores has been consistent in the past several years. CMS published a graph in the 2022 Advance Notice (pg. 44) which illustrates the steady increase in risk scores since 2015. Table 12 displays the CMS published risk scores used to calculate the FFS Normalization factor in CY 2021 and CY 2022.

Table 12 CMS Published Risk Scores by Year

Year	2021 Final Notice	2022 Advance Notice
2015	1.000	N/A
2016	1.020	1.020
2017	1.031	1.031
2018	1.049	1.049
2019	1.063	1.064
2020	N/A	1.084
Average Trend	1.55%	1.60%
Years of trend (denominator to payment year)	6	7
FFS Normalization Factor	1.097	1.118

COVID Impact on FFS Normalization

The calculation of 2022 FFS Normalization factors are not affected by COVID. Although the 2020 FFS risk score is included in the calculation, the diagnoses were based on 2019 dates of service submitted through January 2021. Therefore, we expect no material impact to 2020 FFS risk scores due to COVID. As you can see in Table 12, CMS expects a 1.88% increase from 2019 to 2020 (1.084 versus 1.064).

The 2023 FFS Normalization factors, however, will include 2021 FFS risk scores which are based on 2020 diagnoses submitted through January 2022. We anticipate the 2021 FFS risk scores could be lacking diagnoses submissions due to implications caused by COVID. With a decrease in utilization, it is likely members are not being coded as frequently and accurately. Therefore, we anticipate the 2021 FFS risk scores may not follow the same trend as we see in Table 12.

Although the trend of the underlying risk scores for the FFS normalization factor for CY 2021 and CY 2022 does not include the impact due to COVID, one could argue the projection piece should consider an adjustment. For example, for CY 2022, the trend is set based on risk scores from 2016-2020. The FFS Normalization factor assumes that trend will be consistent from the denominator year (2015 to 2022). However, if we know risk scores in CY 2021 will likely be decreased due to COVID, the seven-year trend should be adjusted to account for the anomaly year. CMS should consider using emerging 2020 diagnosis data relative to prior years to estimate a 2020 risk score impact and adjust the expected trend and normalization factors accordingly.

Part D Risk Adjustment Model for CY2022

CMS is proposing an updated RxHCC model for CY2022 that reflects revisions to coefficients, but does not change HCC categories themselves. The updates are intended to reflect the exclusive use of encounter-based filtering for diagnoses and updates to data and the threshold for the Part D catastrophic benefit phase.

In a November 13, 2020 memorandum, CMS announced that plans could see the impact to Part D risk scores using the new model by downloading scores via the Health Plan Management System (HPMS). No information regarding a nationwide average expected impact of the new model was published.

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 2022 is 1.056. 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 2022 RxHCC model, the denominator year is 2019, so three years of trend are needed.

Table 13 shows these calculations for both the 2022 RxHCC and 2020 RxHCC models.

Table 13 – Observed Trend in Part D Risk Scores

	2022	
Year	RxHCC	2020 RxHCC
2015	0.922	0.976
2016	0.958	1.008
2017	0.972	1.017
2018	0.986	1.030
2019	1.000	1.041
Slope	1.8%	1.5%

The 1.056 factor for 2022 is then calculated as $(1+1.8\%)^3$.

The calculations used by CMS to derive the 2022 factor 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 Advance Notice publications.

The higher slope will translate directly into lower Part D risk scores for Medicare Advantage Organizations in 2022.

The proposed 2022 RxHCC model exhibits a materially higher trend than the current 2020 RxHCC model. In addition, the observed slope for CY2022 represents a significant increase over that in the 2021 and 2020 Advance Notices.

Table 15 compares the observed slope as published in the 2020 through 2022 Advance Notice, Part II.

Table 15 – RxHCC Observed Slope

Advance Notice	2022 RxHCC	2020 RxHCC	Filtering	Averaging Period Used
2022	1.8%	1.5%	EDS	2015-2019
2021	NA	1.0%	RAPS [1]	2014-2018
2020	NA	0.8%	RAPS [1]	2013-2017

[1] CMS did not explicitly state the RAPS filtering was used.

Other than the apparent change in filtering logic, CMS did not provide any further perspective as to why the observed slope increased so significantly.

Appendix A – Method and Assumptions

CMS Part C Benchmarks

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

- The 2022 benchmark projections use the information and methodology presented in file *CalculationData2021.xlsx* trended forward by the growth rates provided in the Advance Notice.
- We summarized nationwide data using the October 2020 MA county level enrollment file and published Star Rating data to be used for payments years 2021 and 2022.
- Please note the estimated benchmark changes do not include any changes due to repricing or county rebasing for 2022.

Removal of RAPS IP

Wakely relied on the following client files for this analysis:

1. Monthly Membership Reports (MMR)
2. Diagnosis data from RAPS and CMS-generated Phase III Version 3 MAO-004 files for dates of service (DOS) January 1, 2018 through December 31, 2018 submitted through January 31, 2020.

The general approach is as follows:

Step 1: Process the data and calculate a 2019 risk score for each member. For payment year 2019, this is based on EDS (50%) and RAPS (50%) and includes RAPS-IP in the EDS based calculation.

Step 2: Divide the 2019 membership into 2 groups based on our ability to match our calculated final-sweep risk score with the risk score included in the appropriate MMR files and the length of time as a member of the plan during the diagnosis period. For this analysis we only focused on members with complete data, where we are able to tie the calculated risk score to the MMR. (For simplicity, we will call these members “Group 1”)

Step 3: Calculate Group 1 member’s EDS risk score excluding the RAPS-IP.

Step 4: Calculate the difference between EDS risk scores including RAPS-IP and excluding RAPS-IP for Group 1 members.

We took the average results from steps 1-4 for 13 MAO's. The resulting impact is displayed in table 10.