Wakely

2020 Medicare Advantage Advance Notice

Summary and Analysis

February 27, 2019

Prepared by:
Wakely Consulting Group

Tim Courtney, FSA, MAAA
Director and Senior Consulting Actuary

David Walters, ASA, MAAA
Consulting Actuary

Table of Contents

Executive Summary

On December 20, 2018 and January 30, 2019, the Centers for Medicare & Medicaid Services (CMS) released the payment year (PY) 2020 Advance Notice Parts 1 and 2 (Notice), respectively. Part 2 also included the Call Letter.

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 impact of two proposed Encounter Data Submission (EDS) risk adjustment models described in Part 1 of the Notice.

The CY2020 fee-for-service (FFS) growth rate, which is now the major driver of Part C benchmark rates, is 4.52%. There are several other components of the benchmark determination that affect the expected benchmarks and payment for 2020 as compared with 2019.

These components can be broken down into two main parts:

- Change in Part C benchmark payment rates, which is comprised of the growth rate, changes in applicable percentages, changes in average star rating (which impacts the quality bonus payment), and the impact of the benchmark cap required by the Affordable Care Act. Wakely estimates the combined impact of these items is 4.55% for 2020 as compared with 2019.

- Impact of changes to the calculation in MA risk scores for payment year 2020. Wakely estimates the combined impact of these items is -2.74% for 2020 as compared with 2019. This impact is comprised of changes in FFS normalization, the risk model revision, and the changing blend for RAPS and EDS in 2020. Our estimates rely on independent analysis of FFS data and information provided in the CMS fact sheet.

More details on the analyses underlying these estimates are described in this report.

In Part 1 of the Advance Notice, CMS propose to use a new Part C risk model that adds Payment Condition Counts (PCC) as a payment variable and is the same as that proposed in the previous year's Advance Notice Part 1; although, it was not adopted for PY2019. An alternative PCC model that adds three Hierarchical Condition Categories (HCCs) was also offered "for consideration". Wakely estimates that the proposed PCC model will increase Traditional Medicare (TM) risk scores for the TM population by 0.55% as compared with the PY2019 EDS "No Count" model. We estimate that the alternative PCC model will increase TM scores by 0.32% relative to the PY2019 EDS "No Count" Model.

The HIP fee imposed by the 2010 Affordable Care Act is expected to be in effect for PY2020, after a moratorium in 2019. The impact of the return of the HIP fee will be a function of how plans

react; however, it will certainly put pressure on plans' ability to retain the same premiums and benefits as offered in CY2019. We estimate a HIP fee of 2.15% for 2020.

The Advance Notice Part 2 announced several proposed changes to benefit parameters and cost sharing standards for 2020. Most of these were similar to 2019; however, the Part D true out-of-pocket threshold (TrOOP) increased significantly for 2020. The proposed PY2020 TrOOP is $6,350, as compared with $5,100 for PY2019. Although the majority of this increase will be absorbed by increased drug manufacturer liability, this will mean beneficiaries will spend longer in the coverage gap phase of the Part D benefit, and that federal reinsurance expenses will be lower. It may also make it more challenging to estimate the national average Part D bid and premium, since this is an unusual change. We recommend that plans carefully examine their rebate reallocation strategy, including sensitivity testing if the estimated National averages entered in the June bid submission vary significantly from the final value published in late July or early August 2019.

The Advance Notice also proposed numerous changes to Star Rating measures which would impact payment years 2021 and future years. A crucial change for 2020, however, is that the star rating for a cross-walked plan will now be calculated based on a weighted average of the merging plans based on enrollment from November of the year Star Ratings are released. Previously, the star rating of only the "continuing" plan would apply for the newly cross-walked plan. This new provision may change the strategic options available to larger plans with offerings in multiple contracts in multiple regions.

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

Growth Rate and Expected Average MA Payment Change for 2020

Estimated MA Payment Change for 2020

The CY2020 fee-for-service (FFS) growth rate, which is now the major driver of Part C benchmark rates, is 4.52%. This is 66 basis points higher than the November 27, 2018 estimate in the CMS early preview of growth rates, indicating that CMS continues to experience restatement in cost projections even over a matter of two months.

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 2019 to 2020 will be 4.55%.

Further, we estimate that the aggregate impact of several changes to Part C risk scores for 2020 will be -2.74%.

Below is a brief definition of each of the elements underlying the growth rate and risk score impact estimates.

Growth Rate. This is the impact of the FFS growth rate. Please note there are still a handful of counties impacted by the IME phase out which produces an effective growth rate less than the CMS published value of 4.55%.

Applicable %. We estimate that average benchmark rates will increase by 0.14% for 2020 due changes in applicable percentages by county, based on the enrollment by Medicare Advantage contract and county as of January 2019. The applicable percentage varies according to a county's quartile ranking. The 2020 county quartiles are determined by the 2019 FFS rates. The slight increase for 20202 is driven by increased enrollment in MA plans with higher than average applicable percentages.

Star Rating/Quality Bonus. On average, we estimate changes to plans' star ratings will decrease benchmark payments by 0.23% in 2020. This estimate is based on MA enrollment as of January 2019.

We discuss the reduction in star ratings further in the "Enhancements to the 2020 Star Rating Measures" section.

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 vary year-to-year as plans change star ratings, and as the National Per Capita Medicare Growth Percentage (NPCMGP) differs from the FFS trend. For 2020, we estimate the impact of the benchmark cap to be +0.12% on average benchmark payment rates. The 2020 NPCMGP of 4.84% is higher than the FFS growth rate of 4.52%, which contributes to the positive year-over-year impact of +0.12% (i.e. the cap applies to fewer contracts than before). The impact of benchmark caps by county vary depending on a contract's star rating. We estimate that 32% fewer combinations of star rating (i.e. <4 star, 4+ star, and 3.5% bonus) and county will be impacted by the benchmark cap from 2019 to 2020.

Part C Fee-for-Service (FFS) Normalization Factor. The 2019 Part C FFS normalization factor was a 75%/25% blend of the 2017 RAPS CMS-HCC model (1.041) and the CMS "No Count" model (1.038). For 2020, the FFS normalization factor is proposed to be a 50%/50% blend of the 2017 RAPS CMS-HCC model (1.075) and the CMS Payment Condition Count model (1.069). Calculating the change between the blended 2019 factor and the proposed blended 2020 factor, the impact is $(1/1.0403)/(1/1.0720) - 1 = -2.96\%$.

We believe this estimate differs slightly from the -3.08% estimate in the CMS fact sheet because CMS likely calculates the impact using actual RAPS and EDS risk scores,

which impact the weighting. Because the RAPS based score is slightly higher than the EDS based score, and the weights are shifting from 75%/25% to 50%/50% (RAPS/EDS), the effective change is worth more than the straight difference in the FFS normalization factors.

Change in Coding Pattern Adjustment. The coding pattern adjustment is -5.90% for PY2020, which is the minimum adjustment required by the Affordable Care Act. This is the same adjustment used in PY2019, so there is no impact for PY2020.

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. CMS intends to rebase county FFS rates in 2020 (which is the basis of the "Specified Amount"); although the rebasing will not be published until the Final Announcement. Table 1 shows the top five and bottom five growth rates by State (these changes include changes due to star rating, double bonus status, applicable percentage, and benchmark cap).

Table 1 – States with Highest and Lowest Expected Benchmark Change

Rank	State	Change
1	DC	11.4%
2	HI	7.0%
3	ID	6.4%
4	MS	5.7%
5	LA	5.6%
47	NH	3.0%
48	KS	2.4%
49	NE	2.2%
50	NJ	2.0%
51	OK	1.2%

Table 1 is based on the January 2019 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.

Health Insurer Providers Fee

Although it is not addressed in the Advance Notice, it is important for MAOs to be aware that the moratorium on the health insurer providers (HIP) fee in place for PY2019 will not apply for PY2020 unless Congress enacts another change. Wakely estimates that the average 2020 HIP fee will be 1.9% to 2.4%. The impact of the return of the HIP fee will depend on how plans react. If plans choose to maintain PY2019 margin levels, then member premiums will need to

increase or benefits will need to be scaled back. The PMPM impact on premiums or benefits will depend on each plan's bid levels and rebate percentages.

Benchmarks based on Part A and/or Part B Eligibility

Despite a past recommendation from the Medicare Payment Advisory Commission (MedPAC), 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, approximate 12% of FFS beneficiaries in the Limited Data Set (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%.

Part C Risk Adjustment Model for PY2020

CMS published for public comment the proposed Part C EDS risk adjustment model in Part 1 of the Advance Notice, released December 20, 2018. The proposed model is the same as the Payment Condition Count (PCC) model first introduced in the December 27, 2017 Advance Notice Part 1.

CMS also proposed "for consideration" an alternative PCC model that adds the following HCCs:

- HCC 51 Dementia with Complications

- HCC 52 Dementia without Complication

- HCC 159 Pressure Ulcer of Skin with Partial Thickness Skin Loss

Wakely analyzed the impact of these new EDS models on FFS risk scores. Our analysis is discussed in the "Analysis of the Impact of New EDS PCC Risk Adjustment Models" section, below.

The EDS/RAPS blend is proposed to be 50%/50% for PY2020, which is consistent with the schedule published in the Final Announcement for PY2019.

FFS Normalization Factor

The proposed FFS normalization factor for PY2020 is 1.075/1.069 for the RAPS/EDS models, respectively. This compares with PY2019 factors of 1.041/1.038. The EDS model for PY2019 uses a different model than the proposed PY2020 model, so the normalization factors are not directly comparable.

Although CMS did not provide quantitative analysis in support of the normalization factor, it did say it believes that the increase in the FFS 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

- Incentive to report diagnosis codes more completely in alternative payment models.

Based on recent and past Wakely analyses, we have the following comments on the significant increase in the FFS normalization factor.

Demographics. Based on the proposed 2020 Payment Condition Count Model Relative Factors and the non-dual FFS population in the Limited Data Set (LDS), the average demographic factors decreased over 2014 through 2017. Table 2 shows these results.

Table 2 – Average Change in HCC Demographic Factor in FFS Population [1]

Year	Average Demographic Factor	Percent Change
2014	0.4867	
2015	0.4830	-0.77%
2016	0.4828	-0.03%
2017	0.4808	-0.41%

[1] Continuing and new enrollees, non-dual, non-institutional only; includes disabled beneficiaries

Health Status. While not the only factor, one important measure of health status is whether a beneficiary is disabled or dual eligible. Again using LDS data, we found that both the percentage of disabled beneficiaries and dual eligible beneficiaries has been steadily decreasing from 2014 through 2017. Table 3 shows the percentage of disabled beneficiaries in the FFS population from 2014 through 2017. Table 4 shows the percentage of dual eligible beneficiaries in the FFS population from 2014 through 2017.

Table 3 – Disabled Beneficiaries as a Percent of Total in FFS Population

Year	% Disabled	Percent Change
2014	23.97%	
2015	23.82%	-0.6%
2016	23.59%	-1.0%
2017	23.16%	-1.8%

Table 4 – Dual Eligible Beneficiaries as a Percent of Total in FFS Population

Year	% Dual Eligible	Percent Change
2014	16.69%	
2015	16.78%	0.5%
2016	16.30%	-2.9%
2017	16.20%	-0.7%

ICD-10 diagnoses. At the time of the 2018 Advance Notice (released February 1, 2017), Wakely conducted an analysis comparing risk scores by quarter for payment years 2014, 2015, and 2016 (i.e. diagnoses would come from one year prior in each case). Since the conversion to the ICD-10 system began October 1, 2015, we looked to see if the relationship of fourth quarter scores for PY2016 as compared with first through third quarters would be different than prior years, which were entirely based on ICD-9 diagnoses. In that analysis, we did not find a material difference for PY2016 versus prior years. While it is possible that the impacts of ICD-10 have changed since then, we believe that initial indications did not support ICD-10 conversion being a factor in increasing risk scores.

The coding pattern adjustment for PY2020 is proposed to stay the same at -5.90%, the Statutory minimum. CMS introduced this adjustment for PY2010 and provided supporting analysis in the February 20, 2009 Advance Notice. No such follow up analysis has since been published; although, the Affordable Care Act mandated minimum annual changes in the adjustment factor, ending with a -5.9% adjustment for PY2019 and beyond.

Analysis of the Impact of New EDS PCC Risk Adjustment Models

Wakely has analyzed the differences between the current No Count model in place for 2019, the Payment Condition Count model first proposed last year alongside the No Count model, and the Alternative Payment Condition Count model with 86 HCCs proposed for consideration in the December 20th Advance Notice Part 1.

Proposed changes to Risk Adjustment

As stated earlier, in Part 1 of the 2020 MA Advance Notice, CMS proposed changes to the CMS-HCC risk adjustment model for the upcoming plan year. From the 21st Century Cares Act, section 1853(a)(1)(I)(iii) mandates that CMS must consider the number of conditions individual beneficiaries have as an additional additive factor to the relative factors assigned for demographics, Medicaid and originally disabled status, individual payment conditions, disease interactions, and disabled/disease interactions.

To comply with the requirements of the 21st Century Cares Act, three new CMS-HCC models were originally proposed in Part 1 of the 2019 CMS Advance Notice, to be applied to the encounter data-based risk scores.

In the 2020 Advance Notice Part 1, CMS proposed two payment condition count models for consideration;

1. The same Payment Condition Count model first introduced in last year's Advance Notice

2. An Alternative Payment Condition Count model that is similar in concept to the 2019 payment condition count model, but with three additional HCCs added to the model (for Dementia with and without complications, and for Pressure Ulcer of Skin).

The alternative model presented by CMS in Part 1 of the 2020 Advance Notice is a suggested answer to research and commentary that the PCC model first proposed in 2019 still under-predicts cost for some high-morbidity beneficiaries with multiple chronic conditions, and as such does not fully satisfy the 21st Century Cares Act requirements to improve the predictive accuracy of the CMS-HCC model for high need beneficiaries.

Data and Results

Using 2016 diagnoses and 2017 claims from the Medicare Limited Data Set (LDS), we estimate that the impact of the proposed PCC model and Alternative PCC model will be an increase in EDS risk scores of 0.55% and 0.32%, respectively, as compared with the "No Count" model currently in place for PY2019. Note, this impact factor considers only the ratios of raw risk scores calculated with each model, and is not diminished by a factor of 0.5 (which would represent the share of the total 2020 risk score contributed from the EDS Count model). Neither does this estimate account for the transition impact of extra weighting on the EDS portion of the risk score, which is discussed earlier in the paper.

The total membership in the LDS data sample reviewed is 2,446,669 unique beneficiaries. This includes ESRD and Hospice beneficiaries. For those unique beneficiaries, the distribution by member type is shown in Table 5:

Table 5-Distribution of Membership by Risk Model

Risk Model	Member Count	% of Distribution
Community, Non-Dual, Aged	1,764,145	72.1%
Community, Non-Dual, Disabled	180,570	7.4%
Community, Full-Dual, Aged	154,244	6.3%
Community, Full-Dual, Disabled	130,658	5.3%
Community, Partial-Dual, Disabled	57,337	2.3%
Community, Partial-Dual, Aged	79,966	3.3%
Institutional	79,749	3.3%
Total	2,446,669	100.0%

When the membership is grouped by HCC Count (exclusive of New Enrollees), most of the membership has an HCC count that falls below the threshold of a payment condition count coefficient for most of the risk score models (under four HCC counts). However, there are a significant number of members with over four HCC counts in the sample, so the results should be credible given there are 435k non-New Enrollee members with four or more HCC counts. The distribution of membership by HCC Count (with the highest morbidity members grouped as "10+") is shown in Table 6:

Table 6-Distribution of Membership by HCC Count

HCC Count	Member Count	% of Distribution
0	1,207,792	49.4%
1	396,748	16.2%
2	253,290	10.4%
3	153,371	6.3%
4	92,993	3.8%
5	58,184	2.4%
6	36,947	1.5%
7	24,342	1.0%
8	15,915	0.7%
9	16,241	0.7%
10+	190,846	7.8%

The overall findings of the study show that the risk scores differences between the models is on average less than 0.01. With the exception new enrollees, for almost all other member types, the conversion to either the 2020 proposed Payment Condition Count (PCC) model or the 2020 Alternative Payment Condition Count (APCC) model results in a slight risk score increase for the beneficiary. Only Full Dual Aged Community beneficiaries see a decrease in risk scores, and for these beneficiaries only the Alternative Payment Condition Count model results in a decrease. On average, the PCC model increased Medicare FFS member risk scores by 0.005, or 0.55%, while the average increase on the APCC model is 0.003, or 0.32%. Table 7 shows the average risk scores by risk model cohort, along with the member count by risk model.

Table 7-Overall Risk Model Change Impact by Model Type

Risk Model	Member Count	No Count to PCC Difference	No Count to APCC Difference	No Count to PCC % Change	No Count to APCC % Change
Community, Non-Dual, Aged	1,764,145	0.005	0.002	0.54%	0.29%
Community, Non-Dual, Disabled	180,570	0.006	0.006	0.71%	0.70%
Community, Full-Dual, Aged	154,244	0.007	-0.003	0.53%	-0.22%
Community, Full-Dual, Disabled	130,658	0.007	0.005	0.65%	0.44%
Community, Partial-Dual, Disabled	57,337	0.007	0.007	0.79%	0.76%
Community, Partial-Dual, Aged	79,966	0.006	0.002	0.75%	0.19%
Institutional	79,749	0.006	0.013	0.30%	0.63%
Total	2,446,669	0.005	0.003	0.55%	0.32%

Overall, risk scores are increasing for Medicare members. Within the payment/HCC count distribution, however, the increase in risk scores from the current No Count model to the PCC and APCC models varies by the number of HCCs the member has. Per CMS, the PCC and APCC models are intended to account for and adjust risk scores to reflect the increasing cost curves of members with multiple chronic conditions that are not explicitly adjusted for with current co-morbidity adjustments. Also, as stated in Part 1 of the Advance Notice, a criticism of the PCC model proposed in the 2019 Advance Notice was that the model still under predicted costs for members with multiple chronic conditions. The APCC model proposed in December attempts to more accurately adjust revenue for these sickest Medicare beneficiaries. When beneficiaries are grouped by HCC Count and model scores are compared by HCC Count cohort, the adjustments the models are intended to perform is clear. Tables 8 and Table 9 show the impact of each model type cohort by HCC Count.

Table 8- Risk Scores by HCC Count and Risk Model
No Count Model to PCC Count Model % Change

HCC Count	Member Count	Comm. ND Aged	Comm. ND Dis-abled	Comm. FD Aged	Comm. FD Disabled	Comm. PD Aged	Comm. PD Disabled	Insti-tutional
0	1,207,792	1.7%	5.2%	1.7%	9.3%	2.1%	7.2%	2.4%
1	396,748	0.6%	1.0%	1.0%	2.2%	1.2%	1.8%	1.7%
2	253,290	-0.2%	-0.9%	0.4%	-1.2%	0.1%	-0.9%	0.9%
3	153,371	-1.0%	-2.3%	-0.2%	-3.2%	-0.7%	-2.9%	0.1%
4	92,993	-1.2%	-3.7%	-0.8%	-3.2%	-1.7%	-4.3%	-0.5%
5	58,184	-0.8%	-3.2%	-1.3%	-3.3%	-1.0%	-1.7%	-1.1%
6	36,947	-0.3%	-1.6%	-0.5%	-1.5%	-0.7%	-3.0%	-0.7%
7	24,342	0.1%	-0.2%	-0.6%	-0.6%	-1.6%	1.7%	0.2%
8	15,915	1.5%	2.8%	-0.2%	1.0%	0.8%	2.3%	0.4%
9	16,241	1.7%	1.8%	0.8%	1.8%	3.4%	2.8%	0.2%
10+	190,846	4.2%	5.7%	3.1%	5.5%	5.3%	5.5%	1.1%

Table 9- Risk Scores by HCC Count and Risk Model
No Count Model to Alt PCC Count Model % Change

HCC Count	Member Count	Comm. ND Aged	Comm. ND Disabled	Comm. FD Aged	Comm. FD Disabled	Comm. PD Aged	Comm. PD Disabled	Insti-tutional
0	1,207,792	0.0%	5.0%	-2.4%	7.9%	0.2%	7.0%	0.8%
1	396,748	0.4%	0.7%	-0.1%	1.6%	0.6%	1.6%	0.1%
2	253,290	0.0%	-1.0%	0.9%	-1.0%	0.0%	-1.0%	0.2%
3	153,371	-0.5%	-2.4%	0.7%	-2.7%	-0.4%	-2.9%	0.3%
4	92,993	-0.7%	-3.6%	0.1%	-4.1%	-1.5%	-4.2%	0.4%
5	58,184	0.1%	-2.9%	-0.4%	-3.3%	-0.7%	-1.8%	0.5%
6	36,947	0.4%	-1.1%	0.4%	-1.2%	0.1%	-2.2%	0.5%
7	24,342	1.0%	-0.7%	0.3%	-0.4%	-0.6%	1.3%	0.7%
8	15,915	2.4%	3.6%	0.4%	1.4%	-0.6%	3.2%	0.7%
9	16,241	2.5%	2.1%	1.2%	2.0%	5.3%	2.4%	0.9%
10+	190,846	4.9%	5.8%	3.1%	5.5%	5.9%	5.5%	1.3%

The apparent intended impacts of the models, reviewing the results of both tables, is to increase risk scores for the members with the highest number of payment conditions. For both the PCC and APCC models, the risk score ratios of the current No count model to the proposed PCC/APCC models are relatively close to 1.000 for lower HCC counts (except for the PCC model zero-count demographic factors), both models show a "dip" for middle HCC count cohorts, and both models forecast significantly higher risk scores for the beneficiaries with the highest HCC counts. As we would expect given CMS's reasoning for proposal of the APCC model, the difference in risk score change for the highest HCC-count members between the No Count and APCC model is greater than the difference between the No Count and PCC model.

Finally, we examined several high frequency/high cost diseases to assess the model change impact for beneficiaries with these condition categories. Most of the condition-specific analyses show model differences mostly in line with the overall population adjustments. In Tables 10 and 11, we show the results of the model analysis on beneficiaries with prominent conditions to illustrate the relative stability in risk scores amongst the three models.

Table 10- PCC Risk Model Change Impact for Beneficiaries with Prominent Diseases

No Count Model to PCC Count Model % Change								
Model Type	Cancer	Diabetes	CHF	Cardio Respir Failure	COPD	Renal Issues	Sepsis	Pressure Ulcer
Comm ND Aged	0.2%	0.5%	0.4%	0.4%	0.3%	0.4%	0.5%	0.6%
Comm ND Disabled	0.3%	0.6%	0.5%	0.7%	0.5%	0.3%	0.8%	0.8%
Comm FD Aged	0.2%	0.4%	0.2%	0.2%	0.2%	0.3%	0.3%	0.3%
Comm FD Disabled	0.2%	0.3%	0.0%	0.3%	0.2%	-0.1%	0.5%	0.8%
Comm PD Aged	0.1%	0.5%	0.3%	0.1%	0.2%	0.3%	0.2%	0.0%
Comm PD Disabled	0.3%	0.2%	0.2%	0.5%	0.2%	-0.1%	0.3%	0.5%

Table 11- APCC Risk Model Change Impact for Beneficiaries with Prominent Diseases

	No Count Model to Alt PCC Count Model % Change							
Model Type	**Cancer**	**Diabetes**	**CHF**	**Cardio Respir Failure**	**COPD**	**Renal Disease**	**Sepsis**	**Pressure Ulcer**
Comm ND Aged	0.4%	0.6%	0.5%	0.5%	0.5%	0.6%	0.8%	7.4%
Comm ND Disabled	0.3%	0.6%	0.6%	0.7%	0.5%	0.3%	0.9%	3.8%
Comm FD Aged	0.2%	0.4%	0.1%	0.0%	0.1%	0.0%	0.1%	6.6%
Comm FD Disabled	0.1%	0.2%	-0.1%	0.2%	0.2%	-0.3%	0.4%	3.1%
Comm PD Aged	0.1%	0.5%	0.1%	0.0%	0.2%	0.2%	-0.2%	7.0%
Comm PD Disabled	0.3%	0.3%	0.1%	0.4%	0.2%	-0.1%	0.2%	5.9%

Major, significant disease states like cancer are not demonstrating large risk score increases. For most models and higher incidence rate disease states, the differences are similar; risk score increases due to model change are not significantly different from risk score changes in the wider population. However, risk score changes for members with Pressure Ulcers (the added HCC 159) see substantial increases in risk scores under the new APCC model compared with both the current 2019 No Count Model and the 2020 proposed PCC Model.

Enhancements to the 2020 Star Rating Measures

In the Call Letter, CMS describes numerous proposed changes to Star Rating measures for 2020 and future years. Topics addressed include:

- Temporary removal of measures

- Categorical Adjustment Index

- Extreme and Uncontrollable Circumstances Policy

- Display measures

- Potential changes to existing measures

- Potential new measures

It is beyond the scope of this report to describe these in detail; however, the following issues related Star Ratings are notable:

- For CY2020, the star rating for a cross-walked contract will now be determined by the enrollment weighted average of what would have been the Quality Bonus Payments (QBPs) of both contracts using November enrollment from the year the Star Ratings were released. In prior years, the star rating would be determined entirely by the surviving contract, with no consideration for the terminated contract. This change will change the strategic considerations for plans considering cross-walks.

- As noted in the "Growth Rate and Expected Average MA Benchmark for 2020" section, average star ratings are decreasing for 2020. Wakely estimates the average impact on benchmarks to be -0.23%.

  Wakely analyzed publicly available data on star ratings for PY2020 compared with PY2019 to try to understand this decrease in average star rating. The main reason for the decrease is that a greater number of contracts with a star rating of four or higher in PY2019 saw a reduction in rating to below four stars for PY2020 than contracts moving from below four to four or more. Further, this movement is not due to contracts with a Status of New Plan/New Parent getting a first Star Rating for PY2020. Based on our review, no contracts with New/New status in PY2019 received a data-based star rating for PY2020; although, many received a status of "Low Enrollment" for PY2020. While these findings do not fully explain the change in average rating, it does eliminate New/New plans as being the cause.

Medicare Annual Part D Benefit and Risk Score Adjustments for 2020

Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit

As in prior years, CMS is proposing changes to the Part D Defined Standard benefit for PY2020. The most notable change is that the true out-of-pocket (TrOOP) maximum threshold will increase from $5,100 in 2019 to $6,350 for 2020.

This increase is the direct result of Section 1860D-2(b)(4) of the Social Security Act, which modified the out-of-pocket threshold growth rate for 2014 through 2019. More specifically, for 2014 and 2015, the Act required that the out-of-pocket threshold be updated by the API[1] minus 0.25%, while for contract years 2016 through 2019 the Act required that the out-of-pocket

---

[1] API is defined as "the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States for Part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the Secretary shall specify"

threshold be updated from the previous year by the lesser of (1) the API or (2) two percentage points plus the annual percentage increase in the Consumer Price Index (CPI).

For 2020, the out-of-pocket threshold must be calculated as if the calculation of the out-of-pocket threshold for years 2014 through 2019 had not be modified (i.e., as if the thresholds for each of years 2014 through 2019 had been updated using the API). For 2021 and future years, the TrOOP increase will increase the prior year's value by the API.

The Defined Standard benefit will also continue to see the phase-in of reduced non-LIS cost sharing in the gap, with ultimate levels (95% for brand drugs and 25% for generic drugs) to be accomplished by PY2020. The non-LIS gap cost sharing for 2020 changes as follows:

- Non-LIS 25% coinsurance for non-applicable drugs (mainly generics) in the gap (was 37% in 2019).

- Non-LIS 95% coinsurance for applicable drugs (mainly brand) in the gap (versus 85% in 2019). Note that member liability is approximately 25% after 70% manufacturer discount. This is the same cost sharing scheme used in PY2019.

Reductions in non-LIS coinsurance will result in lower TrOOP, which will be reflected in the 2020 bids.

Update of the RxHCC Model

Following are the changes to the RxHCC model for 2020:

Re-Calibration for 2020 Benefit Structure: Updated to reflect gap plan liability for non-LIS beneficiaries of 75% for generics and 5% for brand scripts – this increases plan liability for non-LIS beneficiaries relative to LIS beneficiaries.

CMS is considering recalibration of the model under two different data sets:

- 2014 diagnoses and 2015 PDE data: Note that this is the same as the current model.

- 2015 diagnoses and 2016 PDE: Since RxHCCs are determined based on ICD-9 codes, ICD-10 codes submitted during the last quarter of 2015 were mapped to associated RxHCCs based on a standard crosswalk between ICD-9 and ICD-10.

FFS normalization factors for the two potential recalibrated models are 1.043 and 1.035 for the 2014/2015 and 2015/2016 approaches, respectively. The normalization factor for PY2019 was 1.020.

Comments were requested in relation to the data set that will be used for model recalibration. Quantification of the changes was not provided.

Appendix A – Method and Assumptions

CMS Part C Benchmarks

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

- The 2020 benchmark projections use the information and methodology presented in file *CalculationData2019.xlsx* trended forward by the growth rates provided in the Advance Notice.

- We summarized nationwide data using the January 2019 MA county level enrollment file and star rating data for 2019 and 2020 bids.

- Please note the estimated benchmark changes do not include any changes due to repricing or county rebasing.

Risk Model Impact

For the comparison study of the three CMS-HCC models, Wakely used Medicare FFS data from the Limited Data Set (LDS) to perform the analysis. The Medicare FFS claim data for the analysis is from 2016, and the eligibility data on which members are classified is 2017 data. The time frame used for the calibration of the three models under consideration is 2014 (for claim/diagnosis data) and 2015 (the cohort of beneficiaries).

One key difference between the data CMS employed for model calibration and the data used the Wakely study is the underlying diagnosis classification system; CMS's claim data from 2014 reflects the ICD-9 system, while the claim data in the Wakely study is on the ICD-10 system.

For purposes of model comparison, we believe the distinction is acceptable for several reasons. First, the data run through all three models is on the same diagnosis classification system, so any variability introduced by the difference in ICD system between the model calibration data and the data for this analysis is present in all three of the study's estimates, and therefore should not drive material differences.

Second, the ICD-9 diagnoses used to calibrate the current 2019 No Count model were phased out of medical claim data before the model's active measurement year in 2018. CMS did not recalibrate the No Count model for the active year. Therefore, since CMS made no adjustment to account for ICD-9 to ICD-10 changes, Wakely likewise made no adjustment.

To filter the diagnoses between those acceptable for MA risk adjustment and those ineligible for payment condition consideration, Wakely used both the filtering methodology prescribed by CMS for plans to filter the RAPS data submitted to CMS, and the EDS filtering methodology described by CMS in their published December 22, 2015 memo entitled "Final Encounter Data Diagnosis

Filtering Logic". For the numbers shown above, EDS filtering was used, as that will be the methodology applied to Medicare Advantage members being scored under this model. Please note, however: while the current No Count model and proposed Payment Condition Count model will be used only for encounter data risk scores for beneficiaries with Medicare Advantage experience in the measurement period, we do not believe CMS has publicly clarified which filtering logic will be applied to the Payment Condition Count Model risk scores for members in Medicare Advantage plans with FFS diagnosis data in the measurement period.

We used the CMS-provided software to calculate member risk scores under all three models. The current 2019 No Count model was run with the CMS-HCC V2318.83.P1 software, the proposed 2020 Payment Condition Count model was run with the CMS-HCC V2317.83.P2 software, and the Alternative Payment Condition Count model first proposed in the 2020 Advance Notice Part 1 was run with the CMS-HCC V2418.86.P1 software.

The CMS-HCC V2318.83.P1 coefficient input file provides the user with relative coefficients with a denominator of $9,367.51 used to convert the dollar coefficients to relative risk factors. Both the CMS-HCC V2317.83.P2 software and the CMS-HCC V2418.86.P1 software provide coefficient input files that are dollar denominated, so Wakely calculated the relative risk scores after the data was run through each of the V2317.83.P2 and V2418.86.P1 models.

The denominators for calculating the risk score outputs for the Payment Condition Count and Alternative Payment Condition Count models were sourced from footnotes in the model coefficient tables published in the 2020 Advance Notice Part 1. The dollar denominator to normalize the Payment Condition Count risk scores is $9,367.34, and the dollar denominator to normalize the Alternative Payment Condition Count risk scores is $9,365.50.