www.wakely.com

2021 Medicare Advantage Advance Notice

Summary and Analysis

March 4, 2020

Prepared by:
Wakely Consulting Group

Tim Courtney, FSA, MAAA
Director and Senior Consulting Actuary

Rachel Stewart
Senior Actuarial Analyst

Table of Contents

Executive Summary

On January 6, 2020 and February 5, 2020, the Centers for Medicare and Medicaid Services (CMS) released the contract year (CY) 2021 Advance Notice Parts I and II (Notice), respectively. Shortly thereafter, CMS published two key memoranda:

- Contract Year 2021 Part C Benefits Review and Evaluation
- Contract Year 2021 Final Part D Bidding Instructions

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 an analysis of the financial impact of ESRD beneficiaries being allowed to proactively enroll in MA plans beginning in 2021 and the proposed FFS normalization factors.

Key highlights of our analysis are:

- The CY2021 fee-for-service (FFS) growth rate is significantly lower than expected as compared with previous CMS projections, including projections published just a few months ago in the CY2021 Early Preview.
- Kidney acquisition costs, which CMS is proposing to exclude from Part C benchmark rates, may have been overestimated by CMS, will have highly variable impacts by county when carved out, and the overall impact of their removal was not reflected in the Net Payment Impact estimate from the February 5, 2020 CMS Advance Notice Part II Fact Sheet.
- The state end-stage renal disease (ESRD) benchmark rates currently do not cover the costs of Medicare beneficiaries with ESRD on average, and many counties face severe underpayments. The allowance of ESRD beneficiaries to proactively enroll in Medicare Advantage Organizations (MAOs) will increase costs that will not be fully offset by the maximum out-of-pocket (MOOP) limit and Total Beneficiary Cost (TBC) changes proposed by CMS.
- The Part C FFS normalization factor continues to trend upward, which reduces payment to plans. Wakely analysis of the Limited Data Set (LDS) shows a substantially lower overall trend than the CMS calculation, and mixed results when we attempted to validate some of the explanations cited by CMS for the increasing normalization trend. These results are concerning and indicate further study is warranted.

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

Growth Rate and Expected Average MA Payment Change for 2021

Estimated MA Payment Change for 2021

The CY 2021 FFS growth rate, which is now the major driver of Part C benchmark rates, is 2.57%. The MA growth rate is 4.52%. The FFS growth rate is 189 basis points (bps) lower than the December 3, 2019 estimate in the CMS Early Preview of growth rates, indicating that CMS and the Office of the Actuary (OACT) continue to see new information emerge that affects cost projections even over a matter of two months. Both announced growth rates represent substantial decreases as compared with the December 3, 2019 and April 1, 2019 projections.

Table 1 compares these growth rate estimates.

Table 1 – CMS Projected 2021 Growth Rate

Component	2021 Advance Notice, Part II	Dec-2019 Early Preview	2020 Final Notice
Non-ESRD FFS	2.57%	4.46%	5.00%
Non-ESRD MA	4.52%	5.28%	4.84%

In the February 20, 2020 CMS User Group call, the Office of the Actuary (OACT) described the changes as being primarily driven by updates to historical enrollment and claims. More specifically, OACT offered the following rationale for the downturn in non-ESRD FFS growth rates:

- Revised 2017 and 2018 FFS enrollment: -80 bps
- Re-classification of Part A home health spending from non-ESRD to ESRD, bad debt, improvements in modeling of incurred claims for Part A buy in beneficiaries, and re-mapping of some Part B services to new benefit categories: -70 bps
- Additional run-out and changes to the 2020 projection factors: -39 bps (implied)

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 2020 to 2021 will be 3.13%. We further estimate that the nationwide average change in the blended MA Payment will be 0.82%.

Table 2 presents the components of these changes.

Table 2 – Estimated Change in MA Payment – 2020 to 2021

Component	Wakely Estimated Annual Change	CMS Estimated Annual Change
Effective Growth Rate	3.06%	2.99%
Rebasing/Re-pricing (AGA)	0.00%	0.00%
Change in Star Ratings	0.52%	0.23%
Kidney Acquisition Cost Removal	-0.43%	0.00%
Total Benchmark Change	**3.13%**	**3.22%**
MA Coding Pattern	0.00%	0.00%
Risk Model Transition	0.25%	0.25%
FFS Normalization	-2.48%	-2.54%
Total Risk Score Change	**-2.24%**	**-2.29%**
Total	**0.82%**	**0.93%**

Note that our estimate of the change in Star Ratings is based on static January 2020 enrollment. Changes in enrollment impacting Star Ratings could result in a reduced estimate and therefore a lower bottom line impact relative to what CMS originally estimated.

Below is a brief definition of each of the elements in Table 2.[1]

> ***Effective Growth Rate***. This is the combined impact of the FFS growth rate (2.57%), applicable percentage, and the benchmark cap. The requirement that restatements of prior estimates are factored into the growth rate produces a change that is well below the total growth rate for 2021, and is also well below the 2021/2020 trend of +4.53% based on CMS's current projection of 2020 and 2021 Non-ESRD FFS costs (i.e. $923.20 and $964.99, respectively).
>
> We estimated the average nationwide change in applicable percentage, based on the enrollment by Medicare Advantage contract and county to be 0.18%. The applicable percentage varies according to a county's quartile ranking. The 2021 county quartiles

[1] The estimates in Table 2 do not consider the potential impact of changes to the Health Insurance Provider (HIP) fee for 2021. The HIP fee imposed by the 2010 Affordable Care Act was in effect for CY 2020, but is being repealed beginning in 2021 as a result of the December 20, 2019 Further Consolidated Appropriations Act.

are determined by the 2020 FFS rates. The 0.18% 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 2021 MA growth rate of 4.52% is higher than the FFS growth rate of 2.57%, which contributes to a positive year-over-year impact of +0.32% (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 2020 to payment year 2021.

The difference between the FFS growth rate and the MA growth rate is materially higher than in prior years. Given that Medicare Advantage represents about one third of total Medicare spending, if we assign a two-thirds weight to the 2.57% FFS growth rate, it implies that CMS projects a MA payment rate change of over 8.4%. Applying a similar exercise to the 2020 rates produces an implied MA growth rate of 6.2%. We do not have details on this MA payment portion of the CMS projection, but it is unclear what components of MA payment could account for this significant an increase.

Star Rating/Quality Bonus. Difference in quality bonus impact on benchmarks between 2020 and 2021. This is based on a static enrollment mix, so it only reflects changes in average star ratings by contract, and not a shift in enrollment toward plans with higher or lower star ratings. In addition, it does not include terminated contracts or the potential for new contracts with a 3.5% bonus in 2021. 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. 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.

CMS will reflect the removal of these costs at the county level, similar to the process for removing Indirect Medical Education (IME) payments. Using January 2020 MA enrollment, Wakely estimates the average impact nationwide to be -0.43%[2], due to 2020

[2] Using the values published by CMS results in a nationwide impact of -0.35%, but this is based on enrollment prior to the January 2020 values, and so would not include annual enrollment changes for 2020.

MA enrollment being disproportionally in counties impacted more adversely than average by the change.

It is important to note that the nationwide non-ESRD FFS growth rate of 2.57% includes kidney acquisition costs (KAC). The removal is only reflected at the county level. It should also be noted that the carve-out factors vary quite drastically at a county level (from 0.0% to 4.29%). Many counties in Puerto Rico are among the highest in terms of KAC.

In Part II of the Notice, CMS indicated that the anticipated impact of removing KAC from FFS experience would result in a weighted average reduction in MA non-ESRD rates of $4.00 PMPM. The comparable impact for ESRD Dialysis State rates was $36.00. It is not clear how these estimates relate to Table 29 in the Proposed Rule, which shows a CMS estimated KAC of $2.82 PMPM for 2021, and CMS did not provide additional details as to how it identified kidney acquisition costs.

We attempted to conduct reasonableness tests on the CMS estimates by calculating the number of kidney transplants in the 2014 through 2018 Limited Data Set (LDS) data. We compared the number of kidney transplants nationwide in LDS to Table 26 in the Proposed Rule. For 2017, we identified about 567 kidney transplants in LDS (note that LDS is a 5% sample). Assuming full credibility of the kidney transplant count, scaling the counts up to100%, we get 11,340 kidney transplants in 2017, which compares with 15,346 cited in the Proposed Rule. While we would not expect such a comparison to be exact given the nature of sampling, we would expect to be reasonably close, yet our estimate is 26% below the CMS statistic.

We also compared transplant counts in 82 counties with carve-out factors above 1.0% and found that only 20 of them had identifiable kidney transplants in any of the five years of LDS data reviewed. Again this is not an exact comparison, but we would have expected to see a comparably higher number of transplants, especially for those counties with high carve-out factors (greater than 2%). Table 3 displays the top ten counties with the highest KAC carve-out factors and the total number of kidney transplants from LDS (excluding Puerto Rico).

Table 3 – Top 10 Counties with Highest KAC Carve-out Factors [1]

State	County	KAC carve-out factor	Total Kidney Transplants (2014-2018 LDS)
OREGON	COLUMBIA	2.79%	0
WISCONSIN	DANE	1.85%	6
LOUISIANA	PLAQUEMINES	1.85%	0
CALIFORNIA	SAN FRANCISCO	1.66%	3
LOUISIANA	ORLEANS	1.66%	7
MISSOURI	ST LOUIS CITY	1.64%	6
NORTH CAROLINA	ORANGE	1.60%	0
MINNESOTA	OLMSTED	1.52%	1
PENNSYLVANIA	MONTOUR	1.44%	1
MINNESOTA	DODGE	1.35%	0

[1] Excluding Puerto Rico

As noted above, Puerto Rico counties have some of the highest carve-out factors. Puerto Rico's FFS rates (including IME and KAC) are on average about 50% less than the national average FFS USPCC. Given the starting Puerto Rico FFS PMPM is significantly lower, and the carve out factors are greater than average, Puerto Rico as a whole will experience greater year over year decreases in the benchmarks compared with the nationwide average.

Table 4 – Dollar Impact of KAC Removal

	KAC carve-out factor	FFS Rate Including IME	$ Impact of KAC Removal
Nationwide	0.35%	$964.99	$3.35
Puerto Rico Only	1.90%	$490.26	$9.31

The removal of FFS KAC from total FFS costs will have a negative year over year impact on revenue that is likely to be disproportionate to the decrease in expected costs for MA plans. This occurs because there is a materially higher mix of ESRD beneficiaries in FFS than in MA, even after taking into consideration that additional beneficiaries are

likely to join MA plans. This disconnect will be particularly acute in counties with very high KAC reduction factors.

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 2021 is proposed to be 25%/75% as compared with 50%/50% for CY 2020. In the Fact Sheet, CMS estimates that the change in blend will have a +0.25% impact on MA risk scores.

The 2020 Part C FFS normalization factors were applied separately to the 2017 RAPS CMS-HCC model (1.075) and the CMS Payment Condition Count model (1.069), which were then blended 50%/50% to determine a beneficiary's risk score. For 2021, the blend of the two models is proposed to be 25%/75% 2017 RAPS CMS-HCC model (1.106) and 2020 CMS-HCC Payment Condition Count model (1.097), respectively. Calculating the change between the blended 2020 factor (1.072) and the proposed blended 2021 factor (1.0993), the impact is (1/1.072)/(1/1.0993) - 1 = -2.48%.

We believe this estimate differs slightly from the -2.54% estimate in the CMS fact sheet because CMS likely calculates the impact using actual RAPS and EDS risk scores, which impact the weighting.

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, plan star rating and applicable percentage. For 2021, the removal of KAC will cause further variation by county. As noted above, the KAC removal impact varies significantly by county, ranging from no change to -4.3%.

CMS intends to rebase county FFS rates in 2021 (which is the basis of the "Specified Amount"); although, the rebasing will not be published until the Final Announcement. 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 removal), as estimated by Wakely.

Table 5 is based on the January 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 5 – States with Highest and Lowest Expected Benchmark Change

Rank	State	Change
1	AL	6.1%
2	NJ	5.4%
3	OH	5.1%
4	NE	5.0%
5	CT	4.7%
47	OR	1.8%
48	HI	1.7%
49	DC	1.6%
50	TX	1.6%
51	PR	1.1%

Benchmarks based on Part A and/or Part B Eligibility

Despite a past recommendation from the Medicare Payment Advisory Commission (MedPAC), with the exception of Puerto Rico benchmarks, CMS did not address the inconsistency of calculating MA benchmarks using FFS costs from beneficiaries eligible for Part A only, Part B only, and both Parts A and B even though beneficiaries joining MA plans must be eligible for both Parts A and B.

Based on an internal 2017 Wakely study, approximately 12% of FFS beneficiaries in LDS have only Part A or only Part B coverage. In that study, we estimated that excluding these members would increase nationwide average LDS costs by 2.8%.

It is also notable that the CMS method for determining a Direct Contracting Entity's regional expenditures under the Center for Medicare & Medicaid Innovation Direct Contracting model includes an adjustment to the MA ratebook to reflect only beneficiaries enrolled in both Parts A and B. Eligibility for Medicare Advantage also requires enrollment in both Parts A and B, so it is actuarially inconsistent not to also modify the ratebook for MA plans.

Analysis of the Financial Impact due to Changes in ESRD Beneficiary Eligibility

Beginning in 2021, ESRD beneficiaries can select an MA plan during open enrollment regardless of previous coverage. Wakely published a White Paper[3] on this topic in February 2019, highlighting the potential financial challenges MA plans may encounter with this eligibility change. This has been an area concern for the industry; organizations like Avalere, MedPAC, and Milliman have all published reports with the consistent theme that the risk exposure is unknown but potentially material, and that MA plans should evaluate the implications of this new change for future plan years.

Background and Recent Changes

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 April 1, 2019 Rate Announcement for CY 2020, CMS projected 144,500 ESRD beneficiaries enrolled in MA plans for 2021, which represents about 0.67% of all MA enrollees. If all ESRD beneficiaries enrolled in MA, they would then represent about 2.5% of MA enrollment.

While the proportion of ESRD beneficiaries in MA is low, the health expenditures are very high relative to the population size. 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.

Table 6 – Dialysis-Only ESRD Growth Rates

Year	Rate
2021 (Proposed)	2.80%
2020	-0.48%
2019	9.81%
2018	1.57%
2017	-1.84%

Wakely has done several analyses using both MA data and FFS data to evaluate financial implications for MAOs and identified a few areas where MA plans may face financial challenges

[3] 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.

with the implementation of the Act. 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.

CMS has responded to the 21st Century Cures Act with several proposed changes in the 2021 Advance Notice Part II and the February 6, 2020 Memorandum "Contract Year 2021 Part C Benefits Review and Evaluation." These proposals are to:

- Change the data used to set the mandatory Maximum Out-of-Pocket (MOOP) limits to reflect out-of-pocket expenditures of all MA beneficiaries, including ESRD. The MOOP for 2021 will be $7,550 which is a significant increase over the 2020 value of $6,700. It is important to note that the new level does not account for 100% of ESRD costs. Had CMS included the entire year over year difference due to including ESRD data, the MOOP would be $8,174.
- Increase the Total Beneficiary Cost (TBC) threshold by $1.00 to $37.00 PMPM for 2021. This increase is directly related to the increase in the mandatory MOOP, which increases the average beneficiary cost.

As discussed above, the Act also prescribed that organ acquisition costs for kidney transplants be excluded from determination of the MA benchmark. In addition, MA plans will not be responsible for kidney acquisition costs (KAC) nor organ donor expenses. CMS also stated it will publish a file with key components of the ESRD rate development. Historically, CMS has not published a buildup of the ESRD payment rates as it does for the MA payment rates (risk file). This added layer of transparency will be helpful for projecting rates forward to future years.

Analysis

As we stated above, the historical MLR for an ESRD population is materially higher than the general enrollment population. We evaluated several years of Wakely client bid data and publicly available nationwide bid data to identify the difference in reported MLR experience between ESRD and non-ESRD members. We found the average ESRD MLR was well above 100%, and was about 27 percentage points above the non-ESRD MLR.

If average ESRD penetration in MA plans moved to our estimated maximum of 2.5% at the current MLR, member premiums would have to increase by about $18 PMPM or benefits would have to be pared back by a similar magnitude.

Table 7 displays the impact of the incremental increased ESRD MA enrollment on member premium at current MLR and benefit levels. We found that the total premium would have to increase by about $4.60 PMPM for each 0.46% change in ESRD members as a percent of total enrollment.

Table 7 – Required Premium Change

ESRD % of Total MA Enrollment	Premium Increase at Current MLR
0.67%	$0.00
1.13%	$4.63
1.59%	$9.18
2.05%	$13.78
2.51%	$18.43

We believe there are several likely causes of the significantly higher MLR for ESRD members.

First, we believe medical management efficiencies MAOs have been able to achieve for non-ESRD enrollees are more difficult to replicate for ESRD beneficiaries with Dialysis status. The dialysis provider market is heavily concentrated with two main providers – about 70% of all dialysis centers are owned by DaVita and Fresenius[4]. This environment implies Dialysis providers have significant leverage in contract negotiations and that MAOs may struggle to achieve reimbursement rates comparable to FFS levels. Higher MA dialysis reimbursement levels put more stress on plans' ability to achieve costs comparable to Medicare FFS.

In the Contract Year 2021 and 2022 Medicare Advantage and Part D Proposed Rule, which was published February 5, 2020, CMS proposed a few changes relevant to network adequacy requirements for ESRD beneficiaries. Specifically, CMS is soliciting feedback on the following:

1. Whether CMS should remove outpatient dialysis from the list of facility types for which MA plans need to meet time and distance standards;
2. Allowing plans to attest to providing medically necessary dialysis services in its contract application (as is current practice for DME, home health, and transplant services) instead of requiring each MA plan to meet time and distance standards for providers of these services;
3. Allowing exceptions to time and distance standards if a plan is instead covering home dialysis for all enrollees who need these services;
4. Customizing time and distance standards for dialysis facilities.

[4] Milliman, December 2019, Medicare Advantage: Eight Critical considerations for every organization as ESRD expands eligibility in 2021, p.3, from https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/medicare-advantage-eight-critical-considerations.ashx

The above proposed changes would relax network adequacy requirements for dialysis related services and potentially facilitate increased provider competition to perform these types of services.

Second, the payment does not account for the large potential impact of a MOOP limit that is required of all MA plans. Third, the use of a statewide average dialysis payment can create challenges in counties where costs exceed the state average.

Impact of FFS Costs not Reflecting a MOOP Provision

The Part C benchmark calculation is based on the cost of benefits in Original Medicare, which do not include a cap on beneficiary cost sharing. Under MA, all plans must include a MOOP equal or less than the "Mandatory" MOOP. Given the cost of dialysis treatment, a beneficiary receiving dialysis treatment is much more likely than a non-ESRD beneficiary to hit a cap on member out of pocket costs. In reviewing the 2018 member level spend in the LDS, we found that about 79% of all ESRD beneficiaries in Original Medicare have out-of-pocket costs exceeding the MA mandatory MOOP level of $6,700.

As noted above, CMS is proposing a mandatory MOOP of $7,550 for 2021. Although CMS has proposed a higher MOOP to account for this potential additional expense, our analysis shows that the increase would have little impact on addressing the cost effects of increased ESRD beneficiary enrollment in MA. Based on our analysis of the 2018 LDS, imposing a $6,700 MOOP would increase costs per FFS beneficiary by 9.2% relative to no MOOP. Our analysis further suggests that increasing the MOOP by $850 to $7,550, as CMS has proposed for 2021, would only lower these beneficiary costs by 1 percentage point. The increased costs to the Medicare FFS program from applying a $7,550 MOOP would still be 8.2%.

To estimate the potential impact, we modeled adding a MOOP to Original Medicare. We analyzed the 2018 LDS costs pre and post MOOP and found the difference – which illustrates the difference between the Part C benchmarks and expected costs under an MA plan with a MOOP – is much greater for ESRD dialysis beneficiaries than for non-ESRD beneficiaries.

Table 8 shows the spending PMPM and percentage impact of various MOOP levels. For a non-ESRD population we estimate that the Original Medicare spending PMPM assuming no MOOP increases by 2.9%, from $831 to $855, when a $6,700 MOOP applies. Our analysis shows that this impact triples in size for an ESRD population, where spending PMPM increases from $7,221 to $7,883 (or 9.2%). The proposed increase in the mandatory MOOP from $6,700 to $7,550 would have a minor impact on the spending PMPM. For a non-ESRD population, the higher MOOP results in a net spending PMPM decrease of 0.4% to 2.5%. The same MOOP change for the ESRD population results in

a decrease of about 1.0% to 8.2%. In other words, applying a $7,550 MOOP in Original Medicare would increase Medicare spending PMPM by 8.2% relative to applying no MOOP – this scenario illustrates the additional cost borne by MA plans due to the MOOP.

Table 8 – Estimated LDS FFS Costs by MOOP Level

Measure	Population	MOOP Level None	$3,450	$6,700	$7,550
Estimated LDS Spending PMPM	Non-ESRD	$831	$877	$855	$852
	ESRD	$7,221	$8,173	$7,883	$7,813
% Change vs. No MOOP	Non-ESRD		5.5%	2.9%	2.5%
	ESRD		13.2%	9.2%	8.2%

CMS also proposed to increase the TBC threshold from $36.00 PMPM to $37.00 PMPM in 2021 to account for the increase in the MOOP limit. We tested the proposed CMS TBC change to evaluate how the $1 TBC threshold increase compares with the increase in members' out-of-pocket expenses if the mandatory MOOP limit is increased by $850 to $7,550. For plans that already apply the mandatory MOOP limit of $6,700, only one of the plans had a change in out-of-pocket cost (OOPC) value less than $1. The majority of the plans had an OOPC change ranging from $1.10 to $1.91. Therefore, for plans with a current MOOP limit of $6,700, our analysis shows the $1 increase in the TBC threshold may not be enough to cover the impact of increasing the MOOP to the $7,550 level.

Based on nationwide 2019 PBPs, the majority of MA plans (about 60% nationwide) have a mandatory MOOP less than $6,700 and greater than voluntary MOOP amount of $3,400. Including these plans in our analysis, and increasing the MOOP levels they apply by $850 (the same absolute increase in the mandatory MOOP level), we saw the OOPC change is about double that of a plan moving from $6,700 to $7,550. Having a lower MOOP means a higher percentage of beneficiaries are going to hit the limit, which is why the OOPC change gets amplified. The increase in the TBC threshold would therefore need to be even higher to account for plans with MOOP levels below the mandatory limit of $6,700 increasing their MOOP levels by $850 for 2021.

Use of Statewide Average Dialysis Payment Rates

For beneficiaries in dialysis status, MA plans are paid based on statewide average ESRD benchmarks. We observed in the 2018 LDS that total spend for ESRD beneficiaries can vary significantly within a state; although, it is important to note that costs at the county level may not be fully credible in counties with a small number of ESRD beneficiaries with Dialysis status. This means individual counties experience ESRD FFS costs that exceed the MA payment rate. We sorted the counties from the January 2020 MA penetration files published by CMS based on MA enrollees, and looked at the top fifteen counties. Of the

fifteen counties, eleven had costs that exceeded the ESRD payment rate with Cost/Payment ratios ranging from 101.9% in Maricopa, AZ to 136.5% in Kings County, NY. Table 9 displays these fifteen counties and their 2018 Cost/Payment ratio.

Table 9 – Comparison of 2018 FFS Cost/Payment Ratios

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%
NV	Clark	398,628	41.4%	97.2%
MI	Wayne	354,164	45.9%	114.5%

In conclusion, there is evidence which suggests the current ESRD payment system is not adequate to cover the high costs generated by ESRD members. Although CMS has proposed changes to limit the burden on plans, while simultaneously increasing the burden on MA beneficiaries, our analyses show it may not be sufficient to offset the potential increase in premiums and/or decrease in benefits.

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

Part I of the Advance Notice, released January 6, 2020, proposed that the 2017 CMS-HCC RAPS and 2020 CMS-HCC EDS models continue to be used for 2021.

The RAPS/EDS blend is proposed to be 25%/75% for CY 2021, which is consistent with the schedule published in the Final Announcement for CY 2020.

Part C FFS Normalization Factor

The proposed Part C FFS normalization factor for CY 2021 is 1.106/1.097 for the RAPS/EDS models, respectively. This compares with CY 2020 factors of 1.075/1.069.

Table 10 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 10 – Change in Part C FFS Normalization Factors

Contract Year	FFS Normalization		Year over Year Payment Impact	
	RAPS	EDS	RAPS	EDS
2018	1.017			
2019	1.041		-2.3%	
2020	1.075	1.069	-3.2%	
2021	1.106	1.097	-2.8%	-2.6%

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, and
- An incentive to report diagnosis codes more completely in alternative payment models.

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 2020, the average trend was 1.46% calculated from risk scores for years 2014 through 2018. For CY 2021, the average trend published by CMS in the Advance Notice was 1.70% and uses risk scores for years 2015 through 2019.
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 5 years of trend for CY 2020 and 6 years of trend for CY 2021.

The impact of changing the years underlying the five-year average has been significant in the past few years due to a spike in risk scores in 2016. In the final notice for CY 2018, CMS published a graph which illustrated their estimates of future year scores. The graph showed not only a large increase from 2015 to 2016, but it showed that trend continuing in the proceeding years. Table 11 displays the CMS published risk scores used to calculate the FFS Normalization factor in CY 2020 and CY 2021.

In order to better understand the CMS analysis, Wakely calculated average risk scores for payment years 2014 through 2018 using 2013 through 2018 LDS data on FFS beneficiaries. Because LDS only represents a 5% sample, the aggregate scores do not tie exactly to the CMS published values; however, the trends produced from the LDS output are about 0.5% lower than what has been published by CMS. Table 11 displays the Wakely calculated risk scores from LDS along with the implied trend and 2020 FFS Normalization Factor. The difference between the 1.075 and the 1.051 is concerning, and we believe further studies should be done to confirm the 1.075 is appropriate.

Table 11 CMS Published Risk Scores by Year

Year	2020 Final Notice	2021 Advance Notice	Wakely Calculated from LDS
2014	0.999	N/A	0.978
2015	1.000	1.001	0.980
2016	1.021	1.021	1.001
2017	1.034	1.035	1.012
2018	1.055	1.054	1.018
2019	NA	1.069	N/A
Average Trend	1.46%	1.70%	0.99%
Years of trend (denominator to payment year)	5	6	5
FFS Normalization Factor	1.075	1.106	1.051

Changes in Demographics

CMS stated in the 2018 Final Notice, that the increase in trend was partly driven by a smaller proportion of new enrollees in 2016 than in 2015 and a higher proportion of community enrollees. The 2017 HCC model uses eight different models:

- Community Non-Dual Aged
- Community Non-Dual Disabled
- Community Full Benefit Dual Aged
- Community Full Benefit Dual Disabled
- Community Partial Benefit Dual Aged
- Community Partial Benefit Dual Disabled
- Institutional
- New enrollee

Table 12 displays the distribution of member months on the community, new enrollee and institutional models. While, the distribution has slowly shifted between community and new enrollee over time, it is not a dramatic change.

Table 12 – LDS Distribution of FFS Enrollment by Risk Model

Year	Community	New Enrollee	Institutional
2012	83.60%	11.88%	4.53%
2013	83.68%	11.98%	4.34%
2014	84.52%	11.75%	3.73%
2015	84.73%	11.64%	3.63%
2016	84.73%	11.77%	3.50%
2017	85.04%	11.54%	3.42%
2018	85.32%	11.33%	3.35%

Focusing just on the Community and New Enrollee beneficiaries and risk scores, we see an overall increase in the Community model scores; however, New Enrollee scores have stayed relatively steady. Table 13 compares combined risk score trends using the actual distribution of Community and New Enrollee beneficiaries in each year with scores based on a fixed distribution from 2014. The actual combined Community and New Enrollee risk scores have an average trend of 1.0%, which is slightly higher than the average trend of 0.96% if the 2014 risk score

distribution was held constant, due to growth in the Community risk scores over time. Although the Community model scores are higher than the New Enrollee model scores, the shifts in distribution by year do not have a material impact on the overall trends.

Table 13 – Comparison of Combined Community and New Enrollee Scores with Dynamic versus Fixed Distribution

Year	Community	New Enrollee	Combined Risk Score	Combined Risk Score with Static (2014) Distribution
2014	87.80%	12.20%	0.9414	0.9414
2015	87.90%	12.10%	0.9443	0.9439
2016	87.80%	12.20%	0.9654	0.9654
2017	88.10%	11.90%	0.9759	0.9752
2018	88.30%	11.70%	0.9814	0.9800
Average Trend			1.00%	0.96%

Changes in Reported Health Status

CMS has also stated that changes in reported health status are a contributing factor to the increase in FFS normalization factor. It is not clear how CMS defines "health status". As a proxy for health status, we looked at the proportion of aged vs disabled enrollees. The 2017 CMS-HCC model defines all beneficiaries under the age of 65 as disabled, therefore, anyone 65+ is scored on the aged models. However, if a beneficiary is 65+ and has an original reason of entitlement indicator as anything other than age-in, the beneficiary will receive an additive increase in their score for being disabled. In the Non-Dual Community aged model, which is the majority of enrollees, females over the age of 65 with disability status receive a +0.244 increase and males receive a +0.152 increase in risk score.

The percentage of 65+ beneficiaries with disability status is increasing over time. In addition, the year over year change in 65+ females with disability status is increasing at a higher rate than males. Given, the significant difference in the demographic weight for female and male, it is clear that this statistic is having a material impact on the overall trend. Table 14 shows the female and male annual changes. However, this trend alone cannot explain the sustained growth in FFS risk scores estimated by CMS.

Table 14 – Annual Change in Percentage of LDS Enrollees Classified as Originally Disabled

Year	Yearly Increase in Females 65+ Originally Disabled	Yearly Increase in Males 65+ Originally Disabled
2013	2.80%	2.80%
2014	2.20%	1.80%
2015	2.80%	3.10%
2016	3.40%	3.10%
2017	2.00%	1.30%
2018	1.70%	0.90%

Participation in Alternative Payment Models

We also considered CMS's explanation that increasing risk score trend may be partly due to "an incentive to report diagnosis codes more completely in alternative payment models (which are increasing in penetration)". To examine this theory, we analyzed how LDS risk scores vary with the percentage of beneficiaries assigned to Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Programs (MSSP) by county. We used ACO beneficiary participant counts from published CMS public use files.[5]

Based on the MSSP beneficiary participation data, there is dramatic increase from 2016 to 2017; however, the risk score trend from 2016 to 2017 does not differ from previous years. The annual trend is also not unusually high for payment year 2018, which would be the first year where diagnoses would have been submitted by a much greater number of ACOs participating in MSSP the prior year. Table 16 shows these results.

[5] See for example, https://data.cms.gov/browse?category=Special%20Programs%2FInitiatives%20-%20Medicare%20Shared%20Savings%20Program%20(MSSP)

Table 16 – LDS Risk Scores by Payment Year and MSSP Participation

Payment Year	MSSP Participants as % of Total	2017 CMS-HCC Risk Score	Annual Trend
2018	26%	1.018	0.6%
2017	23%	1.012	1.0%
2016	4%	1.001	2.1%
2015	3%	0.980	0.2%
2014	2%	0.978	
2014-2016			1.2%

We further analyzed risk scores by grouping counties with at least 25% of beneficiaries assigned to an ACO participating in MSSP. We compared results for counties where the MSSP participation changed from below 25% to 25% or more in either 2016 or 2017. We also looked at counties where the participation rate was below 25% in all years or 25% or more in all years. Table 17 shows these results.

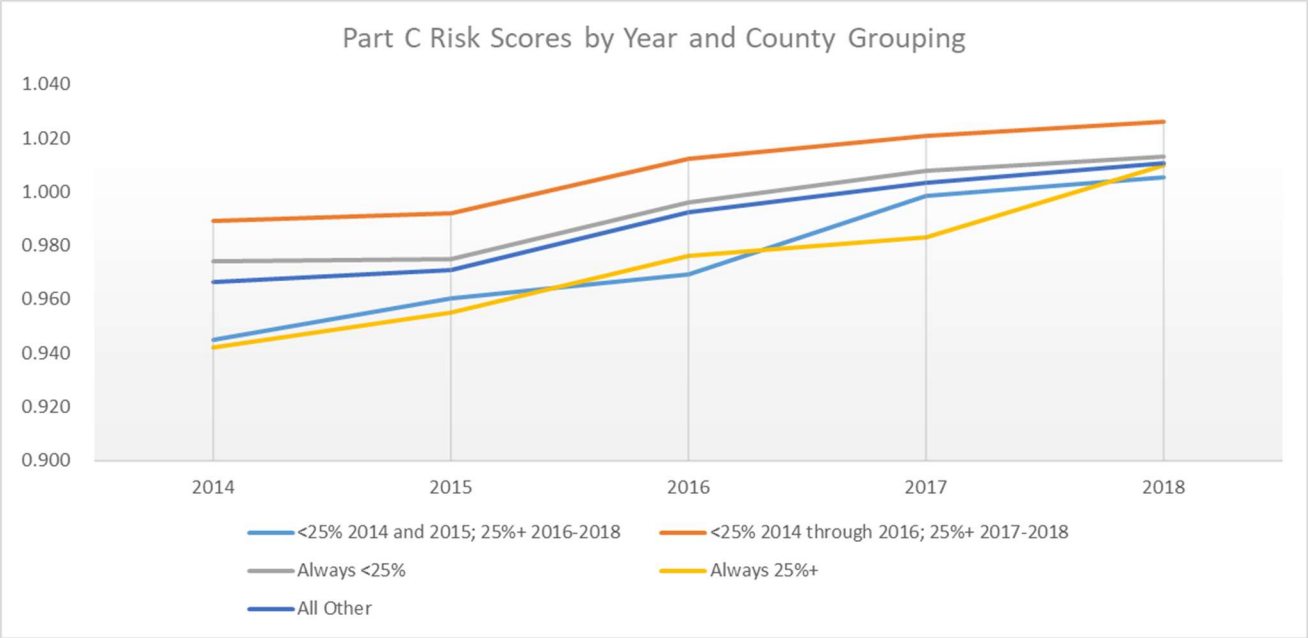
Table 17 - LDS Risk Scores by Payment Year and County Groupings of MSSP Participation

Payment Year	<25% 2014 and 2015; 25%+ in 2016-2018	<25% 2014 through 2016; 25%+ 2017-2018	Always <25%	Always 25%+
2018	1.006	1.026	1.013	1.010
2017	0.999	1.021	1.008	0.983
2016	0.969	1.013	0.996	0.976
2015	0.960	0.992	0.975	0.955
2014	0.945	0.989	0.974	0.942
2014-2018	1.5%	0.9%	1.0%	1.7%

Table 17 shows that the risk score trend over 2014 to 2018 is highest for counties where beneficiary participation in MSSP was 25% or more in all years. The average trends are also higher than average for counties that saw participation below 25% in 2014 through 2016, followed by 25% or more in both 2017 and 2018. Cutting off the <25%/25%+ year at 2017 rather than 2016 does not yield similar results, however. It is also interesting to note that absolute scores for counties that saw participation below 25% in all years were higher than all other groupings besides

the 2014-2016 versus 2017-2018 grouping. This analysis further suggests growth in beneficiary participation in alternative payment models is not clearly leading to FFS risk score growth.

The graph below compares risk scores by payment year for the different cohorts presented in Table 17, as well as a "catch-all" grouping of counties that did not meet any of the specified criteria.



Overall, our analysis of risk scores as they relate to MSSP participation does not point to a clear conclusion. The trends in risk scores for the different categories are generally similar, and do not indicate any one category has experienced dramatically different trends in scores over 2014 through 2018. This analysis does highlight that the absolute scores vary, with the <25% 2014-2016; 25%+ 2017-2018 group showing the highest scores and the "Always 25%" group generally showing the lowest scores.

It is important to note that our analysis is not statistically rigorous. A regression study would be the most appropriate approach; however, such a study is beyond the scope of this report.

Appendix A – Method and Assumptions

CMS Part C Benchmarks

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

- The 2021 benchmark projections use the information and methodology presented in file *CalculationData2020.xlsx* trended forward by the growth rates provided in the Advance Notice.
- We summarized nationwide data using the January 2020 MA county level enrollment file and published star rating data to be used for payments years 2020 and 2021.
- Please note the estimated benchmark changes do not include any changes due to repricing or county rebasing for 2021.

FFS Normalization Analysis

The Wakely analysis of CMS FFS normalization factors and the related risk score trends is based on FFS beneficiaries in the CMS Limited Data Set (LDS) over 2013 through 2018. Wakely scored beneficiaries using the prior year diagnoses and the 2017 CMS-HCC risk adjustment model.

For enrollment years 2012 through 2015, LDS did not have an indicator to differentiate partial benefit duals from full benefit duals. To estimate the mix between partial and full benefit duals on both the aged and disabled models, we calculated the average mix at a state level for 2016 and 2017. The state level full benefit/partial benefit mix was then applied to individual member scores (i.e. each member received a weighted average score of the different models).

As mentioned in the body of the report, it is an important caveat that we were not able to tie to CMS's published risk scores or trend values. This is likely due to inconsistencies between the 5% sample and the 100% data set.

Risk score trends in our analysis are calculated by calculating the slope of the 5 year trend line. For example, the underlying trend of 1.46% in the 2021 FFS Normalization factor was calculated by the change in the risk scores from 2015 through 2019 (1.069 – 1.001 = 0.068) divided by the change in years (2019 – 2015 = 4) equating 1.70%.

For the analysis where we analyzed risk scores by groupings of counties depending on the FFS beneficiary assignment to ACOs participating in MSSP, we relied on CMS published enrollment from the "Number of ACO Assigned Beneficiaries by County" public use files. In determining the percentage participation by county, we used Part A FFS enrollment as the total.

ESRD Analysis

Calculation of MLR

We evaluated 2013 Nationwide BPT data, published by CMS, together with Wakely client data in bids filed over 2018 through 2020. The average MLR was calculated by using WS1 data and taking an average across the multiple data sources.

Required Premium Change

To calculate the required premium change as the ESRD mix increases, we used the same claims and revenue data as described in the MLR calculation above. In each iteration we recalculated what the new margin would be as more ESRD members were added to the mix. Then, we were able to back into the required premium increase assuming the same margin levels as the baseline ESRD mix scenario (i.e. ESRD members as 0.67% of total).

MOOP Impact

The MOOP impact is a multi-step process. The results displayed in Table 6 rely on data from the 2018 LDS. First we identified which ESRD beneficiaries had transplant status monthly, by using several procedure codes in the inpatient data tables. Next, we identified which ESRD beneficiaries received dialysis by month. (Dialysis makes up the majority of the ESRD population.) Transplant status is effective from the date of transplant to three months after. Beginning in the fourth month post-transplant, a member moves to Functioning Graft, as long as the member has not returned to dialysis. If the member receives dialysis at any time after the transplant they revert back to Dialysis payment status.

Once we had a unique list of members with status, we pulled claims separately for each of the statuses and calculated the impact on the paid amounts with a MOOP implemented, based on original Medicare benefit cost sharing provisions.