February 5, 2020

NOTE TO: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties

SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies – Part II

Medicare Advantage (Part C) and Medicare prescription drug (Part D) plans have been successful in providing Medicare beneficiaries with options so that they can choose the healthcare that best fits their individual health needs. These programs demonstrate the value of private sector innovation and creativity and CMS is committed to continuing to make changes that promote greater innovation, transparency, flexibility, and program simplification.

On January 6, 2020, we released for comment proposed changes to the Part C risk adjustment model used to pay for aged and disabled beneficiaries with a comment deadline of March 6, 2020. In accordance with section 1853(b)(2) of the Social Security Act, we are now notifying you of additional planned changes in the MA capitation rate methodology and risk adjustment methodology applied under Part C of the Medicare statute for CY 2021. Also included with this notice are annual adjustments for CY 2021 to the Medicare Part D benefit parameters for the defined standard benefit. For CY 2021, CMS will announce the MA capitation rates and final payment policies no later than Monday, April 6, 2020, in accordance with the timetable required by section 1853(b), as established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) and amended by the Securing Fairness in Regulatory Timing Act of 2015 (SFRTA) (Pub. L. 114-106). The Advance Notice of Methodological Changes is published no fewer than 60 days before the publication of the Rate Announcement and provides a minimum 30-day period for public comment.

Attachment I of this document shows the preliminary estimates of the national per capita MA growth percentage and the national Medicare fee-for-service growth percentage, which are key factors in determining the MA capitation rates. Attachment II sets forth changes in the Part C payment methodology for CY 2021. Attachment III sets forth the changes in the Part D payment methodology for CY 2021. Attachment IV presents the annual adjustments for CY 2021 to the Medicare Part D benefit parameters for the defined standard benefit. Attachment V contains updates for the MA and Part D Star Ratings and solicits input on potential measure topics and measures for future rating years. Attachment VI contains economic information for significant provisions in Advance Notice Part II.

To submit comments or questions electronically, go to https://www.regulations.gov, enter the docket number “CMS-2020-0003” in the “Search” field, and follow the instructions for “submitting a comment.”

Comments will be made public, so submitters should not include any confidential or personal information. In order to receive consideration prior to the release of the final Announcement of Calendar Year 2021 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies, comments must be received by 6:00 PM Eastern Standard Time on Friday, March 6, 2020.

/ s /
Demetrios Kouzoukas
Principal Deputy Administrator and Director, Center for Medicare

I, Jennifer Wuggazer Lazio, am a Member of the American Academy of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained in this Advance Notice. My opinion is limited to the following sections of this Advance Notice: The growth percentages and United States per capita cost estimates provided in Attachment I; the qualifying county determination, calculations of Fee for Service cost, IME phase out, MA benchmarks, EGWP rates, and ESRD rates discussed in Attachment II; Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2021 described in Attachment III and in Attachment IV.

/ s /
Jennifer Wuggazer Lazio, F.S.A., M.A.A.A.
Director
Parts C & D Actuarial Group
Office of the Actuary

Attachments

2021 ADVANCE NOTICE – PART II

TABLE OF CONTENTS

Attachment I. Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2021

The MA county rates are based on the specified amount as defined in Attachment II Section A2 below. Section 1853(n)(2)(A) of the Social Security Act ("the Act") defines the specified amount as the base amount (which in rebasing years is the adjusted average fee-for-service (FFS) per capita cost) multiplied by the applicable percentage for the area (set under section 1853(n)(2)(B) through (D)). Section 1853(n)(4) of the Act requires that the benchmark for an area for a year (increased by quality bonus percentages where applicable) be capped at the level of the 1853(k)(1) applicable amount. The 2021 FFS cost is calculated, in part, using the FFS growth percentage. CMS intends to rebase the adjusted average FFS per capita cost (i.e., county FFS rates) as part of the calculation of the rates for 2021.

Section A. MA Growth Percentage

Section 1853(k)(1) of the Act requires that the applicable amount for a county be determined for the purpose of calculating the benchmark amounts, and the applicable amount is calculated, in part, using the national per capita MA growth percentage. The current estimate of the change in the national per capita MA growth percentage for aged and disabled enrollees combined in CY 2021 is 4.52 percent. This estimate reflects an underlying trend change for CY 2021 in per capita cost of 3.985 percent and, as required under section 1853(c)(6)(C) of the Act, adjustments to the estimates for prior years as indicated in the table below.

Table I-1 below summarizes the estimates for the change in the national per capita MA growth percentage for aged/disabled beneficiaries.

Table I-1. Increase in the National Per Capita MA Growth Percentages (NPCMAGP) for 2021

	Prior Increases	Current Increases			NPCMAGP for 2021 With §1853(c)(6)(C) adjustment[1]
	2003 to 2020	2003 to 2020	2020 to 2021	2003 to 2021	
Aged+Disabled	77.909%	78.830%	3.985%	85.957%	4.52%

[1] Current increases for 2003-2021 divided by the prior increases for 2003-2020.

Section B. FFS Growth Percentage

Section 1853(n)(2) of the Act requires that the specified amount for a county be calculated as a percentage of the county FFS costs. Table I-2 below provides the current estimate of the change in the aged/disabled FFS United States per capita cost (USPCC), which will be used as the basis

for the county FFS rates. The percentage change in the FFS USPCC is shown as the current projected FFS USPCC for 2021 divided by the prior projected FFS USPCC for 2020.

Table I-2 also shows the change in the FFS USPCC for dialysis-only ESRD. Statewide dialysis-only ESRD rates are determined by applying a historical average geographic adjustment to a projected FFS dialysis-only ESRD USPCC. We will use a 5-year average of State data to determine the average geographic adjustment, similar to the method used to determine the geographic adjustments for non-ESRD rates.

Table I-2. Increase in the USPCC Growth Percentage for CY 2021

	Total USPCC – Non-ESRD	FFS USPCC – Non-ESRD	Dialysis-only ESRD USPCC
Current projected 2021 USPCC	$1,011.31	$964.99	$8,013.51
Prior projected 2020 USPCC	$967.54	$940.81	$7,795.38
Percent increase	4.52%	2.57%	2.80%

Table I-3 compares last year's estimate of the total non-ESRD USPCC with current estimates for 2003 to 2023, Table I-4 compares last year's FFS non-ESRD USPCC estimates with current estimates, and Table I-5 compares last year's dialysis-only ESRD USPCC estimates with current estimates. The total USPCCs are the basis for the National Per Capita MA Growth Percentages. In addition, these tables show the current projections of the USPCCs through 2023. Caution should be employed in the use of this information. It is based upon nationwide averages, and local conditions can differ substantially from conditions nationwide. None of the data presented here pertain to the Medicare prescription drug benefit.

The tabulation of FFS costs supporting the USPCCs encompass payments made outside the claim systems such as provider settlements via cost reports, innovation model shared savings settlements, and other adjustments. Also included in the USPCCs are the cost impacts of program changes enacted through legislation, regulation, and national coverage decisions applicable for the contract year (2021). Attachment II Section B contains additional information regarding the calculation of FFS costs.

Table I-3. Comparison of Current & Previous Estimates of the Total USPCC – Non-ESRD

	Part A		Part B		Part A + Part B		
Calendar Year	Current Estimate	Last Year's Estimate	Current Estimate	Last Year's Estimate	Current Estimate	Last Year's Estimate	Ratio
2003	$296.18	$296.18	$247.66	$247.66	$543.84	$543.84	1.000
2004	314.08	314.08	271.06	271.06	585.14	585.14	1.000
2005	334.83	334.83	292.86	292.86	627.69	627.69	1.000
2006	345.30	345.30	313.70	313.70	659.00	659.00	1.000
2007	355.44	355.44	330.68	330.68	686.12	686.12	1.000
2008	371.90	371.90	351.04	351.04	722.94	722.94	1.000
2009	383.91	383.91	366.78	367.93	750.69	751.84	0.998
2010	383.94	383.94	375.49	376.79	759.43	760.73	0.998
2011	388.15	388.15	385.31	386.41	773.46	774.56	0.999
2012	377.81	377.72	391.96	392.97	769.77	770.69	0.999
2013	380.48	380.30	398.74	399.64	779.22	779.94	0.999
2014	370.41	372.59	417.71	418.60	788.12	791.19	0.996
2015	373.92	376.08	434.18	435.61	808.10	811.69	0.996
2016	379.90	379.90	443.29	445.63	823.19	825.53	0.997
2017	383.38	385.90	458.22	460.41	841.60	846.31	0.994
2018	387.13	391.41	487.32	493.05	874.45	884.46	0.989
2019	398.25	405.04	519.25	522.40	917.50	927.44	0.989
2020	418.58	419.00	553.97	548.54	972.55	967.54	1.005
2021	433.49	434.24	577.82	580.16	1,011.31	1,014.40	0.997
2022	450.97	452.61	605.19	612.18	1,056.16	1,064.79	0.992
2023	471.31		643.90		1,115.21		

Table I-4. Comparison of Current & Previous Estimates of the FFS USPCC – Non-ESRD

	Part A		Part B		Part A + Part B		
Calendar Year	Current Estimate	Last Year's Estimate	Current Estimate	Last Year's Estimate	Current Estimate	Last Year's Estimate	Ratio
2010	$371.20	$371.20	$373.13	$374.92	$744.33	$746.12	0.998
2011	371.71	371.70	383.18	384.70	754.89	756.40	0.998
2012	357.54	357.52	390.71	392.25	748.25	749.77	0.998
2013	364.34	364.32	394.48	396.04	758.82	760.36	0.998
2014	364.25	367.61	407.86	409.50	772.11	777.11	0.994
2015	369.16	372.34	426.45	428.66	795.61	801.00	0.993
2016	372.04	374.82	431.94	435.52	803.98	810.34	0.992
2017	374.27	378.52	446.64	450.74	820.91	829.26	0.990
2018	376.33	385.24	470.34	482.87	846.67	868.11	0.975
2019	384.52	395.52	497.43	507.69	881.95	903.21	0.976
2020	399.61	409.27	523.59	531.54	923.20	940.81	0.981
2021	415.08	424.78	549.91	563.03	964.99	987.81	0.977
2022	431.45	442.49	575.57	593.81	1,007.02	1,036.30	0.972
2023	450.35		611.63		1,061.98		

Table I-5. Comparison of Current & Previous Estimates of the ESRD Dialysis-only FFS USPCC

	Part A		Part B		Part A + Part B		
Calendar Year	Current Estimate	Last Year's Estimate	Current Estimate	Last Year's Estimate	Current Estimate	Last Year's Estimate	Ratio
2010	$2,952.75	$2,952.75	$3,881.39	$3,881.39	$6,834.14	$6,834.14	1.000
2011	2,862.38	2,862.38	3,908.01	3,908.01	6,770.39	6,770.39	1.000
2012	2,774.49	2,774.49	3,944.59	3,944.59	6,719.08	6,719.08	1.000
2013	2,794.19	2,794.19	4,088.66	4,088.66	6,882.85	6,882.85	1.000
2014	2,784.52	2,784.52	4,115.70	4,115.70	6,900.22	6,900.22	1.000
2015	2,775.84	2,775.84	4,060.87	4,060.87	6,836.71	6,836.71	1.000
2016	2,895.91	2,895.91	4,081.27	4,081.27	6,977.18	6,977.18	1.000
2017	2,883.27	2,883.27	4,102.66	4,102.66	6,985.93	6,985.93	1.000
2018	2,952.60	2,928.10	4,525.19	4,459.82	7,477.79	7,387.92	1.012
2019	3,016.69	2,993.78	4,601.37	4,569.75	7,618.06	7,563.53	1.007
2020	3,130.96	3,098.04	4,687.11	4,697.34	7,818.07	7,795.38	1.003
2021	3,197.62	3,205.96	4,815.89	4,899.79	8,013.51	8,105.75	0.989
2022	3,292.88	3,327.60	4,953.60	5,109.43	8,246.48	8,437.03	0.977
2023	3,421.52		5,153.96		8,575.48		

These estimates are preliminary and could change when the final rates are announced, no later than April 6, 2020, in the Announcement of CY 2021 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies. Further details on the derivation of the national per capita MA growth percentage and the FFS growth percentage will also be presented in the Rate Announcement.

Attachment II. Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2021

Section A. MA Benchmark, Quality Bonus Payments, and Rebate

Section 1853(n)(2) of the Act requires that, in determining the specified amount, CMS use as the base amount the amount described in section 1853(c)(1)(D) for a rebasing year or, for years that are not a rebasing year, the base amount from the previous year increased by the national per capita MA growth percentage. Section 1853(c)(1)(D)(ii) of the Act requires CMS to rebase the county FFS rates, which form the basis of the specified amount described in Section A2 below, periodically but not less than once every three years. When the rates are rebased, CMS updates its estimate of each county's FFS costs using more current FFS claims information. CMS intends to rebase the county FFS rates for 2021 using FFS claims data from 2014 through 2018. (Please note that throughout this document, the terms "benchmark" and "county rate" are used interchangeably, and the term "service area benchmark" indicates the bidding target for an MA plan based on its specific service area.)

Rates for the Programs of All-Inclusive Care for the Elderly (PACE) plans are not developed using the specified amount, per section 1853(n)(5) of the Act.

A1. Applicable Amount

The applicable amount is the rate established under section 1853(k)(1) of the Act. As CMS intends to rebase the rates in 2021, the applicable amount for 2021 is the greater of: (1) the county's 2021 FFS cost or (2) the 2020 applicable amount increased by the CY 2021 National Per Capita Medicare Advantage Growth Percentage. As discussed in Section A5, section 1853(n)(4) of the Act requires that the benchmark (determined taking into account the quality bonus percentage increase) for each county must be capped at the county's applicable amount.

A2. Specified Amount

Under section 1853(n)(2)(A) of the Act, the specified amount is based upon the following formula:

(2021 FFS cost[1] minus (IME phase-out amount and kidney acquisition costs)) × (applicable percentage + applicable percentage quality increase)

Where:

[1] As described in more detail below in section B, the FFS cost is adjusted to exclude costs attributable to payments under sections 1848(o), 1886(n), and 1886(h).

IME phase-out amount is the amount of indirect costs of medical education that is required to be phased out as specified at section 1853(k)(4) and sections 1853(n)(2)(E) and (F);

Kidney acquisition costs are the standardized costs for payments for organ acquisitions for kidney transplants that are required to be excluded, beginning 2021, as specified at section 1853(k)(5) and sections 1853(n)(2)(A)(i) and 1853(n)(2)(G);

Applicable percentage is a statutory percentage applied to the county's base payment amount, as described at section 1853(n)(2)(B); and

Applicable percentage quality increase, referred to in this document as the quality bonus payment (QBP) percentage, is a percentage point increase to the applicable percentage for a county in a qualifying plan's service area.

Section 1853(n)(2)(C) of the Act requires CMS to determine applicable percentages for a year based on county FFS rate rankings for the most recent year that was a rebasing year. To determine the CY 2021 applicable percentages for counties in the 50 States and the District of Columbia, CMS will rank counties from highest to lowest based upon their 2020 average per capita FFS rate adjusted to exclude the IME phase out and, beginning for 2021, payments for kidney acquisition. The 2020 rates are used because 2020 is the most recent rebasing year prior to 2021. CMS will then place the rates into four quartiles. For the territories, CMS will assign an applicable percentage to each territory county based on where the territory county rate falls in the quartiles established for the 50 States and the District of Columbia.

CMS is publishing the 2021 applicable percentages by county with the Advance Notice at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html. Each county's applicable percentage is assigned based upon its quartile ranking, as follows:

Table II-1. FFS Quartile Assignment

Quartile	Applicable Percentage
4th (highest)	95%
3rd	100%
2nd	107.5%
1st (lowest)	115%

Section 1853(n)(2)(D) of the Act provides that, beginning in 2013, if there is a change in a county's quartile ranking for a payment year compared to the county's ranking in the previous

year, the applicable percentage for the area for the year shall be the average of: (1) the applicable percentage for the previous year and (2) the applicable percentage for the current year. For both years, CMS will calculate the applicable percentage that would otherwise apply for the area for the year in the absence of this transitional provision. For example, if a county's ranking changed from the second quartile to the third quartile, the applicable percentage would be 103.75 percent for the year of the change – the average of 107.5 percent and 100 percent.

A3. Quality Bonus Payment Percentage

The Act provides for CMS to make quality bonus payments to MA organizations that meet quality standards measured under a five-star quality rating system. In this document, we refer to this quality bonus as the *quality bonus payment (QBP) percentage* instead of using the statutory term *applicable percentage quality increase*. The QBP percentage is a percentage point increase to the applicable percentage for each county in a qualifying plan's service area, before multiplying the percentage by the FFS rate for the year to determine the specified amount.

Table II-2 shows the QBP percentage for each Star Rating. Plans with fewer than four stars will not receive a QBP percentage increase to the county rates, and plans with four or more stars will receive a QBP percentage increase in the calculation of the county rates, as set forth in sections 1853(n) and 1853(o) of the Act. See Section A6 for rebate percentages.

Table II-2. Percentage Add-on to Applicable Percentage for Quality Bonus Payments

Star Rating	2021 QBP Percentage
Fewer than 4 stars	0%
4 stars	5%
4.5 stars	5%
5 stars	5%

An MA plan's Star Rating is the rating assigned to its contract; the contract rating is applied to each plan under that contract. MA plans with a Star Rating of four or more stars will bid against their service area benchmarks that include the 5-percentage point QBP add-on to the applicable percentage for the benchmark in each county in the service area. MA plans with a Star Rating of fewer than four stars will bid against service area benchmarks that do not include QBP add-ons to the county rates, with the exceptions of new MA plans and low enrollment plans. As discussed below, all benchmarks (determined after application of the QBP percentage) are capped at the section 1853(k)(1) applicable amount per section 1853(n)(4) of the Act.

New MA Plans

New MA plans are treated as qualifying plans that are eligible to receive a QBP percentage increase to the county rates, except that the QBP percentage will be 3.5 percentage points, per section 1853(o)(3)(A)(iii)(I)(cc) of the Act and pursuant to § 422.258(d)(7)(v)(C).[2] That is, new MA plans will bid against a service area benchmark that reflects a 3.5 percentage point increase to the applicable percentage used to set the benchmark for each county in the plan's service area. Per section 1853(o)(3)(A)(iii)(II) of the Act, for the purpose of determining a QBP percentage, the term "new MA plan" refers to an MA plan offered by a parent organization that has not had another MA contract in the preceding three-year period. As discussed below, all rates are capped at the section 1853(k)(1) applicable amount (determined after application of the QBP percentage) – per section 1853(n)(4) of the Act.

Pursuant to § 422.252, a new MA plan means a MA contract offered by a parent organization that has not had another MA contract in the previous 3 years. CMS intends to continue the policy finalized in the 2012 Rate Announcement (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2012.pdf) that for a parent organization that has had a contract with CMS in the preceding three-year-period, any new MA contract under that parent organization will receive an enrollment-weighted average of the Star Ratings earned by the parent organization's existing MA contracts. Such plans under the new MA contract may qualify for a QBP increase based on the enrollment-weighted average rating of the parent organization.

In the Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly Proposed Rule (CMS-4190-P) (referred to hereinafter as the "CY 2021 proposed rule"), which was posted for display at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-02085.pdf on February 5, 2020 and is scheduled for publication in the Federal Register, we are proposing to clarify the policy for the assignment of QBP ratings, codify the policy for the assignment of QBP ratings for new contracts under existing parent organizations, and clarify the definition of new MA plans in the regulations at §§ 422.162, 422.166, and 422.252. We encourage interested stakeholders to submit comments on this proposed rule. Comments must be submitted using the procedures outlined in the proposed rule to be considered.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10) contained provisions to permit reasonable cost reimbursement contracts to transition into MA plans through CY 2019, and allowed Medicare Advantage Organizations (MAOs) to deem the enrollment of their cost enrollees into successor affiliated MA plans that meet specific conditions. MACRA amended section 1853(o)(4) of the Act such that, for its first three years as

[2] All regulatory cites are to Title 42 of the Code of Federal Regulations unless otherwise noted.

a converted MA plan receiving deemed enrollment, the converted plan shall not be treated as a new MA plan.

Low Enrollment Plans

Section 1853(o)(3)(A)(ii)(II) of the Act, as implemented at § 422.258(d)(7)(iv)(B), provides that for 2013 and subsequent years, CMS shall develop a method for determining whether an MA plan with low enrollment is a qualifying plan for purposes of receiving an increase in payment under section 1853(o). We apply this determination at the contract level, and thus determine whether a contract (meaning all plans under that contract) is a qualifying contract. Pursuant to § 422.252, a low enrollment contract is one that could not undertake Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcome Survey (HOS) data collections because of a lack of a sufficient number of enrollees to reliably measure the performance of the health plan.

Section 1853(o)(3)(A)(ii) of the Act does not address the amount of the increase for low enrollment contracts. We intend to continue the current policy that low enrollment contracts be included as qualifying contracts that receive the QBP percentage of 3.5 percentage points, similar to the QBP percentage increase applied to new MA plans. We discussed the basis of this policy in detail in the 2018 Advance Notice (pages 12-13) (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2018.pdf).

Contract Consolidations and QBP

Section 1853(o)(4) of the Act was amended by the Bipartisan Budget Act of 2018 to add subsection (D) regarding the determination of star ratings for consolidating MA plans. In the Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program Final Rule (CMS-4182-F) (hereinafter referred to as the "CY 2019 Final Rule") (83 FR 16440), CMS finalized regulations at §§ 422.162(b)(3) and 423.182(b)(3) to implement section 1853(o)(4)(D) for contract consolidations approved on or after January 1, 2019. Those regulations provide that when consolidations involve two or more contracts for health and/or drug services of the same plan type under the same legal entity combining into a single contract at the start of a contract year, the rating used to determine QBP status ("QBP rating") for the first year following the consolidation will be the enrollment weighted average of what would have been the QBP ratings of the surviving and consumed contracts, using the contract enrollment in November of the year the Star Ratings were released. The process for calculating the rating for contracts that consolidate is specified at §§ 422.162(b)(3) and 423.182(b)(3).

A4. Qualifying County Bonus Payment

Beginning with contract year 2012, section 1853(o)(2) of the Act extends a double QBP percentage to a qualifying plan located in a "qualifying county." A qualifying county is a county that meets the following three criteria:

> (1) has an MA capitation rate that, in 2004, was based on the amount specified in section 1853(c)(1)(B) for a Metropolitan Statistical Area with a population of more than 250,000;
>
> (2) as of December 2009, had at least 25 percent of MA-eligible beneficiaries residing in the county enrolled in a MA plan; and
>
> (3) has per capita FFS County spending for the year (2021) that is less than the national monthly per capita cost for FFS for the year (2021).

See section 1853(o)(3)(B) of the Act and § 422.258(d)(7)(ii).

As an example, as described in Section A3, a plan with a rating of 4.5 stars will have 5 QBP percentage points added to the applicable percentage of each county in its service area. For each county that meets the three criteria stated above in that plan's service area, that percentage will be doubled so that an additional 5 percentage points will be added to that county's applicable percentage for a total increase of 10 percentage points. If this qualifying county otherwise has an applicable percentage of 95 percent, this is increased to 105 percent to reflect the quality bonus payment percentage for that county. As discussed below, all benchmarks are capped at the section 1853(k)(1) applicable amount (determined after application of the QBP percentage) per section 1853(n)(4) of the Act.

CMS will publish a complete list of qualifying counties in the final 2021 Rate Announcement. The listing will contain all counties that meet all three criteria stated above. Two of the three elements for determining a qualifying county (2004 urban floors (Y/N) for each county, and 2009 Medicare Advantage penetration rates) can be found in the 2020 Rate Calculation Data file (columns Y and AA) on the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html. The 2021 FFS rates, which are necessary for the third criterion, are not available at the time this Advance Notice is published. The FFS rates and the national average FFS spending amount will be published in the final 2021 Rate Announcement.

A5. Cap on Benchmarks

Section 1853(n)(4) of the Act requires that the benchmark (determined by taking into account the application of the QBP percentage) for a county must be capped at the level of the county's applicable amount determined under section 1853(k)(1). This provision requires that the QBP increase must be included in the benchmark before the comparison is made to determine if the

cap is applied. Thus, for all counties, post-QBP percentage rates are capped at the section 1853(k)(1) applicable amount.

CMS shares the concerns stakeholders have raised about any rate-setting mechanism that diminishes incentives for MA plans to continuously improve the care provided to Medicare beneficiaries, and agrees that a primary goal of the Star Rating system for MA is to encourage plans to continuously improve the quality of the care provided to their enrollees. However, while we appreciate the concerns stakeholders have raised in connection with the cap on benchmarks, CMS believes that section 1853(n)(4) of the Act prevents elimination of the rate cap or excluding the bonus payment from the cap calculation.

A6. Rebate

Under section 1854(b)(1)(C) of the Act, except for MSA plans, the level of rebate for each plan is based on the plan's Star Rating. Rebates for each plan are calculated as a percentage of the amount by which the risk-adjusted service area benchmark exceeds the risk-adjusted bid. Under § 422.266(b), plans may use rebates to fund mandatory supplemental benefits and/or to buy down beneficiary premiums for Part B and/or Part D prescription drug coverage. Pursuant to section 1854(b)(1)(C), which is implemented in § 422.266(a)(2)(ii), the rebate percentages apply based on a plan's Star Rating, as shown in Table II-3.

Table II-3. MA Rebate Percentages

Star Rating	2021
4.5+ Stars	70%
3.5 to < 4.5 stars	65%
< 3.5 stars	50%

Section 1854(b)(1)(C)(vi)(II) of the Act requires that, for purposes of determining the rebate percentage, a new MA contract under a new parent organization will be treated as having a Star Rating of 3.5 stars for 2012 and subsequent years. The statute is silent on the rebate percentage to assign to low enrollment plans in years after 2012. We view this as a gap in the statute, particularly in light of the direction in section 1853(o)(3)(A)(ii) to treat low enrollment plans as qualifying plans for purposes of the quality bonus payment percentage. As we have in prior years, CMS intends to treat low enrollment plans as having a Star Rating of 3.5 stars for purposes of determining the rebate percentage.

As mentioned above, MACRA amended section 1853(o)(4) of the Act such that, for the first three years that a former reasonable cost reimbursement contract is a converted MA plan receiving deemed enrollment, the converted plan shall not be treated as a new MA plan.

Section B. Calculation of Fee for Service Cost

The FFS per capita cost for each county is a product of (1) the national FFS per capita cost, or United States per-capita cost (USPCC), and (2) a county-level geographic index called the average geographic adjustment (AGA).

Each year, CMS strives to improve the development of the USPCC and AGAs with refinements to how these figures are calculated. We will continue to incorporate refinements developed and used in prior years to update the claims data used to calculate the AGAs and to continue the repricing of historical data in the AGA calculation. Specifically, we will incorporate updates and refinements to the AGA calculation methodology to reflect changes in FFS payment rules. Certain historical claims data will be repriced to reflect the most current wage and cost indices. CMS will re-price hospital inpatient, hospital outpatient, skilled nursing facility, and home health claims to reflect the most current wage indices, and re-tabulate physician claims with the most current Geographic Practice Cost Index. We will also reprice historical claims to account for legislative and regulatory changes made to payments to disproportionate share hospitals and reprice durable medical equipment claims to account for the change in prices associated with the competitive bidding program. Repricing historical claims, in conjunction with rebasing rates, ensures that the FFS rates for each county reflect the most current FFS fee schedules and payment rules.

We will continue a refinement to the methodology used in the ratebook development to include Health Professional Shortage Areas (HPSAs) bonus payments. Specifically, we propose to tabulate the Health Professional Shortage Areas (HPSAs) bonuses by county of residence for years 2014–2018 and add these values to our ratebook FFS expenditures. The HPSA bonuses are disbursed quarterly to providers and are not reflected in the standard claim files.

With this Advance Notice, we are releasing the 2018 FFS cost data by county used in the development of the 2021 ratebook. This data is available on the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data.html. This data will not reflect adjustments for innovation model shared savings and losses and will not reflect adjustments for claim repricing for the most recent Medicare FFS payment rules and parameters.

B1. AGA Methodology

In the first step, CMS is proposing to add the 2018 cost and enrollment data to, and drop the 2013 cost and enrollment data from, the historical claims experience used to develop new geographic cost indices for each county. As a result, the five-year rolling average will be based on Original Medicare claims data from 2014–2018. CMS will then perform a series of adjustments to the Original Medicare data to estimate FFS rates per county, explained below as successive steps.

In the second step, CMS will exclude hospice expenditures and FFS claims paid on behalf of cost plan enrollees from the 2018 claims. Comparable adjustments have been made to claims data in the development of the FFS rates starting with 2009, so the claims data for years prior to 2018 that are used in developing the FFS per capita cost for the 2021 ratebook have already been similarly adjusted.

For Puerto Rico, CMS will continue to only include five (5) years (2014 – 2018) of historical claims and enrollment for beneficiaries with Part A and Part B enrollment at the time of the dates of service for the FFS claim. While most Medicare beneficiaries are automatically enrolled in Part B and must opt out to decline it, beneficiaries in Puerto Rico must take affirmative action to opt-in to Part B coverage. CMS continues to believe it is appropriate to adjust the FFS rate calculation in Puerto Rico used to determine MA rates so that it is based on beneficiaries who are enrolled in both Part A and Part B in order to produce a more accurate projection of FFS costs per capita in Puerto Rico.

In the third step, CMS will re-price the historical inpatient, hospital outpatient, skilled nursing facility, and home health claims from 2014–2018 to reflect the most current (i.e., FY 2020) wage indices, and re-tabulate physician claims with the most current Geographic Practice Cost Indices.[3] We will continue to adjust the uncompensated care payments (UCP) represented in the 2014–2018 claims to reflect the requirements of the final FY 2020 Inpatient Prospective Payment System (IPPS) rule. Repricing for Puerto Rico inpatient claims will continue to reflect the Consolidated Appropriations Act, 2016 (Pub. L. 114-113, Division O, section 601), which amended section 1886(d)(9)(E) of the Act.

We will continue re-pricing Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims, by re-pricing claims from 2014–2018 to reflect the most current DMEPOS prices associated with the Competitive Bidding Program (CBP). Section 1847(b)(5) of the Act requires that "single payment amounts" replace the Medicare DMEPOS fee schedule amounts for certain DMEPOS items furnished in competitive bidding areas (CBAs). During the lapse in the CBP, these single payment amounts are updated by the change in the CPI-U once every 12-month period beginning on the date after the contract periods ended, including mail order items and supplies. HCPCS codes for diabetic supplies were included in the National Mail Order (NMO) program. We will continue to use the most recent single payment amounts without update for non-mail order diabetic supplies to reprice the historical payments for DMEPOS claims. In accordance with section 1834(a)(1)(H) and the American Taxpayer Relief Act, 2012 (Pub.L. 112–240, H.R. 8, 126 Stat. 2313, section 636), the fee schedule amounts for non-mail-

[3] Repricing for Geographic Practice Cost Index will reflect section 101 of the Further Consolidated Appropriations Act, 2020 (P.L. 116-94) which amended section 1848(e)(1)(E) of the Act such that, for services furnished on or after May 23, 2020, the floor on the work geographic index will no longer apply to increase the value to 1.00 for any locality for which such work geographic index is less than 1.00.

order diabetic supplies, including testing strips, are equal to the single payment amounts established under the NMO competition for diabetic supplies. Section 1834(a)(1)(F) of the Act requires CMS to adjust the fee schedule amounts for DMEPOS items furnished on or after January 1, 2016 in non-CBAs based on information from the competitive bidding program. We will continue to use a blend of 50 percent of the adjusted fee schedule amounts and 50 percent of the unadjusted fee schedule amounts to reprice the non-CBA FFS claims in rural and non-contiguous areas for 2014–2018. We will continue to use 100 percent of the adjusted payment amount to reprice the non-CBA FFS claims in non-rural contiguous areas for 2014-2018. These proposals are based on the updates to policies and payment rates in the final rule titled End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals With Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) and Fee Schedule Amounts, and Technical Amendments To Correct Existing Regulations Related to the CBP for Certain DMEPOS (CMS-1691-F) (83 FR 56922).

As indicated in Table B1-1, we will continue to adjust historical FFS experience to reflect shared savings and losses or episode savings and losses experienced under the Medicare Shared Savings Program and Innovation Center models and demonstration programs. All adjustments of this type apply to the non-ESRD ratebook except the model(s) noted as ESRD in Table B1-1.

Table B1-1. The Medicare Shared Savings Program and Innovation Center Models and Demonstration Programs with Ratebook Adjustments

Program/Models and Demonstration Programs	Experience Years		Payment Type
	2020 Ratebook	2021 Ratebook	
Medicare Shared Savings Program	2013-2017	2014-2018	Shared savings / losses
Pioneer ACO	2013-2016	2014-2016	Shared savings / losses
Comprehensive Care for Joint Replacement (CJR)	2016-2017	2016-2018	Episode savings / losses
Next Gen ACO (NGACO)	2016-2017	2016-2018	Shared savings / losses
Oncology Care Model (OCM)	7/1/2016-2017	7/1/2016-2018	Episode savings / losses
Comprehensive Primary Care (CPC)	2014-2016	2014-2016	Shared savings / losses
Bundled Payment for Care Improvement (BPCI)	2013-2017	2014-2018	Episode savings / losses
Medicare-Medicaid Managed FFS Model Under Financial Alignment Initiative	2013-2016	2014-2017	Shared savings
Vermont All-Payer ACO	N/A	2017-2018	Shared savings

Program/Models and Demonstration Programs	Experience Years		Payment Type
	2020 Ratebook	2021 Ratebook	
Pioneer ACO	2014-2016	2014-2016	Population-based payment
Next Gen ACO (NGACO)	2016-2017	2016-2018	Population-based payment
Vermont All-Payer ACO	N/A	2017-2018	Population-based payment
Comprehensive Primary Care Plus (CPC+)	2017	2017-2018	Comprehensive Primary Care payments
Comprehensive Primary Care Plus (CPC+)	2017	2017-2018	Performance payment
Comprehensive Primary Care Plus (CPC+)	2017	2017-2018	Care management fees
ESRD			
Comprehensive ESRD Care (CEC)	2016	2016-2017	Shared savings / losses

The key aspects of these adjustments are:

- The adjustments reflect an allocation of the savings and losses based on the distribution of the participating entity's enrollment by county of residence. The adjustments applied to the non-ESRD ratebook exclude experience for beneficiaries in ESRD status as of July 1 of the experience year. (The adjustments for the model(s) noted as ESRD in Table B1-1, which are applied to the ESRD ratebook in a similar manner, would include experience for beneficiaries in ESRD status.)
- The adjustments include the application of the two percent sequestration reduction on these ACO adjustments for claims incurred on or after April 1, 2013.
- Under the models noted as "population-based payment" type in Table B1-1, participants receive a monthly fee that ultimately offsets a percentage reduction in marginal FFS payments over the same year. For each affected claim, the reduction amount represents the portion of the fee associated with that particular claim and is therefore added back to the reduced FFS amount so that the total reimbursement amount is represented.
- Under the CPC+ models, participants receive quarterly payments that replace a percentage of FFS claim amounts for each affected claim. The "comprehensive primary care payments" are included with claim costs to compile the total reimbursement amount.
- In ratebooks for contract years 2020 and earlier, the allocation of the Medicare Shared Savings Program and Innovation Center model and demonstration payment adjustments between the Part A and Part B trust funds was based on the Part A and Part B proportion of the FFS USPCC for each calendar year. Consistent with the actual payments by the trust fund, we are proposing to allocate the entire amount of following payments for all

experience years to the Part B trust fund: (i) Oncology Care Model episode savings / losses, (ii) Comprehensive Primary Care shared savings / losses, and (iii) Comprehensive Primary Care Plus primary care payments, performance payments, and care management fees. This change is expected to have a minimal impact on the tabulation of FFS data and QBP rates. The remaining Medicare Shared Savings Program and Innovation Center model and demonstration payment adjustments will continue to be allocated between the Part A and Part B trust funds based on the Part A and Part B proportion of the FFS USPCC for each calendar year.

- Further information on the Medicare Shared Savings Program may be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram. Further information on the Innovation Center models and demonstrations may be found at: https://innovation.cms.gov/index.html.

Consideration has been given to adjusting the FFS claims experience for care management fees, per-beneficiary-per-month fees, and/or advance payment of shared savings paid to providers for other Innovation Center models conducted in 2014-2018 period.[4] Continuing prior policy, we will not take fees of this type into account in our adjustments to historical FFS experience when they were not funded under Medicare Parts A or B Trust Funds. We have determined that the fees paid under the Multi-Payer Advanced Primary Care Practice Demonstration are already reflected in historical FFS claims, and therefore, no adjustment is warranted.

Note that we will continue to use, as the source of the county designation of beneficiaries used in the summarization of the risk scores, the county assignment used for the ratebook FFS claims and enrollment. For contract years 2016 and earlier, the county assignment for each FFS beneficiary was based on the ZIP code associated with the beneficiary's mailing address. Beginning with the 2017 ratebook, we used the county of residence provided by the Social Security Administration, which is the same county assignment as the ratebook FFS claims and enrollment.

The statutory component of the Regional MA benchmarks will also continue to be based on this proposed county designation of beneficiaries. Under our implementation of section 1858(f)(2) of the Act, the standardized PPO benchmark for each MA region includes a statutory component consisting of the weighted average of the county capitation rates across the region for each appropriate level of star rating. The enrollment weights for the statutory component will reflect the proposed county designation of beneficiaries.

As in prior years, (1) CMS will make additional adjustments to the FFS costs for the items detailed below, and (2) the average of the five year geographic indices, based on the adjusted

[4] Information about the various innovation models is available in the Report to Congress available at: https://innovation.cms.gov/Files/reports/rtc-2018.pdf.

claims data, will be divided by the county's average five-year risk score from the risk adjustment model used for contract year (2021) payment in order to develop the AGA for that county.

Additional Adjustments

Note that incentive payments for adoption and meaningful use of electronic health record (EHR) technology are not included in the claims used to develop the FFS costs and therefore no explicit adjustment is needed to exclude these payments from the FFS costs to comply with section 1853(c)(1)(D).

The following adjustments are made after the AGA is calculated:

- Direct Graduate Medical Education: removed from FFS county costs (section 1853(c)(1)(D)(i) of the Act).
- Indirect Medical Education: removed from FFS county costs (sections 1853(n)(2)(E) and (F) of the Act).
- Credibility: for counties with fewer than 1,000 members, blend county experience with that of others in the market area.
- Veterans Affairs (VA) and Department of Defense (DoD): apply an adjustment to FFS per capita costs for beneficiaries dually enrolled in VA and/or the DoD health programs (the Uniformed Services Family Health Plan (USFHP) and/or the Veterans Health Administration (VHA)) pursuant to section 1853(c)(1)(D)(iii) of the Act. The VA/DoD adjustment is described in more detail in Section B3 below.
- Organ Acquisition Costs for Kidney Transplants: removed from FFS costs, described in more detail in Section B4 below.

B2. Additional Adjustment to FFS per Capita Costs in Puerto Rico

For the past four years, the Secretary has directed the Office of the Actuary to adjust the fee-for-service experience for beneficiaries enrolled in Puerto Rico to reflect the nationwide propensity of beneficiaries with zero claims. For the 2017 – 2020 Rate Announcements, the Office of the Actuary evaluated experience exclusively for beneficiaries who were enrolled in both Parts A and B and were not dually eligible for Veterans Affairs (VA) coverage. The study for setting the CY2020 rates analyzed experience for calendar years 2013 through 2017 and only considered FFS beneficiaries enrolled mid-year. On average, 14.9 percent of A&B Puerto Rico FFS beneficiaries were found to have no Medicare claim reimbursements per year. This compares to a nationwide, non-territory, proportion of 6.1 percent of FFS beneficiaries without Medicare spending. Based on the Secretary's direction, the Puerto Rico FFS weighting of enrollment and risk scores for the zero-claim cohort was adjusted to reflect the nationwide proportion of zero-claim beneficiaries. The resulting impact was measured as an average increase in the standardized per-capita FFS costs in Puerto Rico of 4.7 percent for 2013 through 2017.

Accordingly, a 4.7 percent adjustment was then applied to the pre-standardized Puerto Rico FFS rates supporting the CY 2020 ratebook development.

We are considering whether a similar adjustment should be applied for 2021. The Office of the Actuary will perform an analysis that is similar to the prior analysis but with an updated five years of data: 2014 – 2018. We welcome comments regarding a similar update to Puerto Rico's experience in the development of the 2021 FFS rates. We will review the results of this study and any comments that we receive, and we will specify in the final Rate Announcement any adjustment that we determine may be necessary based on those results and comments.

We are aware of concerns raised by stakeholders regarding the FFS data used to establish MA benchmarks in Puerto Rico. As discussed in the 2017 Advance Notice, the law requires that Medicare Advantage benchmarks be based on a county's average Medicare FFS per-capita cost, and there is no evidence that FFS costs in Puerto Rico are higher than the costs observed in the FFS claims data, and thus no basis for overhauling Puerto Rico's Medicare Advantage benchmarks. As we stated in the 2017 and 2018 Rate Announcements, we believe that the FFS data in Puerto Rico is sufficient for establishing accurate MA benchmarks. The 2020 Advance Notice (page 21) and Rate Announcement (pages 27 and 28) included discussion and analysis of trends in the FFS data, and concluded that our methodology of using five years of FFS experience mitigates annual fluctuations and anomalies in the data that may occur for a variety of reasons. This methodology provides for stability in the rates despite local or regional short-term events such as natural disasters.

B3. Adjustment to FFS per Capita Costs for VA and DoD Costs

We will continue to adjust the FFS rates by the Veterans Affairs (VA) and the Department of Defense (DoD) ratios concurrently based upon an updated study that uses FFS data from calendar years 2013-2017.

To develop an adjustment to the county FFS payment rates for VA, we first analyzed the cost impact of removing Veterans Affairs (VA) dual-benefit eligibles from the Medicare claims and enrollment. Specifically, we calculated the ratio of standardized per capita costs of all Medicare beneficiaries excluding VA dual-benefit eligibles (that is, all non-veteran beneficiaries) to all Medicare beneficiaries (that is, all beneficiaries) for each county.

Similar analysis was done for Department of Defense (DoD). This analysis was performed separately for all DoD and Uniformed Services Family Health Plan (USFHP)-only enrollees to compare the average FFS costs to determine if there were significant differences between the DoD groups and the total Medicare population. To approximate an adjustment to the county FFS payment rates, we analyzed the cost impact of removing the dual-benefit eligibles from the Medicare claims and enrollment. For this analysis, dual-benefit eligibles were defined as those Medicare beneficiaries who are also eligible to receive care through the Department of Defense.

We calculated the ratio of standardized per capita costs of all Medicare beneficiaries excluding dual-benefit eligibles (DoD) to all Medicare beneficiaries (or all beneficiaries) for each county.

We analyzed the ratios in counties with at least 10 members in the respective groups and found that there was no statistical significance of the DoD ratios, but did find that the USFHP-only ratios were significant. Accordingly, adjustments were made to counties with at least 10 USFHP members.

We will continue to apply the VA and DoD (USFHP) adjustments concurrently to the FFS rates using the ratios calculated from this updated study, and publish these ratios with the Rate Announcement.

B4. Organ Acquisition Costs for Kidney Transplants

Section 17006(b) of the 21st Century Cures Act amended section 1853(k) and (n) of the Act to exclude the agency's estimate of the standardized costs for payments for organ acquisition for kidney transplants from MA benchmarks starting in 2021; the amendments provide for exclusion of these costs from both the applicable amount and the base amount (used in calculating the specified amount). Further, section 17006(c) of the 21st Century Cures Act amends section 1851(i) and 1852(a)(1)(B) to require FFS coverage of organ acquisition costs for kidney transplants incurred by MA beneficiaries and to exclude coverage of organ acquisitions for kidney transplants from the benefits that MA plans must provide to their enrollees.

The 21st Century Cures Act did not require Medicare FFS coverage of organ acquisition costs for kidney transplants incurred by PACE participants. Therefore, PACE organizations must continue to cover organ acquisition costs for kidney transplants consistent with the requirement described in section 1894(b)(1)(A)(i) of the Act that PACE organizations provide all Medicare-covered items and services. Accordingly, CMS will continue to include the costs for kidney acquisitions in PACE payment rates–both the county rates and the state ESRD rates–unlike for MA benchmarks.

In order to exclude costs for kidney acquisitions from MA benchmarks by county (or by state for MA ESRD rates), we will first tabulate FFS kidney acquisition costs from the Medicare Cost Reports (Form CMS-2552-10) for calendar years 2014-2018 (the same five years used for the geographic adjustment) by provider (steps 1-3 below). We will then compute the kidney acquisition cost per discharge by provider and use FFS inpatient claims data to develop kidney acquisition costs (steps 4-5). We will then compute the percentage of kidney acquisition costs to total FFS costs for the five-year historical period (steps 6-8). We then apply these ratios to projected 2021 FFS county and state costs (step 9) to carve-out kidney acquisition costs from the MA benchmarks.

The specific steps are outlined below:

1) Extract Medicare's share of kidney acquisition costs and the number of Medicare discharges from the Cost Reports for certified kidney transplant centers.
   a) Note that the "pass-through" amounts are averaged over all Medicare discharges. Therefore, the number of Medicare discharges tabulated from the Cost Reports include both kidney transplant discharges and discharges not related to kidney transplants for certified kidney transplant centers.
2) Allocate these kidney acquisition costs and discharges to calendar years, in proportion to the number of cost report days in each calendar year (2014-2018).
   a) Note that Cost Reports can span/overlap calendar years, and reports can vary in the length of time included. (For example, one Cost Report may include 10/1/2017 through 9/30/2018, while another Cost Report may include 1/1/2018 through 12/31/2018, etc.)
   b) Some transplant centers will have submitted Cost Reports that include the first part of CY 2018, but have not yet submitted cost reports that cover the later portion of CY 2018.
      i) In these cases, we will estimate kidney acquisition costs per discharge for the discharges that will be reported for the later portion of CY 2018. For example, for Cost Reports ending 9/30/2018, we will apply an annual rate of increase to estimate corresponding cost per discharge for reports ending 9/30/2019. To determine this average increase in costs per discharge, we will compute the average annual rate of increase in kidney acquisition costs per discharge for calendar years 2015–2017, aggregated across all transplant centers. Finally, we take ¾ of the cost per discharge for reports ending 9/30/2018 plus ¼ of the cost per discharge for the estimated reports ending 9/30/2019 to arrive at a CY 2018 cost per discharge.
3) Aggregate these kidney acquisition costs and discharges by provider and calendar year.
4) Calculate the kidney acquisition cost per discharge by dividing the kidney acquisition costs by the number of discharges.
5) Calculate the "pass-through" kidney acquisition costs by multiplying the kidney acquisition cost per discharge by the number of Medicare discharges in the kidney transplant center's fee-for-service inpatient claims.
   a) Similar to step 1, the number of Medicare discharges tabulated include both kidney transplant discharges and discharges not related to kidney transplants for certified kidney transplant centers.
   b) The inpatient claims provide the beneficiary county of residence, allowing the "pass-through" kidney acquisition costs to be allocated to counties based on where beneficiaries reside.
6) Aggregate the "pass-through" kidney acquisition costs for each county, or for each state for MA ESRD rates, for the 5-year historical period (2014–2018).
7) Aggregate the Part A and Part B claims for each county, or for each state for MA ESRD rates, for the 5-year historical period (2014–2018).
8) Compute a ratio of the "carve-out" as a percentage of FFS by dividing the results of step 6 by the results of step 7.

9) Multiply this factor by the projected contract year (2021) county FFS costs, or state-level FFS costs for MA ESRD rates, to calculate the "carve-out" amount.

The impact of excluding kidney acquisition costs from the FFS experience as described above varies by jurisdiction, with a FFS enrollment weighted average impact of about $4 PMPM for the MA (i.e., non-PACE) non-ESRD county rates, and a FFS enrollment weighted average impact of about $36 PMPM for the MA (i.e., non-PACE) ESRD state rates. For the 2021 MA (i.e., non-PACE) county rates the largest impact is estimated to be about $20 PMPM, and for the 2021 MA (i.e., non-PACE) ESRD state rates the largest impact is estimated to be about $75 PMPM. With this Advance Notice, we are releasing the preliminary 2021 kidney acquisition cost carve-out factors for MA plans by county and state. This data is available on the CMS website at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html. The final kidney acquisition cost carve-out factors may be updated from these preliminary values when published with the 2021 Rate Announcement.

Section C. IME Phase Out

Section 161 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275) amended section 1853(k)(4) of the Act to require CMS to phase out indirect medical education (IME) amounts from MA capitation rates. Sections 1853(n)(2)(E) and (F) apply the same phase-out to FFS costs in the calculation of the specified amount in setting MA rates. Pursuant to section 1894(d)(3) of the Act, PACE payment amounts are excluded from the IME payment phase-out. Payment to teaching facilities for indirect medical education expenses for MA plan enrollees will continue to be made under fee-for-service Medicare.

For purposes of making this adjustment, we will first calculate the FFS rates including the IME amount. This initial amount will serve as the basis for calculating the IME reduction that we will carve out of the rates. The absolute effect of the IME phase-out on each county will be determined by the amount of IME included in the initial FFS rate. Under section 1853(k)(4)(B)(ii) of the Act, the maximum reduction for any specific county in 2021 is 7.2 percent of the FFS rate. To help plans identify the impact, CMS will separately identify the amount of IME for each county rate in the 2021 MA ratebook. We will continue to publish the rates with and without the IME reduction for the year.

Section D. ESRD Rates

Pursuant to section 1853(a)(1)(H) of the Act, CMS must establish "separate rates of payment" with respect to ESRD beneficiaries enrolled in MA plans. As we stated in the 2012 Rate Announcement (page 32), it is in keeping with our understanding of the legislative intent to more closely align MA payment rates with fee-for-service costs that the ESRD state rates are also based on fee-for-service costs.

We will use the 2014-2018 FFS reimbursement and enrollment data for beneficiaries in dialysis status for each state to develop the 2021 ESRD Medicare Advantage benchmarks. For each year, we compute the FFS dialysis per capita costs (for Part A and Part B items and services for beneficiaries in dialysis status) by state. The geographic indices for each year are calculated by dividing the state per capita cost by the total per capita cost of the nation. The average geographic adjustment (AGA) by state is then determined by calculating a 5-year weighted average of the geographic indices, which is standardized by dividing by the 5-year average risk scores (calculated using the risk adjustment model for contract year (2021) payment). We calculated the 2018 FFS ESRD dialysis United States per capita cost (ESRD dialysis USPCC) based on the 2018 data above, and, using trend factors, develop the prospective 2021 FFS ESRD dialysis USPCC. The 2021 ESRD state rates are determined by multiplying the 2021 FFS ESRD dialysis USPCC by the state AGA.

We will continue to incorporate refinements developed and used in prior years regarding the repricing of historical data in the AGA calculation for the ESRD rates. Similar to the non-ESRD rate methodology, we are proposing to reprice the ESRD historical inpatient, hospital outpatient, and skilled nursing facility claims from 2014-2018 to reflect the most current (i.e., FY 2020) wage indices, and re-tabulate physician claims with the most current (i.e., CY 2020) Geographic Practice Cost Indices. We are proposing to reprice the ESRD PPS dialysis claims for the years 2014-2018. We are proposing to adjust the uncompensated care payments (UCP) represented in the 2014–2018 claims to reflect the requirements of the final rule (CMS-1716-F) (84 FR 42044) titled “Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2020 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals.” The adjustments will also include 2016-2017 shared savings and shared losses performance-based payments made under the Comprehensive ESRD Care (CEC) model.

Starting in 2021, MA benchmarks, including the MA ESRD state rates, must exclude organ acquisition costs for kidney transplants (described in detail in Section B4 above). In addition, the 2021 MA ESRD state rate is adjusted by removing the direct graduate medical education (GME) expenses and the gradual phase-out of indirect medical education (IME) expenses, consistent with such adjustments for the non-ESRD MA rates discussed in Section B1 of this document.

Starting with the CY 2021 MA ESRD state rates, we will publish a file with the CY 2021 Rate Announcement that includes the key components of the rate development, similar to the rate calculation data supporting the MA non-ESRD county rates.

As stated in Section B4, CMS will continue to include organ acquisition costs for kidney transplants in the PACE ESRD state payment rates. As stated in Section C, the IME payment phase-out does not apply to PACE payment amounts. Therefore, for 2021 we propose that the

ESRD state rates used for PACE organizations will include kidney acquisition costs and indirect medical education amounts.

Section E. Location of Network Areas for PFFS Plans in Plan Year 2022

Section 1852(d)(4) of the Act requires MAOs offering certain non-employer MA PFFS plans in network areas to enter into signed contracts with a sufficient number of providers to meet the access standards applicable to coordinated care plans. Specifically, non-employer MA PFFS plans that are offered in a network area (as defined in section 1852(d)(5)(B) of the Act) must meet the access standards described in section 1852(d)(4)(B) through written contracts with providers. These PFFS plans may not meet access standards by establishing payment rates that are at least the rates that apply under Original Medicare and having providers deemed to be contracted as described in § 422.216(f).

Network area is defined in section 1852(d)(5)(B) of the Act, for a given plan year, as an area that the Secretary identifies (in the announcement of the proposed payment rates for the previous plan year under section 1853(b)(1)(B)) as having at least 2 network-based plans (as defined in section 1852(d)(5)(C)) with enrollment as of the first day of the year in which the Announcement is made. We will include a list of network areas for plan year 2022 in the final Announcement of Calendar Year (CY) 2021 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies. We will make this list available on the CMS website at https://www.cms.gov/Medicare/Health-Plans/PrivateFeeforServicePlans/NetworkRequirements. We will use January 1, 2020 enrollment data to identify the location of network areas for plan year 2022.

Section F. MA Employer Group Waiver Plans

We intend to continue to waive the Bid Pricing Tool bidding requirements for all MA employer/union-only group waiver plans (EGWPs) for 2021. As a condition of the waiver of the bidding requirements and the waivers otherwise provided to EGWPs, CMS will establish payment amounts using the same methodology for 2021 as was used for 2020. As has been the case since 2017, for 2021, Part C entities offering employer/union-only group waiver plans will not be required to submit Part C bid pricing information in the Part C bid pricing tool. CMS has authority under section 1857(i) of the Act to waive or modify requirements that hinder the design of, the offering of, or the enrollment in employment-based Medicare plans offered by employers and unions to their members. Waiving the requirement to submit 2021 Part C bid pricing information will facilitate the offering of Part C plans for employers and unions seeking to establish high quality coverage for their Medicare eligible retirees by avoiding the cost and administrative burden of submitting the complex bids required from non-EGWPs. We refer the reader to the detailed discussion of our rationale and responses to commenters' questions in the CY 2017 Rate Announcement, Attachment III, Section F (pages 27-44) for additional information, and responses to questions received by the Office of the Actuary are available at

https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/ActuarialBidQuestions.

In connection with the continuation of this waiver, for 2021, CMS will continue to use the payment methodology implemented for MA EGWPs, as finalized in the 2020 Rate Announcement.

The calculations for the bid-to-benchmark (B2B) ratios would therefore be as follows:

> First: [(Weighted Average of the Intra-Service Area Rate Adjustment (ISAR) Adjusted County Bid Amounts for 2020 Individual Market Plan Bids by February 2020 Actual Enrollment)/(Weighted Average of the County Standardized Benchmarks for 2020 Individual Market Plans by February 2020 Actual Enrollment)] = 2020 Individual Market B2B Ratios by Quartile.[5]
>
> Second: The 2020 individual market B2B ratios will be calculated separately for HMO plan types and PPO plan types by quartile.[6] The PPO B2Bs by quartile will be weighted by the total proportion of EGWP PPO plan type enrollment, and the HMO B2Bs by quartile will be weighted by the total proportion of EGWP HMO plan type enrollment to result in the final B2B ratios for 2021 by quartile.

As has been in effect since 2017, for 2021:

- The B2B ratios will be applied to each of the published 5%, 3.5%, and 0% bonus county ratebook rates for the payment year to establish Part C base payment amounts for EGWPs based on their Star Rating, for each county.
- In order to calculate a county rebate payment, each county-level EGWP Part C base payment amount will be compared to the corresponding published 5%, 3.5%, and 0% bonus county benchmarks for the payment year (2021), which include adjustments for qualifying counties, to determine the amount of savings. The savings amount will be multiplied by the corresponding rebate percentage to determine the Part C EGWP county-level rebate amount.

---

[5] As in prior years, territories will not be included in the weighted average B2B ratio, but they will be assigned the weighted average of the quartile within which their counties fall. To determine the CY 2021 applicable percentages, CMS ranks counties from highest to lowest based upon their 2020 average per capita FFS costs and places the rates into four quartiles. When calculating the 2020 B2B ratios, CMS will group counties by the 2020 unblended quartiles and will then apply these B2B ratios to the 2021 unblended quartiles.

[6] Consistent with 2020, HMO and HMOPOS plans have been combined into an "HMO plan type" and LPPO and RPPO plans have been combined into a "PPO plan type." "HMO" Health Maintenance Organization, "HMOPOS" Health Maintenance Organization Point of Service, "PPO" Preferred Provider Organization, "LPPO" Local Preferred Provider Organization "RPPO" Regional Preferred Provider Organization. "PFFS" Private Fee-for-Service individual market plans are excluded from these calculations.

- The EGWP Part C base payment amount will be added to the Part C EGWP rebate amount to establish the county-level local EGWP total payment amount.
- The total payment amount will be risk adjusted in payment using beneficiary-specific risk scores. Therefore, the formula applied for local EGWP payment on a per-beneficiary basis would be: (Base County Payment Rate + County Rebate) × Beneficiary-Level Risk Score.

For RPPO EGWPs, the weighted average B2B ratios will continue to be calculated as described above. To establish the Part C base RPPO EGWP payment amount, we will then also continue to apply the same methodology as described above.

In order to calculate the RPPO EGWP rebate amounts, these percentages will continue to be applied for each county within a region to the published payment year regional benchmarks to establish the savings amount and rebate amounts by Star Rating and quartile.

The RPPO EGWP Payment Formula continues to be (Base County Payment Rate + Regional Rebate) × Beneficiary-Level Risk Score, where each is calculated as follows:

- Base County Payment Rate = Bid to Benchmark Ratio × 2021 MA Monthly Capitation Rate
- Regional Rebate = (1 − Bid to Benchmark Ratio) × 2021 Regional Rate × Rebate Percentage
- The 2021 Regional rate is based on a blend of the statutory and bid component. As with non-EGWPs, if there is no bid component of the 2021 Regional rate (i.e., no individual bids in a region), then the EGWP rate will be based solely on the statutory component.

As has been the case since 2017, for 2021 there will be no Part C Regional PPO EGWP bids to include in the calculation of the MA regional benchmarks. The statutory components of the regional standardized A/B benchmarks will continue to be published each year as part of the Announcement of Medicare Advantage Payment Rates. CMS will also continue to publish the final MA regional standardized A/B benchmarks in late summer, which will reflect the average bid component of the regional benchmark based on non-EGWP bid submissions.

For 2021, we will also continue the existing policy permitting MA EGWPs to buy down Part B premiums for their enrollees, using a portion of the Part C payment. A detailed discussion of this policy appears in the CY 2020 Advance Notice, Part II, Section F (pages 26-27).

We will continue to collect a Part B premium buy-down amount in the EGWP's Plan Benefit Package (PBP) submission to CMS. Any MA EGWP that chooses to use a portion of its payment to buy down the Part B premium must do so in accordance with uniformity of benefit rules and apply such Part B premium buy-down amount consistently to every beneficiary enrolled in the EGWP. Those MA EGWPs that choose to use a portion of their payment to buy down the Part B premium for their enrollees will have that amount reduced from their capitated payment. For

example, if an MA EGWP determines that under its benefit offering there will be a $5.00 reduction to each of its enrollee's Part B premium, $5.00 per member per month will entered into the requisite field in the PBP, and then $5.00 will be subtracted from the monthly capitated amount. For local MA EGWPs this will be reflected in the proposed payment formula described above as follows:

Total payment = (base county payment rate + county rebate) × beneficiary level risk score - *Part B buy down amount*.

MA EGWPs will continue to be prohibited from separately refunding Part B premiums for their enrollees outside of this process.

As in 2020, MA EGWPs will be subject to the same maximum CY 2021 Part B buy-down amount as non-EGWP plans. That is, EGWPs may only buy down the Part B premium up to the maximum amount displayed in the CY 2021 MA Bid Pricing Tool Worksheet 6. Additionally, similar to non-EGWP plans, the Part B buy-down amount cannot vary among beneficiaries under a plan. The Part B buy-down amount applies to every beneficiary under the plan ID. Therefore, if an EGWP would like to reduce the Part B premium for one employer group under the plan ID by $5 and reduce the Part B premium for another employer group by $10, then two separate EGWP plan IDs would need to be established/utilized. As an example, the PBP for plan 801 would contain a $5 buy-down amount and the PBP for plan 802 would contain a $10 buy-down amount.

The following rules will continue to apply as they have since 2017 under the EGWP payment methodology:

- CMS will continue to waive the requirement that MA EGWPs must allocate rebate dollars to any specific purpose for 2021.
- MA EGWPs will not receive capitation payments for members that elect Hospice.
- MA EGWPs will continue to be paid using the ESRD ratebook for their ESRD beneficiaries in Transplant and Dialysis status and the individual market MA ratebook for those beneficiaries in Functioning Graft status, in keeping with the current payment policy for non-EGWP MAOs.
- Consistent with how CMS pays capitation for Part B-only enrollees in the non-EGWP context, Part B-only MA EGWPs will continue to receive only the Part B portion of the EGWP payment amount, which is determined by multiplying it by the Part B percentage of the MA rate.
- MA EGWP MSA plans will continue not to submit Bid Pricing Tools for 2021, but the 2021 local EGWP payment rates will continue to not be applied to EGWP MSA plans. The monthly prospective payments for EGWP MSAs will be based on the following formula: 2021 MA Monthly Capitation County Rate x beneficiary risk score – 1/12 of the Annual MSA Deposit Amount. The 2021 Annual MSA Deposit Amount must be submitted in the appropriate Plan Benefit Package field. Consistent with individual

market MSA plans, MA EGWP MSA plans will not be able to use a portion of the Part C payment to buy down the Part B premium.

- Notwithstanding the payment policies as described above, entities offering MA EGWPs must continue to meet all of the CMS requirements that are not otherwise specifically waived or modified, including, but not limited to, submitting information related to plan service areas, plan benefit packages and formularies in accordance with the rules for 2021. MAOs must continue to make a good faith effort in projecting CY 2021 member months for each plan and place the amount in the appropriate section of the 2021 Plan Benefit Package (PBP) submissions to CMS.

Section G. CMS-HCC Risk Adjustment Model for CY 2021

On January 6, 2020, CMS published for public comment the proposal related to the Part C risk adjustment model in Part I of the Advance Notice. For CY 2021, CMS is proposing to continue phasing in the CMS-HCC model that was first implemented for CY 2020 (i.e., the 2020 CMS-HCC model). CMS is proposing to continue using the 2020 CMS-HCC model to calculate encounter data-based risk scores and the 2017 CMS-HCC model to calculate RAPS-based risk scores. Under this proposal, 75% of the risk score calculated with the 2020 CMS-HCC model will be summed with 25% of the risk score calculated with the 2017 CMS-HCC model. Also in Part I, we proposed the continued use of the 2017 CMS-HCC model to calculate risk scores for PACE organizations for non-ESRD aged/disabled participants for CY 2021. As noted in Part I of the Notice, all comments must be submitted to https://www.regulations.gov/. To submit comments or questions electronically, go to https://www.regulations.gov, enter the docket number "CMS-2020-0003" in the "Search" field, and follow the instructions for "submitting a comment." As noted above, comments on Part I proposals will be accepted until 6:00 pm Eastern Standard Time on Friday, March 6, 2020. We will address comments in the 2021 Rate Announcement that will be released no later than April 6, 2020.

Section H. ESRD Risk Adjustment Models for CY 2021

CMS uses separate models to calculate the risk scores applied in payment for the Part A and Part B benefits provided to beneficiaries in ESRD status when enrolled in MA plans, PACE organizations, and certain demonstrations. For CY 2020, CMS began implementation of updated versions of the ESRD dialysis and ESRD functioning graft models (i.e., 2020 ESRD models). For CY 2020 risk adjustment for ESRD, we are blending 50% of the risk score using the 2019 ESRD models (using diagnoses from RAPS and FFS) summed with 50% of the risk score calculated with the 2020 ESRD models (using diagnoses from encounter data, RAPS inpatient records, and FFS).

Consistent with the proposal in Part I of the Advance Notice for the Part C risk adjustment model, for CY 2021, CMS proposes to calculate risk scores for payment of ESRD beneficiaries in MA plans and certain demonstrations by continuing to use the ESRD models implemented in

2020. Specifically, under this proposal, 75% of the risk score calculated with the 2020 ESRD models will be summed with 25% of the risk score calculated with the 2019 ESRD models. For PACE organizations, CMS proposes to continue using the 2019 ESRD dialysis and ESRD functioning graft models to calculate ESRD risk scores for CY 2021.

Refer to Section M for information on encounter data as a source of diagnoses for CY 2021 ESRD risk score calculation.

Section I. Frailty Adjustment for PACE Organizations and FIDE SNPs

Section 1894(d)(2) of the Act requires CMS to take into account the frailty of the PACE population when establishing the capitated payment amounts for PACE organizations. In addition, section 1853(a)(1)(B)(iv) allows CMS to make an additional payment adjustment that takes into account the frailty of beneficiaries enrolled in Fully Integrated Dual Eligible (FIDE) Special Needs Plans (SNPs), if the average level of frailty in the FIDE SNP is similar to the PACE program. For PACE organizations and eligible FIDE SNPs, the adjustment is made by adding a frailty score to a beneficiary's risk score.

CMS applies a frailty adjustment to the payment amounts for PACE organizations and FIDE SNPs in order to address additional costs not explained by diagnoses in the CMS-HCC model. CMS calibrates the frailty factors by regressing the residual, or unexplained, costs from the CMS-HCC risk adjustment model onto counts of activities of daily living (ADLs).[7] Residual costs are unique to each version of the CMS-HCC model, and consequently, so are the frailty factors. For this reason, CMS updates the frailty factors whenever the CMS-HCC model changes.

For FIDE SNPs in CY 2021, we will continue to use the CY 2020 frailty factors for the 2017 CMS-HCC model. We will also continue to use the CY 2020 frailty factors for the 2020 CMS-HCC model. The frailty factors for the 2017 CMS-HCC model are in Table II-4 and the frailty factors for the 2020 CMS-HCC model are in Table II-5; these factors were originally published in the CY 2020 Advance Notice.

Consistent with CMS' proposal described in Part I of the Advance Notice to blend the risk scores calculated for enrollees in MA plans, we also propose to blend the frailty score applied in FIDE SNP's payment. We propose to blend 75 percent of the frailty score calculated with the frailty factors associated with the 2020 CMS-HCC model with 25 percent of the frailty score calculated with the frailty factors associated with the 2017 CMS-HCC model. The blended frailty score will be compared with the PACE level of frailty in the same manner as CY 2020 to determine whether that FIDE SNP has a similar average level of frailty as PACE.

[7] Refer to section 80 of Chapter 7 of the Medicare Managed Care Manual for frailty model calibration information: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf.

MA organizations that are planning to sponsor a FIDE SNP and that wish to receive frailty payments in 2021, must contract with a CMS-approved survey vendor to field the 2020 Health Outcomes Survey (HOS), or the 2020 Modified Health Outcomes Survey (HOS-M) at the PBP level. CMS uses the activities of daily living (ADLs) obtained from the HOS or HOS-M, to calculate frailty scores for FIDE SNPs.

As noted in Part I of the 2021 Advance Notice, for PACE organizations, we propose to continue to use the 2017 CMS-HCC model to calculate risk scores used to pay for Part A and B services in CY 2021. Consistent with the Part I proposal, we will use the frailty factors associated with the 2017 CMS-HCC model (Table II-4) to calculate frailty scores for PACE organizations in CY 2021.

Table II-4. Frailty Factors Associated with the 2017 CMS-HCC Model

ADL	Non-Medicaid	Medicaid
0	-0.083	-0.093
1-2	0.124	0.105
3-4	0.248	0.243
5-6	0.248	0.420

Table II-5. Frailty Factors Associated with the 2020 CMS-HCC Model

ADL	Non-Medicaid	Medicaid
0	-0.078	-0.134
1-2	0.161	0.025
3-4	0.293	0.155
5-6	0.293	0.370

Section J. Medicare Advantage Coding Pattern Adjustment

To meet the requirements of section 1853(a)(1)(C)(ii) of the Act, each year, CMS has implemented an across-the-board adjustment to offset the effects on MA risk scores of higher levels of coding intensity in MA, relative to FFS. Per the statute, the minimum adjustment factor for 2019 and each subsequent year is 5.90 percent.

For CY 2021, CMS proposes to apply the statutory minimum MA coding pattern adjustment of 5.90 percent.

Section K. Normalization Factors

The Part C risk adjustment model is calibrated with diagnostic and cost information for beneficiaries enrolled in Original Medicare who are entitled to Part A, enrolled in Part B, and not in End Stage Renal Disease (ESRD) or hospice status. The model estimates incremental costs for a variety of beneficiary characteristics (e.g., age and gender) and health conditions in a historical

period (or "calibration year"). Each model variable's incremental cost estimate, referred to as a dollar coefficient, is divided by the predicted average per capita expenditure for beneficiaries in Original Medicare in a given year (the denominator) to create relative factors. Risk scores are the sum of relative factors assigned to each beneficiary based on their demographic characteristics and health status. For beneficiaries in Original Medicare, the average risk score is 1.0 in the denominator year.

When a risk adjustment model predicts expenditures in years other than the denominator year (prior or future years), the average risk score for Original Medicare beneficiaries may no longer be 1.0 due to an underlying trend that reflects changes, such as those in coding and population characteristics, between the denominator year and other years. CMS applies a normalization factor to risk scores in the payment year to account for this trend in the average Original Medicare risk score between the denominator year risk score (1.0) and the payment year. The normalization factor is a projection of this trend, and applying the factor effectively keeps the average risk score at 1.0 in the payment year for beneficiaries in Original Medicare.[8]

In determining the Part C normalization factor under each model, we use the observed trend to predict the average risk score of beneficiaries in Original Medicare in the payment year, calculated using the model that will be used in the payment year. In determining the RxHCC normalization factor, we use the observed trend to predict the average risk score of beneficiaries enrolled in Part D plans, including MA-PD plans and PDP plans, in the payment year. As with Part C, the Part D normalization factor is calculated using the model that will be used in the payment year.

CMS calculates each normalization factor annually with historical risk score data and the payment year risk adjustment model. This annual update serves two purposes. First, it is important to keep the average risk score at 1.0 for beneficiaries in Original Medicare so that risk scores in the payment year align with the rates, which are standardized to an average risk score of 1.0. A risk score accounts for the degree to which a beneficiary's health status results in expected costs that are more or less than the expected cost of the average beneficiary in Original Medicare. The rates, which are the benchmarks for Part C bidding, represent the expected cost of an average beneficiary in Original Medicare in the payment year. Normalization helps to ensure that risk adjusted payments for individual Medicare Advantage beneficiaries account for the underlying trend in FFS risk score.

Second, updating the normalization factor annually stabilizes payments between model calibrations. Periodically, CMS updates the risk adjustment model with more current data, and resets the year that the average risk score is 1.0 (i.e., the denominator year). Because there is a trend between the denominator year and the payment year, applying a normalization factor to

[8] See §1853(a)(1)(C)(ii)(I) of the Act.

risk scores provides year-over-year stability and avoids the volatility that would otherwise occur when the model is updated with a more recent denominator.

The risk scores that underlie the normalization factor calculation have been increasing at a faster rate in recent years. We believe there are a number of reasons for this increase, including changes in demographics, the reported health status in the Original Medicare population, and the implementation of ICD-10. We expect the effect on the change in average risk score from implementing ICD-10 to stabilize moving forward. However, we believe that demographic trends, an incentive to report diagnosis codes more completely in alternative payment models (which are increasing in penetration), and a changing case mix in Original Medicare may continue to put upward pressure on Original Medicare risk scores. Therefore, for CY 2021 we are proposing to maintain the same methodology as that used for CY 2020 for calculating the normalization factor. We propose to project the slope, calculated from the observed trend over five years of historical risk scores, from the denominator year to the payment year. We apply the equation (1+X)^n where X is the slope calculated from the trend of historical FFS risk scores and the exponent n is the number of years between the denominator year and the payment year to calculate the normalization factor. Given the observed historical data, this proposed methodology results in an increase in the normalization factor relative to CY 2020.

In Part I of the Advance Notice, published January 6, 2020, CMS proposed to blend 25 percent of the risk score calculated with the 2017 CMS-HCC model with 75 percent of the risk score calculated with the 2020 CMS-HCC model that complies with the requirements in section 1853(a)(1)(I) of the Act. Consistent with that proposal, for CY 2021, CMS proposes to calculate two normalization factors for calculating these two separate risk scores, which will then be blended, for non-ESRD aged/disabled enrollees in MA plans and certain demonstrations. One normalization factor will be used to normalize the risk scores calculated with the 2017 CMS-HCC model, and the other will be used to normalize the risk scores calculated with the 2020 CMS-HCC model. Since we propose to use the 2017 CMS-HCC model for calculating risk scores for non-ESRD aged/disabled participants of PACE organizations, we are proposing to use the 2017 CMS-HCC model normalization factor when calculating PACE risk scores for CY 2021.

The proposed Part C and PACE normalization factor for the 2017 CMS-HCC model is 1.106 and the proposed Part C normalization factor for the 2020 CMS-HCC model is 1.097. The proposed ESRD dialysis normalization factor is 1.079. The proposed ESRD functioning graft normalization factor is 1.118. The preliminary normalization factors for each of these models and the annual trends are in subsections K1 through K3.

The proposed Part D normalization factor for the 2020 RxHCC model, which we will continue to use for CY 2021, is 1.063. The preliminary normalization factor and the annual trend are in subsection K4.

The 2021 Rate Announcement, released no later than April 6, 2020, will contain the finalized CY 2021 normalization factors.

K1. Normalization for the CMS-HCC Models

The proposed 2021 normalization factor estimated from the 2017 CMS-HCC risk adjustment model is 1.106, and estimated from the 2020 CMS-HCC risk adjustment model is 1.097. Both the 2017 CMS-HCC model and the 2020 CMS-HCC model have a 2015 denominator. There are six years of trend between the denominator year and the payment year for both models.

The normalization factors for the CMS-HCC risk adjustment models are applied to the 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, and C-SNP new enrollee risk scores. The risk scores used to calculate the proposed 2021 normalization factor for the 2017 CMS-HCC model and the 2020 CMS-HCC model are included in Table II-6 Part C Normalization Factor Trends.

Table II-6. Part C Normalization Factor Trends

Year	2017 CMS-HCC Model	2020 CMS-HCC Model
2015	1.001	1.000
2016	1.021	1.020
2017	1.035	1.031
2018	1.054	1.049
2019	1.069	1.063

K2. Normalization for the ESRD Dialysis Models

The proposed 2021 normalization factor estimated for the ESRD dialysis risk adjustment models is 1.079. Both the 2019 and 2020 ESRD dialysis models have a 2015 denominator, and there are six years of trend between the denominator year and the payment year. There is minimal difference between the denominator of the 2019 ESRD dialysis model and the 2020 ESRD dialysis model, and the FFS risk scores in the trend under each model are the same. Because of these similarities, the normalization factor for the 2020 ESRD dialysis model is the same normalization factor for the 2019 ESRD dialysis model.

The normalization factor for the ESRD dialysis models is applied to dialysis, dialysis new enrollee, and transplant risk scores. The risk scores in the trend used to calculate the proposed normalization factor for the ESRD dialysis models are included in Table II-7 ESRD dialysis Normalization Factor Trends.

Table II-7. ESRD Dialysis Normalization Factor Trends

Year	ESRD Dialysis Models
2015	1.000
2016	1.015
2017	1.030
2018	1.041
2019	1.051

K3. Normalization for the ESRD Functioning Graft Models

The proposed 2021 normalization factor for the ESRD functioning graft risk adjustment models is 1.118. Both the 2019 and 2020 ESRD functioning graft models have a 2015 denominator, and there are six years of trend between the denominator year and the payment year. There is minimal difference between the denominators for each model and the FFS risk scores in the trend under each model are the same. Because of these similarities, the normalization factor for the 2020 ESRD functioning graft model is the same normalization factor for the 2019 ESRD functioning graft model. The trend for the ESRD functioning graft model is calculated using FFS beneficiaries who are entitled to Part A, enrolled in Part B, and who do not have ESRD, or who are not in hospice status.

The normalization factor for the ESRD functioning graft models is applied to the functioning graft community, functioning graft institutional, and functioning graft new enrollee risk scores. The risk scores in the trend used to calculate the proposed normalization factor for the ESRD functioning graft models are included in Table II-8 ESRD Functioning Graft Normalization Factor Trend.

Table II-8. ESRD Functioning Graft Normalization Factor Trend

Year	ESRD Functioning Graft Models
2015	1.000
2016	1.024
2017	1.039
2018	1.059
2019	1.076

K4. Normalization for the RxHCC Model

The proposed 2021 normalization factor for the 2020 RxHCC risk adjustment model, which we will continue to use for CY 2021, is 1.063. The RxHCC model has a 2015 denominator. There are six years of trend between the denominator year and the payment year.

The normalization factor for the RxHCC model is applied to all Part D risk scores for beneficiaries enrolled in an MA-PD or PDP plan. The risk scores in the trend used to calculate the proposed 2021 normalization factor for the RxHCC model are calculated using beneficiaries enrolled in both MA-PDs and PDPs, and are included in Table II-9 RxHCC Normalization Factor Trend.

Table II-9. RxHCC Normalization Factor Trend

Year	2020 RxHCC Model
2014	0.996
2015	1.000
2016	1.015
2017	1.024
2018	1.035

Section L. Medical Loss Ratio Credibility Adjustment

The regulations at §§ 422.2440 and 423.2440 provide for the application of a credibility adjustment to the medical loss ratios (MLRs) of certain contracts with relatively low enrollment. In the CY 2021 proposed rule, which was posted for display at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-02085.pdf on February 5, 2020 and is scheduled for publication in the Federal Register, we propose to codify in the regulations at §§ 422.2440 and 423.2440 the credibility factors that CMS published in the Medicare Program; Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs Final Rule (78 FR 31284, 31295-96). These factors appear below in Tables II-10 and II-11. We encourage interested stakeholders to submit comments on this proposal. Comments must be submitted using the procedures outlined in the proposed rule to be considered.

Table II-10. Base Credibility Factors for MA Contracts

Member months	Base credibility factor (additional percentage points)
< 2,400	N/A (Non-credible)
2,400	8.4
6,000	5.3
12,000	3.7

Member months	Base credibility factor (additional percentage points)
24,000	2.6
60,000	1.7
120,000	1.2
180,000	1.0
> 180,000	0.0 (Fully credible)

Table II-11. Credibility Adjustments for Part D Contracts

Member months	Credibility adjustment (additional percentage points)
< 4,800	N/A (Non-credible)
4,800	8.4
12,000	5.3
24,000	3.7
48,000	2.6
120,000	1.7
240,000	1.2
360,000	1.0
> 360,000	0.0 (Fully credible)

In the CY 2021 proposed rule, we also proposed to include an additional adjustment factor for MA medical savings account (MSA) contracts that receive an MLR credibility adjustment. We encourage interested stakeholders to submit comments on this proposal. Comments must be submitted using the procedures outlined in the proposed rule to be considered.

Section M. Encounter Data as a Diagnosis Source for CY 2021

On January 6, 2020, CMS published for public comment Part I of the CY 2021 Advance Notice. Part I contains proposals regarding the Part C risk adjustment model and the use of encounter data as a diagnosis source for CY 2021 for risk adjustment payments for aged and disabled beneficiaries based on the 2020 CMS-HCC model, as well as information for PACE risk adjustment. As indicated in that notice, all comments must be submitted to www.regulations.gov. Enter the docket number "CMS-2020-0003" in the "Search" field, and follow the instructions for "submitting a comment." As noted above, comments on the Part I proposals will be accepted until 6 pm EST on Friday, March 6, 2020. We will address comments in the 2021 Rate Announcement that will be released no later than April 6, 2020.

For CY 2021, to calculate ESRD dialysis and ESRD functioning graft risk scores, CMS will continue to use the 2019 ESRD dialysis and functioning graft models (i.e., 2019 ESRD models) to calculate RAPS-based risk scores and the 2020 ESRD dialysis and functioning graft models

(i.e., 2020 ESRD models) to calculate encounter data-based risk scores. Specifically, for CY 2021, we propose to calculate ESRD dialysis and ESRD functioning graft risk scores by summing:

- 75% of the risk score calculated with risk adjustment eligible diagnoses from encounter data (supplemented with RAPS inpatient records) and FFS claims using the 2020 ESRD models, and
- 25% of the risk score calculated with risk adjustment eligible diagnoses from RAPS data and FFS using the 2019 ESRD models.

We envision the inclusion of inpatient RAPS data in the encounter data-based risk scores as a temporary approach to minimize the potential impact on risk scores from incomplete data for the remaining plans that may face operational challenges submitting encounter data records.

For PACE organizations for CY 2021, we propose to continue to use the 2017 CMS-HCC model to calculate risk scores for non-ESRD aged/disabled participants and the 2019 ESRD models to calculate risk scores for participants with ESRD. We propose to continue the same method of separately calculating both sets of risk scores for PACE organizations that we have been using since CY 2015, which is to pool risk adjustment-eligible diagnoses from the following sources to calculate a single risk score (with no weighting): (1) encounter data, (2) RAPS data, and (3) FFS claims.

Attachment III. Changes in the Payment Methodology for Medicare Part D for CY 2021

Section A. RxHCC Risk Adjustment Model

CMS uses the RxHCC risk adjustment model to adjust the direct subsidy payments for Part D benefits offered by stand-alone Prescription Drug Plans (PDPs) and Medicare Advantage-Prescription Drug Plans (MA-PDs). For CY 2021, CMS will continue to use the 2020 RxHCC model to calculate Part D risk scores.

Refer to Section B for information on encounter data as a source of diagnoses for Part D risk score calculation.

Section B. Encounter Data as a Diagnosis Source for CY 2021

For CY 2020, CMS implemented an updated version of the RxHCC model to calculate risk scores by adding 50% of the risk score calculated using diagnoses from encounter data (supplemented with RAPS inpatient data records) and FFS with 50% of the risk score calculated using RAPS data and FFS diagnoses.

For CY 2021, CMS will continue to use the 2020 RxHCC model to calculate Part D risk scores. CMS proposes to calculate risk scores using the 2020 RxHCC model for CY 2021 by adding 75% of the risk score calculated with risk adjustment eligible diagnoses from encounter data (supplemented with RAPS inpatient records) and FFS claims with 25% of the risk score calculated using risk adjustment eligible diagnoses from RAPS data and FFS claims.

As previously noted, we envision the inclusion of RAPS inpatient records in the encounter data risk score as a temporary approach to minimize the potential impact on risk scores from incomplete data for the remaining plans that may face operational challenges submitting encounter data records.

For PACE organizations for CY 2021, we will also continue using the 2020 RxHCC model to calculate Part D risk scores using the same method we have been using since CY 2015, which is to pool risk adjustment-eligible diagnoses from the following sources to calculate a single risk score (with no weighting): (1) encounter data, (2) RAPS data, and (3) FFS claims.

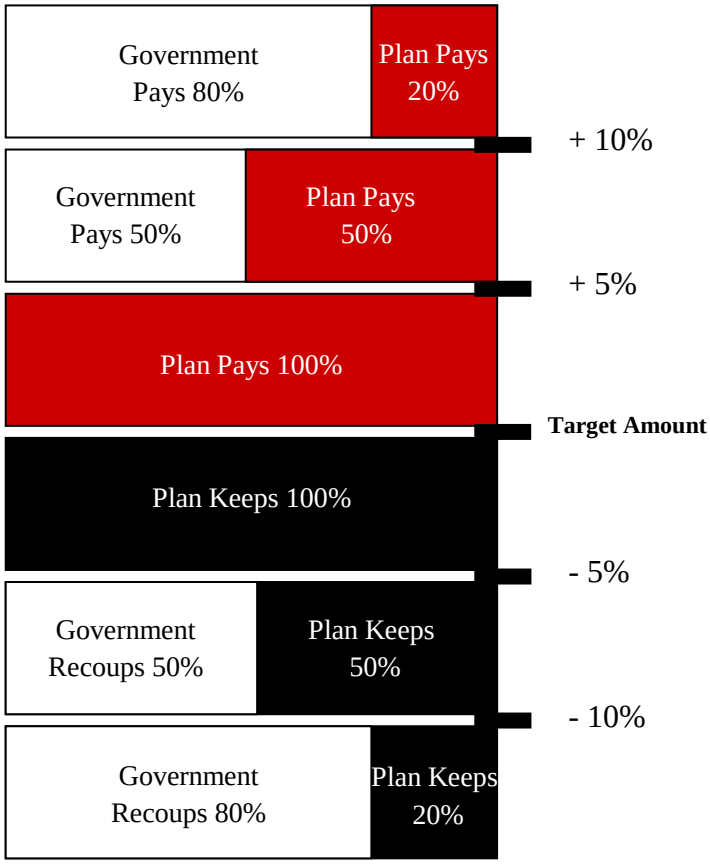
Section C. Part D Risk Sharing

The risk sharing payments provided by CMS limit Part D sponsors' exposure to unexpected drug expenses. Pursuant to section 1860D-15(e)(3)(C) of the Act and § 423.336(a)(2)(ii) of our regulations, CMS may establish a risk corridor with higher threshold risk percentages for Part D risk sharing beginning in contract year 2012. Widening the risk corridor would increase the risk associated with providing the Part D benefit and reduce the risk sharing amounts provided (or recouped) by CMS. While CMS may widen the risk corridors, the statute does not permit CMS to narrow the corridors relative to the 2011 thresholds.

CMS has evaluated the risk sharing amounts for 2008–2017 to assess whether they have decreased or stabilized. A steady decline or stabilization in the Part D risk sharing amounts would suggest that Part D sponsors have significantly improved their ability to predict Part D expenditures. However, CMS has found that risk sharing amounts continue to vary significantly in aggregate from year to year and among Part D sponsors in any given year. Therefore, we do not believe it is appropriate to adjust the parameters at this time, and we will apply no changes to the current threshold risk percentages for contract year 2021. We will continue to evaluate the risk sharing amounts each year to determine if wider corridors should be applied for Part D risk sharing.

Thus, the risk percentages and payment adjustments for Part D risk sharing are unchanged from contract year 2020. The risk percentages for the first and second thresholds remain at +/- 5 percent and +/- 10 percent of the target amount, respectively, for 2021. The payment adjustments for the first and second corridors are 50 percent and 80 percent, respectively. Figure 1 below illustrates the risk corridors for 2021.

Figure 1. Part D Risk Corridors for 2021



C1. Risk sharing when a plan's adjusted allowable risk corridor costs (AARCC) exceed the target amount

For the portion of a plan's adjusted allowable risk corridor costs (AARCC[9]) that is between the target amount and the first threshold upper limit (105 percent of the target amount), the Part D sponsor pays 100 percent of this amount. For the portion of the plan's AARCC that is between the first threshold upper limit and the second threshold upper limit (110 percent of the target amount), the government pays 50 percent and the plan pays 50 percent. For the portion of the plan's AARCC that exceeds the second threshold upper limit, the government pays 80 percent and the plan pays 20 percent.

Example: If a plan's AARCC is $120 and its target amount is $100, the Part D sponsor and the government cover $9.50 and $10.50, respectively, of the $20 in unanticipated costs. The sponsor's responsibility is calculated as follows:

$$100\% \text{ of } (\$105 - \$100) + 50\% \text{ of } (\$110 - \$105) + 20\% \text{ of } (\$120 - \$110).$$

C2. Risk sharing when a plan's adjusted allowable risk corridor costs (AARCC) are below the target amount

If a plan's AARCC is between the target amount and the first threshold lower limit (95 percent of the target amount), the plan keeps 100 percent of the difference between the target amount and the plan's AARCC. If a plan's AARCC is between the first threshold lower limit and the second threshold lower limit (90 percent of the target amount), the government recoups 50 percent of the difference between the first threshold lower limit and the plan's AARCC. The plan would keep 50 percent of the difference between the first threshold lower limit and the plan's AARCC, as well as 100 percent of the difference between the target amount and first threshold lower limit. If a plan's AARCC is less than the second threshold lower limit, the government recoups 80 percent of the difference between the plan's AARCC and the second threshold lower limit, as well as 50 percent of the difference between the first and second threshold lower limits. In this case, the plan would keep 20 percent of the difference between the plan's AARCC and the second threshold lower limit, 50 percent of the difference between the first and second threshold lower limits, and 100 percent of the difference between the target amount and the first threshold lower limit.

Example: If a plan's AARCC is $80 and its target amount is $100, the Part D sponsor keeps $9.50 while the government recoups $10.50 of the $20 in unexpected savings generated. The sponsor's share is calculated as follows:

---

[9] Per §423.336(a), the "adjustment allowable risk corridor costs" for a Part D plan are the allowable risk corridor costs for a Part D plan for the coverage year, reduced by the sum of the total reinsurance payments and total low income cost-sharing subsidies paid to the sponsor of the Part D plan for the coverage year.

100% of ($100 − $95) + 50% of ($95 − $90) + 20% of ($90 − $80)

Section D. Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2021

In accordance with section 1860D-2(b) of the Act, CMS updates the statutory parameters for the defined standard Part D prescription drug benefit each year. These annual adjustments ensure that the actuarial value of the drug benefit remains consistent with changes in Part D drug expenses.

As required by statute, the following Part D benefit parameters are updated using the annual percentage increase in average expenditures for Part D drugs per eligible beneficiary ("Annual Percentage Increase" or API):

- the deductible, initial coverage limit, and out-of-pocket threshold for the defined standard benefit;
- minimum copayments for costs above the annual out-of-pocket threshold;
- maximum copayments below the out-of-pocket threshold for certain low-income full subsidy eligible enrollees;
- the deductible for partial low-income subsidy (LIS) eligible enrollees; and
- maximum copayments above the out-of-pocket threshold for partial LIS-eligible enrollees.

The maximum copayment limit below the out-of-pocket threshold for full benefit dual eligible enrollees with incomes not exceeding 100 percent of the Federal Poverty Level (FPL) is indexed to the annual percentage increase in the Consumer Price Index (CPI) (all items, U.S. city average).

D1. Annual Percentage Increase in Average Expenditures for Part D Drugs

The benefit parameters indexed to the API will be increased by 2.85 percent for 2021, as summarized by Table III-1 below. This increase reflects the 2020 annual percentage trend of 3.16 percent as well as a multiplicative update of -0.30 percent for prior year revisions. See Attachment IV for additional information on the calculation of the API.

Per § 423.886(b)(3) of our regulations, the cost threshold and cost limit for qualified retiree prescription drug plans are also indexed to the API. Thus, the cost threshold and cost limit for qualified retiree prescription drug plans will be increased by 2.85 percent from their 2020 values.

D2. Annual Percentage Increase in Consumer Price Index

Section 1860D-14(a)(4) of the Act requires CMS to use the annual percentage increase in the CPI for the 12-month period ending in September 2020 to update the maximum copayments up to the out-of-pocket threshold for full benefit dual eligible enrollees with incomes not exceeding

100 percent of the FPL for 2021. CMS uses an estimate of the September 2020 CPI based on projections from the President's FY2021 Budget for this purpose. These maximum copayments will be increased by 1.88 percent for 2021 as summarized in Table III-1 below.

This increase reflects the 2020 annual percentage trend in CPI of 2.44 percent as well as a multiplicative update of -0.54 percent for prior year revisions.

See Attachment IV for additional information on the calculation of the annual percentage increase in the CPI.

D3. Determining Total Covered Part D Spending at Out-of-Pocket Threshold

Each year, CMS calculates the Total Covered Part D Spending at the Out-of-Pocket Threshold, which is the amount of total drug spending, regardless of payer, required to reach the out-of-pocket threshold under the defined standard benefit. Due to reductions in beneficiary cost-sharing for drugs in the coverage gap phase for applicable (i.e., non-LIS) beneficiaries per section 1860D-2 of the Act, the total covered Part D spending may be different for applicable and non-applicable (i.e., LIS) beneficiaries. Therefore, CMS is releasing the two values described below:

- Total Covered Part D Spending at Out-of-Pocket Threshold for Non-Applicable Beneficiaries. This is the amount of total drug spending for a non-applicable (i.e., LIS) beneficiary to reach the out-of-pocket threshold in the defined standard benefit. If the beneficiary has additional prescription drug coverage through a group health plan, insurance, government-funded health program, or similar third party arrangement, this amount may be higher. This amount is calculated based on 100 percent cost-sharing in the deductible and coverage gap phases and 25 percent cost-sharing in the initial coverage phase.
- Estimated Total Covered Part D Spending at Out-of-Pocket Threshold for Applicable Beneficiaries. This is an *estimate* of the average amount of total drug spending for an applicable (i.e., non-LIS) beneficiary to reach the out-of-pocket threshold in the defined standard benefit. If the beneficiary has additional prescription drug coverage through a group health plan, insurance, government-funded health program, or similar third party arrangement, this amount may be higher. This amount is estimated based on 100 percent beneficiary cost-sharing in the deductible phase, 25 percent cost-sharing in the initial coverage phase, and in the coverage gap, 25 percent cost-sharing for "non-applicable" drugs, and 95 percent cost-sharing – consisting of 25 percent beneficiary coinsurance and 70 percent Coverage Gap Discount Program discount – for "applicable" drugs.[10] Please

[10] An applicable drug is defined in section 1860D-14A(g)(2) of the Act to generally include covered Part D brand drugs that are either approved under a new drug application (NDA) under section 505(c) of the Federal Food, Drug, and Cosmetic Act or, in the case of a biological products, licensed under section 351 of the Public Health Service

see Attachment IV for additional information on the calculation of the estimated total covered Part D spending at the out-of-pocket threshold for applicable beneficiaries.

The values can be found in Table III-1 below.

Table III-1. Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy, and Retiree Drug Subsidy

Annual Percentage Increases

	Annual percentage trend for 2020	Prior year revisions	API for 2021
API: Applied to all parameters except those noted	3.16%	-0.30	2.85%
September CPI (all items, U.S. city average) (1)	2.44%	-0.54	1.88%

Part D Benefit Parameters

	2020	2021
Standard Benefit		
Deductible	$435	$445
Initial Coverage Limit	$4,020	$4,130
Out-of-Pocket Threshold	$6,350	$6,550
Total Covered Part D Spending at Out-of-Pocket Threshold for Non-Applicable Beneficiaries (2)	$9,038.75	$9,313.75
Estimated Total Covered Part D Spending for Applicable Beneficiaries (3)	$9,719.38	10,048.39
Minimum Cost-Sharing in Catastrophic Coverage Portion of the Benefit		
Generic/Preferred Multi-Source Drug	$3.60	$3.70
Other	$8.95	$9.20
Full Subsidy-Full Benefit Dual Eligible (FBDE) Individuals		
Deductible	$0.00	$0.00
Copayments for Institutionalized Beneficiaries [category code 3]	$0.00	$0.00
Copayments for Beneficiaries Receiving Home and Community-Based Services] [category code 3] (4)	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL [category code 2]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug (5)	$1.30	$1.30
Other (5)	$3.90	$4.00
Above Out-of-Pocket Threshold	$0.00	$0.00
Over 100% FPL [category code 1]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.60	$3.70

Act (PHSA). Applicable drugs also include any biosimilar or interchangeable products licensed under section 351(k) of the PHSA, per section 1860D-14A(g)(2)(A) of the Act, as amended by section 53113 of the BBA of 2018. Non-applicable drugs generally are covered Part D drugs that do not meet the definition of an applicable drug, such as generic drugs.

	2020	2021
Other	$8.95	$9.20
Above Out-of-Pocket Threshold	$0.00	$0.00
Full Subsidy-Non-FBDE Individuals		
Applied or eligible for QMB/SLMB/QI or SSI, income at or below 135% FPL and resources ≤ $9,360 (individuals, 2020) or ≤ $14,800 (couples, 2020) [category code 1] (6)		
Deductible	$0.00	$0.00
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.60	$3.70
Other	$8.95	$9.20
Maximum Copayments above Out-of-Pocket Threshold	$0.00	$0.00
Partial Subsidy		
Applied and income below 150% FPL and resources below $14,160 (individual, 2020) or $29,160 (couples, 2020) [category code 4] (6)		
Deductible (5)	$89.00	$92.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.60	$3.70
Other	$8.95	$9.20
Retiree Drug Subsidy Amounts		
Cost Threshold	$435	$445
Cost Limit	$8,950	$9,200

(1) September CPI adjustment applies to copayments for non-institutionalized beneficiaries up to or at 100% of the FPL.

(2) For a beneficiary who is not considered an "applicable beneficiary," as defined at section 1860D-14A(g)(1), and is not eligible for the Coverage Gap Discount Program, this is the amount of total drug spending required to reach the out-of-pocket threshold in the defined standard benefit.

(3) For a beneficiary who is an "applicable beneficiary," as defined at section 1860D-14A(g)(1), and is eligible for the Coverage Gap Discount Program, this is the estimated average amount of total drug spending required to reach the out-of-pocket threshold in the defined standard benefit.

(4) Per section 1860D-14(a)(1)(D)(i), full-benefit dual eligible beneficiaries qualify for zero cost-sharing if they would be institutionalized individuals (or couple) if the individuals (couple) were not receiving home and community-based services.

(5) The partial LIS deductible is increased from the unrounded 2020 value of $89.49. Increases to the maximum copayments for non-institutionalized FBDE individuals with incomes no greater than 100% of the FPL are applied to the unrounded 2020 values of $1.30 for generic/preferred multi-source drugs and $3.90 for all other drugs.

(6) These resource limit figures will be updated for contract year 2021. Additionally, these amounts include $1,500 per person for burial expenses. See the HPMS memorandum titled, "2020 Resource and Cost-Sharing Limits for Low-Income Subsidy (LIS)" for additional details.

Section E. Reduced Coinsurance for Applicable Beneficiaries in the Coverage Gap

The law requires phased reduction in applicable beneficiary cost-sharing for drugs in the coverage gap phase of the Medicare Part D benefit. This gradual reduction in cost-sharing began in CY 2011 and continued through CY 2019 for applicable drugs and CY 2020 for non-applicable drugs, ultimately resulting in 95 percent cost-sharing for applicable drugs, prior to the application of the 70 percent manufacturer discounts required by statute, and 25 percent cost-sharing for other, non-applicable Part D covered drugs. An applicable drug is defined in section 1860D-14A(g)(2) of the Act to generally include covered Part D brand drugs that are either approved under a new drug application (NDA) under section 505(c) of the Federal Food, Drug, and Cosmetic Act or, in the case of a biological products, licensed under section 351 of the Public Health Service Act (PHSA). Note that applicable drugs also include any biosimilar or interchangeable products licensed under section 351(k) of the PHSA, per section 1860D-14A(g)(2)(A) of the Act, as amended by section 53113 of the BBA of 2018. Non-applicable drugs generally are covered Part D drugs that do not meet the definition of an applicable drug, such as generic drugs. The reductions in cost-sharing, in conjunction with the Coverage Gap Discount Program, effectively served to close the Medicare Part D coverage gap for applicable (i.e., non-LIS) beneficiaries in CY 2019 for applicable drugs and did the same in CY 2020 for non-applicable drugs.

In 2021, after applying the 70 percent manufacturer discount, the beneficiary coinsurance for non-LIS beneficiaries under basic prescription drug coverage is 25 percent for applicable covered Part D drugs purchased during the coverage gap phase of the Part D benefit.

In addition, the coinsurance for applicable (i.e., non-LIS) beneficiaries under basic prescription drug coverage is 25 percent for non-applicable covered Part D drugs purchased during the coverage gap phase of the Part D benefit.

Table III-2. Cost-Sharing for Applicable Drugs in the Coverage Gap

Year	Beneficiary Coinsurance	Plan Liability	Manufacturer Discount
2010	100% minus $250 rebate[11]	0%	0%
2011	50%	0%	50%
2012	50%	0%	50%
2013	47.5%	2.5%	50%
2014	47.5%	2.5%	50%
2015	45%	5%	50%
2016	45%	5%	50%
2017	40%	10%	50%
2018	35%	15%	50%
2019+	25%	5%	70%

Table III-3. Cost-Sharing for Non-Applicable Drugs in the Coverage Gap

Year	Beneficiary Coinsurance	Plan Liability
2010	100%	0%
2011	93%	7%
2012	86%	14%
2013	79%	21%
2014	72%	28%
2015	65%	35%
2016	58%	42%
2017	51%	49%
2018	44%	56%
2019	37%	63%
2020+	25%	75%

To be eligible for reduced cost-sharing in the coverage gap, a Part D enrollee must have incurred gross covered drug costs above the initial coverage limit but true out-of-pocket costs (TrOOP) below the out-of-pocket threshold. Moreover, Medicare beneficiaries enrolled in a qualified retiree prescription drug plan or those entitled to the low-income subsidy are not eligible for this reduced cost-sharing.

Section F. Dispensing Fees and Vaccine Administration Fees for Applicable Drugs in the Coverage Gap

As described in the previous section, the law phased in a reduction in beneficiary cost-sharing for drugs in the coverage gap phase of the Medicare Part D benefit. Consistent with our policy on

[11] The law authorized a coverage gap rebate payment of $250 to any Part D beneficiary who reached the initial coverage phase in 2010. The rebate was not required to be spent on drugs.

liability for dispensing and vaccine administration fees, as described in the Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, applicable beneficiaries will pay a portion of the dispensing fee (and vaccine administration fee, if any) that is commensurate with their coinsurance in the coverage gap, after the application of the coverage gap discount program discount when applicable. The Part D sponsor will pay the remainder of the dispensing fee and vaccine administration fee, if any.

In 2021, applicable beneficiaries will pay 25 percent and plans will pay 75 percent of dispensing fees and vaccine administration fees for applicable drugs in the coverage gap.

Section G. Part D Calendar Year Employer Group Waiver Plans Prospective Reinsurance Payment Amount

CMS makes prospective reinsurance payments to all Part D Calendar Year EGWP (CY EGWP) sponsors based on the average per member-per month (PMPM) actual (final) reinsurance amounts paid to Part D CY EGWP sponsors for the most recently reconciled payment year, which for PY 2021 is PY 2018. The average PMPM actual reinsurance amount paid to Part D CY EGWPs for 2018 was $48.52.

Attachment IV. Medicare Part D Benefit Parameters for the Defined Standard Benefit: Annual Adjustments for 2021

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) directs CMS to update the statutory parameters for the defined standard Part D drug benefit each year. These parameters include the standard deductible, initial coverage limit, out-of-pocket threshold, and minimum copayments for costs above the out-of-pocket threshold. In addition, CMS is required by statute to update the parameters for the low-income subsidy benefit and the cost threshold and cost limit for qualified retiree prescription drug plans eligible for the Retiree Drug Subsidy each year. This Attachment provides information on the methodologies for updating these parameters. See Table III-1 in Attachment III for the updated parameters for the Part D defined standard benefit and the low-income subsidy benefit and for the updated cost threshold and cost limit for qualified retiree prescription drug plans.

All of the Part D benefit parameters are updated using one of two indexing methods specified by statute:

(i) the annual percentage increase in average expenditures for Part D drugs per eligible beneficiary (API); or
(ii) the annual percentage increase in the Consumer Price Index (CPI) (all items, U.S. city average).

Section A. Annual Percentage Increase in Average Expenditures for Part D Drugs per Eligible Beneficiary (API)

Section 1860D-2(b)(6) of the Act defines the API 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." The following parameters are updated using the "annual percentage increase":

Deductible: From $435 in 2020 and rounded to the nearest multiple of $5.

Initial Coverage Limit: From $4,020 in 2020 and rounded to the nearest multiple of $10.

Minimum Cost-Sharing after the Out-of-Pocket Threshold (i.e., in the catastrophic phase): From $3.60 per generic or preferred drug that is a multi-source drug and $8.95 for all other drugs in 2020, rounded to the nearest multiple of $0.05.

Maximum Copayments up to the Out-of-Pocket Threshold for Certain Low-Income Full Subsidy Eligible Enrollees: From $3.60 per generic, preferred drug that is a multi-source drug, or biosimilar and $8.95 for all other drugs in 2020, rounded to the nearest multiple of $0.05.

Deductible for Low Income (Partial) Subsidy Eligible Enrollees: From $89.00[12] in 2020 and rounded to the nearest $1.

Maximum Copayments above the Out-of-Pocket Threshold for Low Income (Partial) Subsidy Eligible Enrollees: From $3.60 per generic, preferred drug that is a multi-source drug, or biosimilar and $8.95 for all other drugs in 2020, rounded to the nearest multiple of $0.05.

Out-of-Pocket Threshold: From $6,350 in 2020 and rounded to the nearest multiple of $50.

Section B. Annual Percentage Increase in Consumer Price Index (CPI)

Annual Percentage Increase in Consumer Price Index, September (September CPI)

Section 1860D-14(a)(4) of the Act specifies that CMS use the annual percentage increase in the CPI, All Urban Consumers (all items, U.S. city average) as of September of the previous year to update the maximum copayment amounts up to the out-of-pocket threshold for full benefit dual eligible enrollees with incomes not exceeding 100 percent of the Federal Poverty Level. These copayments are increased from $1.30 per generic, preferred drug that is a multi-source drug, or biosimilar, and from $8.95 for all other drugs in 2020 and rounded to the nearest multiple of $0.05 and $0.10 respectively.[13]

Section C. Calculation Methodology

Annual Percentage Increase in Average Expenditures for Part D Drugs per Eligible Beneficiary (API)

For contract years 2007 and 2008, the APIs, as defined in section 1860D-2(b)(6) of the Act, were based on the National Health Expenditure (NHE) prescription drug per capita estimates because sufficient Part D program data was not available. Beginning with contract year 2009, the APIs are based on Part D program data. For the contract year 2021 benefit parameters, Part D program data is used to calculate the annual percentage trend as follows:

$$\frac{August\ 2019 – July\ 2020}{August\ 2018 – July\ 2019} = \frac{\$4{,}037.06}{\$3{,}913.47} = 1.0316$$

In the formula, the average per capita cost for August 2018 – July 2019 ($3,913.47) is calculated from actual Part D PDE data, and the average per capita cost for August 2019 – July 2020 ($4,037.06) is calculated based on actual Part D PDE data incurred from August 2019 – December 2019 and projected through July 2020.

---

[12] Per section 1860D-14(a)(4)(B) of the Act, the update for the deductible for partial low income subsidy eligible enrollees is applied to the unrounded 2020 value of $89.49.

[13] Per section 1860D-14(a)(4)(A) of the Act, the copayments are increased from the unrounded 2020 values of $1.30 for multi-source generic or preferred drugs, and $3.90 for all other drugs.

The 2021 benefit parameters reflect the 2020 annual percentage trend, as well as an update for revision to prior year estimates for API. Based on updated NHE prescription drug per capita costs and PDE data, the annual percentage increases are now calculated as summarized by Table IV-1.

Table IV-1. Revised Prior Years' Annual Percentage Increases

Year	Prior Estimates of Annual Percentage Increases	Revised Annual Percentage Increases
2007	7.30%	7.30%
2008	5.92%	5.92%
2009	4.69%	4.69%
2010	3.14%	3.14%
2011	2.36%	2.36%
2012	2.15%	2.15%
2013	2.53%	2.53%
2014	−3.14%	-3.14%
2015	10.12%	10.12%
2016	9.90%	9.90%
2017	3.98%	3.99%
2018	1.90%	1.89%
2019	4.09%	4.08%
2020	5.25%	

Accordingly, the 2021 benefit parameters reflect a multiplicative update of -0.30 percent for prior year revisions. In summary, the 2020 parameters outlined in Section A are updated by 2.85 percent for 2021, as summarized by Table IV-2.

Table IV-2. Annual Percentage Increase

Annual percentage trend for July 2020	3.16%
Prior year revisions	-0.30%
Annual percentage increase for 2021	2.85%

Note: Percentages are multiplicative, not additive. Values are carried to additional decimal places and may not agree to the rounded values presented above.

Annual Percentage Increase for Out-of-Pocket Threshold

In accordance with section 1860D-2(b)(4)(B), we calculated the change in the out-of-pocket threshold using the 2020 threshold value of $6,350 as our starting point. To calculate the 2021 value, we applied the 2021 API described above and rounded to the nearest $50. The resulting 2021 out-of-pocket threshold value is $6,550.

Annual Percentage Increase in Consumer Price Index, September (September CPI)

To ensure that plan sponsors and CMS have sufficient time to incorporate cost-sharing requirements into the development of the benefit, any marketing materials, and necessary systems, CMS includes in its methodology to calculate the annual percentage increase in the CPI for the 12-month period ending in September 2020, an estimate of the September 2020 CPI based on projections from the President's FY2021 Budget.

The September 2019 value is from the Bureau of Labor Statistics. The annual percentage trend in the September CPI for contract year 2021 is calculated as follows:

$$\frac{\text{Projected September 2019 CPI}}{\text{Actual September 2017 CPI}} \; or \; \frac{263.0}{256.8} = 1.0244$$

(Source: President's FY2021 Budget and Bureau of Labor Statistics, Department of Labor)

The 2021 benefit parameters reflect the 2020 annual percentage trend in the September CPI of 2.44 percent, as well as a revision to the prior estimate for the 2019 CPI increase over the 12-month period ending in September 2019. Based on the actual reported CPI for September 2019, the September 2019 CPI increase is now estimated to be 1.71 percent. Accordingly, the 2021 update reflects a -0.54 percent multiplicative correction for the revision to last year's estimate. In summary, the maximum copayments below the out-of-pocket threshold for full benefit dual eligible enrollees with incomes not exceeding 100 percent of the Federal Poverty Level are updated by 1.88 percent for 2021, as summarized by Table IV-3.

Table IV-3. Cumulative Annual Percentage Increase in September CPI

Annual percentage trend for September 2020	2.44%
Prior year revisions	-0.54%
Annual percentage increase for 2021	1.88%

Note: Percentages are multiplicative, not additive. Values are carried to additional decimal places and may not agree to the rounded values presented above.

Section D. Retiree Drug Subsidy Amounts

Per 42 CFR 423.886(b)(3), the cost threshold and cost limit for qualified retiree prescription drug plans are also updated using the API, as defined previously in this document. The updated cost threshold is rounded to the nearest multiple of $5 and the updated cost limit is rounded to the nearest multiple of $50. The cost threshold and cost limit are defined as $415 and $8,500, respectively, for plans that end in 2019, and as $435 and $8,950 for plans that end in 2020. For 2021, the cost threshold is $445 and the cost limit is $9,200.

Section E. Estimated Total Covered Part D Spending at Out-of-Pocket Threshold for Applicable Beneficiaries

For 2021, the estimated total covered Part D spending at out-of-pocket threshold for applicable beneficiaries is $10,048.39. The figure is calculated given the following basic assumptions:

- 100 percent beneficiary cost-sharing in the deductible phase.
- 25 percent beneficiary cost-sharing in the initial coverage phase.
- 25 percent beneficiary cost-sharing for non-applicable drugs purchased in the coverage gap phase of the benefit.
- 95 percent cost-sharing for the ingredient cost and sales tax for applicable drugs purchased in the coverage gap phase of the benefit—comprised of 25 percent beneficiary coinsurance and 70 percent Coverage Gap Discount Program discount.
- 25 percent cost-sharing for the dispensing and vaccine administration fees for applicable drugs purchased in the coverage gap phase of the benefit.

In this estimate, it is assumed that the dispensing and vaccine administration fees account for 0.097 percent of the gross covered brand drug costs used by non-LIS beneficiaries in the coverage gap. Therefore, a 75 percent reduction in cost-sharing for dispensing and vaccine administration fees results in an overall reduction of 0.068 percent to 94.932 percent in cost-sharing for applicable (brand) drugs in the coverage gap.

The estimated total covered Part D spending at out-of-pocket (OOP) threshold for applicable beneficiaries is calculated as follows:

$$\text{ICL} + \frac{\text{100\% beneficiary cost sharing in the gap}}{\text{weighted gap coinsurance factor}} \; or \; \$4{,}130 + \frac{\$5{,}183.75}{87.582\%} = \$10{,}048.39$$

- *ICL* is the Initial Coverage Limit equal to $4,130.

- *100 percent beneficiary cost-sharing in the gap* is the estimated total drug spending in the gap assuming 100 percent coinsurance and is equivalent to:

  *(*OOP threshold) – (OOP costs up to the ICL) *or* $6,550 − $1,366.25 = $5,183.75

- *Weighted gap coinsurance factor* is calculated as follows:

  (Brand Gross Drug Cost Below Catastrophic [GDCB] % for non-LIS × 94.932% gap cost-sharing for applicable drugs) + (Generic GDCB % for non-LIS × 25% gap cost-sharing for non-applicable drugs)

  or

  (89.50% × 94.932%) + (10.50% × 25%) =87.5872%

- *Brand GDCB % for non-LIS* is the percentage of gross covered drug costs below the OOP threshold for applicable beneficiaries (i.e., non-LIS) attributable to applicable drugs, as reported on the 2019 PDEs.

- *Gap cost-sharing for applicable drugs* is the coinsurance incurred by applicable beneficiaries (i.e., non-LIS) for applicable drugs in the coverage gap, where:

  - *Coinsurance for applicable drugs* = is calculated as follows:

    [(percentage of gross covered brand drug costs attributable to ingredient cost and sales tax) × (cost-sharing percentage)] + [(percentage of gross covered brand drug costs attributable to dispensing and vaccine administration fees) × (cost-sharing coinsurance percentage)]

    or

    94.932 = [(99.903% ×95%) + (0.097% × 25%)]

- *Generic GDCB % for non-LIS* is the percentage of gross covered drug costs below the OOP threshold for applicable beneficiaries (i.e., non-LIS) attributable to non-applicable drugs as reported on the 2019 PDEs.

  Gap cost-sharing for non-applicable drugs is the coinsurance incurred by applicable beneficiaries (i.e., non-LIS) for non-applicable drugs in the coverage gap.

Attachment V. Updates for Part C and D Star Ratings

Part C and D Star Ratings and Future Measurement Concepts

The Part C and D Star Ratings measure the quality of and reflect the experiences of beneficiaries in Medicare Advantage (MA) and Prescription Drug Plans (PDPs or Part D plans), assist beneficiaries in finding the best plan for their needs, and determine MA Quality Bonus Payments. The Star Ratings support CMS's efforts to make the patient the focus in all of our programs.

CMS codified the methodology for the Part C and D Star Ratings program in the CY 2019 Final Rule for performance periods beginning with 2019; that final rule lays out the methodology for the 2021 Star Ratings. This Attachment provides updates that are required by regulation to be made through the process described for changes in, and adoption of, payment and risk adjustment policies in section 1853(b) of the Act. In addition, we are soliciting input on future measures and concepts as we continue to enhance the Star Ratings over time.

Reminders for 2021 Star Ratings

We provide various datasets and reports to plan sponsors throughout the year. Part C and D sponsors should regularly review their underlying measure data that are the basis for the Part C and D Star Ratings and immediately alert CMS if errors or anomalies are identified so any issues can be resolved prior to the first plan preview period. As described at §§ 422.164(h)(1) and 423.184(h)(1), CMS must annually set and announce a deadline for MA organizations or Part D sponsors to request that CMS or the Independent Review Entity (IRE) review its appeals data or CMS review its Complaints Tracking Module (CTM) data. CMS is announcing a deadline of June 30, 2020 for all contracts to make their requests for review of the 2021 Star Rating appeals and CTM measure data. Sponsoring organizations can view their Part C appeals data on the website medicareappeal.com/AppealSearch, and Part D plan sponsors should use the medicarepartdappeals.com website to monitor their appeal timeliness and effectuation compliance data. Sponsoring organizations should refer to the May 10, 2019 HPMS memo, Complaints Tracking Module (CTM) File Layout Change and Updated Standard Operating Procedures, for instructions on how to make a request for review of CTM data.

Measure Updates for 2021 Star Ratings

Improvement Measures (Part C & D). Under §§ 422.164(f) and 423.184(f), improvement measures are calculated using performance on measures that meet specific conditions. The measures that will be used to calculate the 2021 improvement measures are listed in Table 1.

Table 1: 2021 Star Ratings Improvement Measures

Part C or D	Measure	Measure Type	Weight	Improvement Measure
C	Breast Cancer Screening	Process Measure	1	Yes
C	Colorectal Cancer Screening	Process Measure	1	Yes
C	Annual Flu Vaccine	Process Measure	1	Yes
C	Improving or Maintaining Physical Health	Outcome Measure	3	No
C	Improving or Maintaining Mental Health	Outcome Measure	3	No
C	Monitoring Physical Activity	Process Measure	1	Yes
C	Adult BMI Assessment	Process Measure	1	Yes
C	Special Needs Plan (SNP) Care Management	Process Measure	1	Yes
C	Care for Older Adults – Medication Review	Process Measure	1	Yes
C	Care for Older Adults – Functional Status Assessment	Process Measure	1	Yes
C	Care for Older Adults – Pain Assessment	Process Measure	1	Yes
C	Osteoporosis Management in Women who had a Fracture	Process Measure	1	Yes
C	Diabetes Care – Eye Exam	Process Measure	1	Yes
C	Diabetes Care – Kidney Disease Monitoring	Process Measure	1	Yes
C	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3	Yes
C	Rheumatoid Arthritis Management	Process Measure	1	Yes
C	Reducing the Risk of Falling	Process Measure	1	Yes
C	Improving Bladder Control	Process Measure	1	Yes
C	Medication Reconciliation Post-Discharge	Process Measure	1	Yes
C	Getting Needed Care	Patients' Experience and Complaints Measure	2	Yes
C	Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	2	Yes
C	Customer Service	Patients' Experience and Complaints Measure	2	Yes
C	Rating of Health Care Quality	Patients' Experience and Complaints Measure	2	Yes
C	Rating of Health Plan	Patients' Experience and Complaints Measure	2	Yes
C	Care Coordination	Patients' Experience and Complaints Measure	2	Yes
C	Complaints about the Health Plan	Patients' Experience and Complaints Measure	2	Yes
C	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2	Yes
C	Health Plan Quality Improvement	Improvement Measure	5	No
C	Plan Makes Timely Decisions about Appeals	Measures Capturing Access	2	Yes
C	Reviewing Appeals Decisions	Measures Capturing Access	2	Yes
C	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2	Yes
C	Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1	Yes
D	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2	Yes
D	Appeals Auto–Forward	Measures Capturing Access	2	Yes
D	Appeals Upheld	Measures Capturing Access	2	Yes

Part C or D	Measure	Measure Type	Weight	Improvement Measure
D	Complaints about the Drug Plan	Patients' Experience and Complaints Measure	2	Yes
D	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2	Yes
D	Drug Plan Quality Improvement	Improvement Measure	5	No
D	Rating of Drug Plan	Patients' Experience and Complaints Measure	2	Yes
D	Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	2	Yes
D	MPF Price Accuracy	Process Measure	1	No
D	Medication Adherence for Diabetes Medications	Intermediate Outcome Measure	3	Yes
D	Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measure	3	Yes
D	Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measure	3	Yes
D	MTM Program Completion Rate for CMR	Process Measure	1	Yes
D	Statin Use in Persons with Diabetes	Intermediate Outcome Measure	3	Yes

2021 Star Ratings Program and the Categorical Adjustment Index

The methodology for the Categorical Adjustment Index (CAI) is described at §§ 422.166(f)(2) and 423.186(f)(2), as well as in the annual Medicare Part C & D Star Ratings Technical Notes available on the CMS webpage at https://go.cms.gov/partcanddstarratings. As finalized at §§ 422.166(f)(2)(iii) and 423.186(f)(2)(iii), all measures identified as candidate measures will be included in the determination of the 2021 CAI values. The candidate measure set for the 2021 CAI [for both Part C and Part D] is as follows: Adult BMI Assessment, Annual Flu Vaccine, Breast Cancer Screening, Colorectal Cancer Screening, Diabetes Care – Blood Sugar Controlled, Diabetes Care – Eye Exam, Diabetes Care – Kidney Disease Monitoring, Improving Bladder Control, Medication Reconciliation Post-Discharge, MTM Program Completion Rate for CMR, Monitoring Physical Activity, Osteoporosis Management in Women who had a Fracture, Reducing the Risk of Falling, Rheumatoid Arthritis Management, Medication Adherence for Diabetes Medications, Medication Adherence for Hypertension, Medication Adherence for Cholesterol, Statin Therapy for Patients with Cardiovascular Disease, and Statin Use in Persons with Diabetes.

In keeping with our commitment to transparency, a summary of the analysis of the candidate measure set that includes the minimum, median, and maximum values for the within-contract variation for the low-income subsidy (LIS)/dual eligible (DE) differences is posted at http://go.cms.gov/partcanddstarratings.

2021 Categorical Adjustment Index (CAI) Values

MA contracts have up to three mutually exclusive and independent CAI adjustments – one for the overall Star Rating and one for each of the summary ratings (Part C and Part D). PDPs have one adjustment for the Part D summary rating. Tables 2-13 provide the rating-specific categories

for classification of contracts based on the percentage of LIS/DE and disabled beneficiaries along with the final adjustment categories. Table 2 provides the range for the percentages that correspond to the LIS/DE categories determined by dividing the distribution of MA contracts' LIS/DE percentages into ten equal-sized groups. Table 3 provides the range of the percentages that correspond to the disability quintiles for the categorization of MA contracts for the CAI for the overall Star Rating.

The upper limit for each category is not included in that category, but rather the next higher category. For example, if a contract's percentage of LIS/DE beneficiaries is 42.483931%, the contract's LIS/DE initial category is L8. The exception for the upper limit exclusion for an initial group is the final category: (i) tenth initial category for the percentage of LIS/DE beneficiaries in the MA contract.

Table 2: Categorization of MA Contracts into Initial LIS/DE Groups for the Overall Rating

LIS/DE Initial Group	Percentage of Contract's LIS/DE Beneficiaries
L1	0.000000 to less than 6.226272
L2	6.226272 to less than 9.492635
L3	9.492635 to less than 11.700648
L4	11.700648 to less than 15.731573
L5	15.731573 to less than 21.329120
L6	21.329120 to less than 30.242072
L7	30.242072 to less than 42.483931
L8	42.483931 to less than 74.172176
L9	74.172176 to less than 100.00000
L10	100.000000

Table 3: Categorization of MA Contracts into Disability Quintiles for the Overall Rating

Disability Quintile	Percentage of Contract's Disabled Beneficiaries
D1	0.000000 to less than 15.391010
D2	15.391010 to less than 22.218675
D3	22.218675 to less than 28.749095
D4	28.749095 to less than 40.962138
D5	40.962138 to 100.000000

Table 4 provides the description of each of the final adjustment categories for the overall Star Rating for MA contracts and the associated values of the CAI.

Table 4: Final Adjustment Categories and CAI Values for the Overall Rating

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1-L3	D1	-0.044353
2	L4-L8 L1-L7	D1 D2	-0.010315
3	L1-L4 L5 L6-L7	D3-D5 D3-D4 D3	0.008868
4	L9-10 L8-L9 L6-L8 L5-L7	D1 D2-D3 D4 D5	0.059906
5	L10 L9 L8	D2-D4 D4-D5 D5	0.109975
6	L10	D5	0.202674

Tables 5 and 6 provide the range of the percentages that correspond to the initial LIS/DE groups and disability quintiles for the initial categories for the determination of the CAI values for the Part C summary rating.

Table 5: Categorization of MA Contracts into Initial LIS/DE Groups for the Part C Summary Rating

LIS/DE Initial Group	Percentage of Contract's LIS/DE Beneficiaries
L1	0.000000 to less than 5.887522
L2	5.887522 to less than 9.054903
L3	9.054903 to less than 11.512945
L4	11.512945 to less than 15.627683
L5	15.627683 to less than 20.944993
L6	20.944993 to less than 28.388132
L7	28.388132 to less than 41.562546
L8	41.562546 to less than 73.400323
L9	73.400323 to less than 100.00000
L10	100.000000

Table 6: Categorization of MA Contracts into Disability Quintiles for the Part C Summary Rating

Disability Quintile	Percentage of Contract's Disabled Beneficiaries
D1	0.000000 to less than 14.650120
D2	14.650120 to less than 21.841155
D3	21.841155 to less than 28.561203
D4	28.561203 to less than 40.733564
D5	40.733564 to 100.000000

Table 7 provides the description of each of the final adjustment categories for the Part C summary rating and the associated values of the CAI.

Table 7: Final Adjustment Categories and CAI Values for the Part C Summary Rating

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1-L3	D1	-0.006188
2	L4-L9 L1-L5 L6-L7 L8 L9	D1 D2-D5 D2-D4 D2-D3 D2	0.007997
3	L10 L9-L10 L8 L6-L7	D1-D2 D3-D4 D4-D5 D5	0.049144
4	L9-L10	D5	0.082496

Tables 8 and 9 provide the range of the percentages that correspond to the initial LIS/DE groups and the disability quintiles for the initial categories for the determination of the CAI values for the Part D summary rating for MA-PDs.

Table 8: Categorization of MA-PD Contracts into Initial LIS/DE Groups for the Part D Summary Rating

LIS/DE Initial Group	Percentage of Contract's LIS/DE Beneficiaries
L1	0.000000 to less than 6.888285
L2	6.888285 to less than 9.784551
L3	9.784551 to less than 12.684900
L4	12.684900 to less than 17.276374
L5	17.276374 to less than 23.019521
L6	23.019521 to less than 34.571784
L7	34.571784 to less than 50.696749
L8	50.696749 to less than 83.010704
L9	83.010704 to less than 100.00000
L10	100.000000

Table 9: Categorization of MA-PD Contracts into Disability Quintiles for the Part D Summary Rating

Disability Quintile	Percentage of Contract's Disabled Beneficiaries
D1	0.000000 to less than 15.753425
D2	15.753425 to less than 23.065548
D3	23.065548 to less than 30.125523
D4	30.125523 to less than 42.781053
D5	42.781053 to 100.000000

Table 10 provides the description of each of the final adjustment categories for the Part D summary rating for MA-PDs and the associated values of the CAI.

Table 10: Final Adjustment Categories and CAI Values for the Part D Summary Rating for MA-PDs

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
1	L1-L6 L1	D1 D2	-0.088634
2	L7 L2-L7 L1-L4	D1 D2 D3	-0.027026

Final Adjustment Category	LIS/DE Initial Group	Disability Quintile	CAI Value
3	L5-L6	D3	0.009996
4	L8-L10 L7-L8 L1-L7 L8	D1-D2 D3 D4-D5 D4	0.073898
5	L9-L10 L8-L9	D3-D4 D5	0.176661
6	L10	D5	0.289172

Tables 11 and 12 provide the range of the percentages that correspond to the LIS/DE and disability quartiles for the initial categories for the determination of the CAI values for the Part D summary rating for PDPs. Quartiles are used for both dimensions (LIS/DE and disability) due to the limited number of PDPs as compared to MA contracts.

Table 11: Categorization of PDP Contracts into LIS/DE Quartiles for the Part D Summary Rating

LIS/DE Quartile	Percentage of Contract's LIS/DE Beneficiaries
1	0.000000 to less than 1.602465
2	1.602465 to less than 3.809318
3	3.809318 to less than 14.050885
4	14.050885 to 100.000000

Table 12: Categorization of PDP Contracts into Disability Quartiles for the Part D Summary Rating

Disability Quartile	Percentage of Contract's Disabled Beneficiaries
1	0.000000 to less than 7.288366
2	7.288366 to less than 11.838028
3	11.838028 to less than 17.788557
4	17.788557 to 100.000000

Table 13 provides the description of each of the final adjustment categories for the Part D summary rating for PDPs and the associated values of the CAI.

Please note that the CAI values for the Part D summary rating for PDPs are different from the CAI values for the Part D summary rating for MA contracts. Under §§ 422.166(f)(2)(i)(A) and 423.186(f)(2)(i)(A), categories are chosen to enforce monotonicity (i.e., values increase as percent LIS/DE and disabled increases) in the final adjustment categories. There are three final adjustment categories for PDPs for the Part D summary rating.

Table 13: Final Adjustment Categories and CAI Values for the Part D Summary Rating for PDPs

Final Adjustment Category	LIS/DE Quartile	Disability Quartile	CAI Value
1	L1-L2 L1	D1-D2 D3	-0.267247
2	L3 L2-L3 L1	D1-D2 D3-D4 D4	-0.138287
3	L4	D1-D4	0.128671

Extreme and Uncontrollable Circumstances Policy

Extreme and uncontrollable circumstances such as natural disasters can directly affect Medicare beneficiaries and providers, as well as the Parts C and D organizations that provide beneficiaries with important medical care and prescription drug coverage. These extreme and uncontrollable circumstances may negatively affect the underlying operational and clinical systems that CMS relies on for accurate performance measurement in the Star Ratings program.

In the CY 2020 Final Call Letter and the CY 2020 Final Rule, published in the Federal Register on April 16, 2019 (84 FR 15680, 15830-15831), we finalized a set of rules for adjusting the calculation of Star Ratings for the Parts C and D organizations that are impacted by extreme and uncontrollable circumstances. The same policy as used for adjustments to 2020 Star Ratings based on extreme and uncontrollable circumstances will be continued for CY 2021 Star Ratings.

Table 14 lists the Section 1135 waivers that could affect the 2021 Star Ratings.

Table 14: List of Section 1135 Waivers Issued in Relation to the FEMA Major Disaster Declarations

Section 1135 Waiver Date Issued	Waiver or Modification of Requirements Under Section 1135 of the Social Security Act	FEMA Major Disaster Declaration	FEMA Incident Type	Affected State	Incident Start Date	Declared Major Disaster
01/08/2020	Puerto Rico as the result of earthquakes	DR-4473	Earthquakes	PR	12/28/2019	01/16/2020

Table 15 lists the Individual Assistance counties from the FEMA major disaster declaration.

Table 15: Individual Assistance Counties in FEMA Major Disaster Declared States

FEMA Declaration	State	FEMA Individual Assistance Counties
DR-4473	Puerto Rico	Adjuntas, Cabo Rojo, Corozal, Guanica, Guayanilla, Jayuya, Lajas, Lares, Maricao, Penuelas, Ponce, San German, San Sebastian, Utuado, Villalba, Yauco

To ensure it is applied to those contracts most likely to have experienced the greatest adverse effects, this policy is limited to Individual Assistance disaster declarations. Individual Assistance

includes assistance to individuals and households, crisis counseling, disaster case management, disaster unemployment assistance, disaster legal services, and the disaster Supplemental Nutrition Assistance Program (https://www.fema.gov/disaster-declaration-process). We focus on counties or county-equivalent areas eligible for Individual Assistance as a result of a major disaster because most Star Ratings measures are based on services provided directly to beneficiaries in their local area. Therefore, adjustments to the Star Ratings are most appropriately targeted to areas where beneficiaries were eligible for individual and household assistance as a result of the extreme and uncontrollable circumstance.

To determine whether a contract was impacted (such that it would be an "affected contract" eligible for adjustments), we compare the number of enrollees in the Individual Assistance area at the time of the extreme and uncontrollable circumstance to the number of enrollees outside the Individual Assistance area. Using the Individual Assistance major disaster declaration as a requirement for the extreme and uncontrollable circumstance policy ensures that the policy applies only when the event is extreme, meriting the use of special adjustments to the Star Ratings, and targeting the specific area affected by the extreme and uncontrollable circumstance.

In cases where contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas were affected by consecutive year disasters (2018-2019), for all measures except HOS, these doubly-affected contracts would receive the higher of the 2021 Star Rating or what the 2020 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2018 disaster for each measure (we will use the corresponding measure score for the Star Ratings year selected). For HOS, these doubly-affected contracts would receive the higher of the 2021 Star Rating or what the 2020 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2017 disaster for each measure (we will use the corresponding measure score for the Star Ratings year selected). This is due to the longitudinal nature of the HOS data collection.

Changes to Existing Star Ratings and Display Measures

CMS will continue to solicit feedback on new measure concepts as well as new and updated measures through the process described for changes in, and adoption of, payment and risk adjustment policies in section 1853(b) of the Act. We will also continue to provide advance notice regarding measures considered for implementation as future Star Ratings measures. As codified at §§ 422.164(c)(2)-(4), 422.164(d)(2), 423.184(c)(2)-(4), and 423.184(d)(2), new measures and measures with substantive specification changes must remain on the display page for at least two years prior to becoming a Star Ratings measure. CMS will announce non-substantive specification changes as described at §§ 422.164(d)(1) and 423.184(d)(1).

Display measures on CMS.gov are published separately from the Star Ratings, and include measures that are transitioned from inclusion in the Star Ratings, new or updated measures before inclusion into the Star Ratings, or informational-only measures. Organizations and

sponsors have the opportunity to preview the data for their display measures prior to release on CMS's website. We anticipate all 2020 display measures will continue to be shown on CMS.gov in 2021 unless noted below.

Care for Older Adults – Functional Status Assessment Indicator (Part C). NCQA is moving forward with refining the hybrid specification for the Functional Status Assessment indicator in the Care for Older Adults measure. Currently, the specification states that documentation of a complete functional status assessment must include (1) notation that Activities of Daily Living (ADLs) were assessed; (2) notation that Instrumental Activities of Daily Living (IADLs) were assessed; (3) result of assessment using a standardized functional assessment tool; or (4) notation that at least three of the following four components were assessed: (a) cognitive status; (b) ambulation status; (c) hearing, vision and speech (i.e., sensory ability); (d) other functional independence (e.g., exercise, ability to perform job). Because the clinical field of functional status assessment is moving toward agreement on assessment using ADLs, IADLs, or another standardized tool, and to improve the clarity of the specification, NCQA is removing the fourth option for meeting the numerator requirements for this indicator. Given the potential impact of removing this fourth option on measure scores, NCQA is implementing this change for HEDIS 2021 based on the 2020 measurement year. This would be considered a substantive update under § 422.164(d)(2) and the measure will be moved to display for the 2022 and 2023 Star Ratings. We would propose to include the updated measure in the Star Ratings through future rulemaking.

Reviewing Appeals Decisions (Part C). Currently, if a reopening occurs and is decided prior to May 1 of the subsequent measurement year, the reopened decision is used in place of the reconsideration decision. However, reopenings decided on or after May 1 are not reflected in the Star Ratings data, so the original reconsideration decision is used. Over the past several years, we have received feedback from plans that we should extend the date for reopenings as any decision the IRE overturns in a reopening could positively impact a contract's measure rating. It has been our longstanding policy that any necessary changes to IRE data must be made by June 30 of the following year in order for the changes to be reflected in a contract's Star Ratings data (e.g., changes to 2019 IRE data must be made by June 30, 2020 for the 2021 Star Ratings).

We believe allowing reopenings through June 30 is a non-substantive change since this adds additional cases that would meet the numerator requirements. *See* § 422.164(d)(1)(iv)(A). Although this change will increase the numerator, we expect the increase to only be by a small amount as reopenings are infrequent.

Controlling High Blood Pressure (Part C). The current denominator specification for this measure looks for two outpatient visits with a diagnosis of hypertension in the measurement year or the year prior. For measurement year 2020, NCQA is exploring modifying the timing of the denominator to look for two outpatient visits with a diagnosis of hypertension in the first six months of the measurement year or the year prior. The numerator would still assess the most recent blood pressure reading on or after the date of the second qualifying denominator event.

This change to the denominator provides a minimum six-month window for interventions that might assist in bringing members' blood pressure under control. CMS welcomes feedback on this potential update.

We believe this would be considered a non-substantive change as described at § 422.164((d)(1)(i) as it will effectively narrow the denominator or population covered by the measure. Please note that this measure is on the display page for the 2020 and 2021 Star Ratings and we finalized returning it to the 2022 Star Ratings in the recent final rule published April 16, 2019 (84 FR 15761-15762).

Transitions of Care (Part C). For measurement year 2020, NCQA is exploring four updates to the Transitions of Care (TRC) measure. First, NCQA proposes to revise the requirement of using one medical record from a specific provider to, instead, allow numerator information to be captured from "the outpatient medical record as well as other information accessible to the primary care provider (PCP) or ongoing care provider". This change would help the specification capture additional communication forms (e.g., admissions, discharges, and transfers (ADT) feeds, shared electronic medical records (EMRs)) that occur regularly in the field and meet the intent of the measure. This change would also ensure that scores for the TRC measure and the standalone Medication Reconciliation Post-Discharge (MRP) measure would match. As such, the additional stand-alone MRP measure would no longer need to be separately reported. Second, NCQA proposes revising the timeframe for the Notification of Inpatient Admission and Receipt of Discharge Information indicators to "the day of admission or discharge, respectively, or within the following two calendar days." This change would clarify expectations for documentation related to admissions or discharges that take place over the weekend. Third, NCQA proposes to more broadly allow "instructions for patient care post-discharge" to count in the numerator of the Receipt of Discharge Information indicator rather than limiting it to only instructions given specifically to the PCP; thus, allowing additional data sources. This change would align these indicator criteria with a more standard element found within all hospital summaries generated. If approved, measure updates would be implemented in measurement year 2020. CMS welcomes feedback on these potential updates.

Although this measure is currently a display page measure, we believe all of these changes are non-substantive since they add additional tests that would meet the numerator requirements as described at § 422.164(d)(1)(iv)(A); add alternative data sources as described at § 422.164(d)(1)(v); and do not change the population covered by the measure.

Patient-Used Device Data for HEDIS (Part C). As technology is changing, HEDIS is continuing to add additional sources of data to meet the numerator requirements of their measures. One HEDIS advancement is incorporating data from patient-used devices. For example, for the Controlling High Blood Pressure measure, readings are allowed from home blood pressure machines (which digitally store and transfer data on patient's blood pressure) to be used to fulfill the numerator of the measure. The following CPT codes are included in the

2019 version of the measure: 99091, 93784, 93788, 93790. (Note: There are newer codes NCQA is considering adding as well.) NCQA is looking forward to the wider use of other technologies that facilitate the incorporation of patient data into clinical data repositories in the future.

Digital Specifications for HEDIS (Part C). NCQA is continuing to develop digital specifications for existing HEDIS Effectiveness of Care measures. The process of converting the measures to a digital format allows for improvements to the HEDIS specifications by providing greater specificity and standardization of the language used to define the measure data elements. The digital specifications are produced using clinical quality language (CQL) and standard terminologies and may reference clinical concepts directly in addition to using claims-based proxies for measure definitions. Digital specifications provide both human readable and executable files of the measure logic, which can aid programmers in producing consistent results for the measure and reduce the need for interpretation of specifications. Selected HEDIS measures already have digital specifications available. NCQA will continue this digitalization process, converting another subset of existing HEDIS measures to the digital format in the coming year. Please note that as NCQA creates digital specifications for existing HEDIS measures, that process does not change the existing measure specification under § 422.164(d). We strongly encourage MA contracts to begin using and referencing the digital specifications.

HEDIS: Cross-Cutting Exclusions (Part C). NCQA is continuing work on cross-cutting exclusions for HEDIS measures. While HEDIS measures are designed to assess the quality of care provided to general populations or disease-specific care provided to individuals with a chronic condition, the measures may not be clinically appropriate for certain individuals and may overlook the quality of care issues that are specific to these patients. NCQA is exploring if there are additional methods that could be used to identify individuals who require nursing home level care but who reside in the community. Additionally, NCQA is exploring the development of a new cross-cutting exclusion for individuals receiving palliative care. NCQA is exploring how to identify individuals receiving palliative care, what their clinical needs are, and for which measures this exclusion would be appropriate. If approved, updates to existing exclusions and the new potential exclusion for palliative care would be implemented for measurement year 2020. CMS welcomes feedback on these potential updates.

Initiation and Engagement of Alcohol and Other Drug Abuse and Dependence Treatment (Part C). This measure, which is currently included on the display page, assesses the percentage of adolescents and adult members with a new episode of alcohol and other drug abuse or dependence who 1) initiate treatment within 14 days of the start of their new episode, and 2) engage in ongoing treatment within 34 days of their treatment initiation. The reevaluation of the measure will include potential revisions to all aspects of the measure, including the denominator, numerator, and overall structure. Potential revisions include: the replacement of the single measure with three diagnosis-specific measures (opioid, alcohol, and other drug use disorder treatment); updates to the definitions for both “new episode” and “initiation and engagement of treatment”; consideration of comorbid behavioral health and substance use conditions; and the

allowance for pharmacotherapy alone, without the concurrent use of psychosocial treatment, to satisfy the measure numerator. NCQA has been testing these potential revisions in fall 2019 for measurement year 2020. CMS welcomes feedback on these potential updates.

Hospitalization for Potentially Preventable Complications (Part C). NCQA is considering updates to this HEDIS measure, which is currently on the display page. NCQA is considering removing hospitalizations without an overnight stay from the measure numerator and aligning the value sets with those in the related AHRQ Prevention Quality Indicators as well as updates to the risk adjustment model used for the measure. If approved, these measure updates would be implemented in measurement year 2020. CMS welcomes feedback about these potential updates.

Concurrent Use of Opioids and Benzodiazepines (COB), Use of Opioids at High Dosage in Persons Without Cancer (OHD), Use of Opioids from Multiple Providers in Persons Without Cancer (OMP), and Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) (Part D). As discussed in the 2020 Call Letter, the COB, OHD, OMP, and OHDMP measures will be added to the display page for 2021 (using 2019 data). In the April 17, 2019 HPMS memo, UPDATES - 2019 Medicare Part D Patient Safety and Overutilization Monitoring System Reports, we announced updates to the measures for the 2019 measurement year based on clarifications received from the Pharmacy Quality Alliance (PQA).

When calculating the denominator requirement of $\geq$15 total days' supply of opioid medication the following steps are applied: i) when dispensed on different days, the days' supply is summed for the total days' supply, and ii) in the case of multiple prescriptions dispensed on the same day, total days' supply will only include the supply of the prescription with the longest days' supply.

Starting with the 2020 year of service (YOS) data, per the updated PQA specifications, beneficiaries with a sickle cell diagnosis at any time during the measurement year will be excluded from these measures.

Antipsychotic Use in Persons with Dementia Overall (APD), Antipsychotic Use in Persons with Dementia, for Community-only Residents (APD-COMM), and Antipsychotic Use in Persons with Dementia, for Long-term Nursing Home Residents (APD-LTNH) (Part D). In the April 17, 2019 HPMS memo referenced above, we also described updated methodology for the APD, APD-COMM, and APD-LTNH measures for the 2019 measurement year for the 2021 display page.

The denominator requirement of $\geq$ 2 prescription claims must have different dates of service. The PQA clarified that >60 days' supply is cumulative for any cholinesterase inhibitor or NMDA receptor antagonist. The days' supply of eligible antipsychotic drugs in the numerator is cumulative.

Also, when calculating the numerator and denominator total days' supply requirements, the following steps are applied: i) when dispensed on different days, the days' supply is summed for the total days' supply, and ii) in the case of multiple prescriptions dispensed on the same day, total days' supply will only include the supply of the prescription with the longest days' supply.

Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications, and Medication Adherence for Cholesterol (Statins) (Part D). As discussed in past Call Letters, the PQA tested their medication adherence measures, which are used for the Star Ratings, for potential risk adjustment of the measures (i.e., adjustment for socioeconomic status (SES) or sociodemographic status (SDS)). PQA included the following draft recommendations in their Measure Manual:

- All three adherence measures should be risk adjusted for SDS characteristics to adequately reflect differences in patient populations.
- The measures should be adjusted for the following beneficiary-level SDS characteristics: age, gender, dual eligibility/low-income subsidy (LIS) status, and disability status.
- The measures should be stratified by the beneficiary-level SDS characteristics listed above to allow health plans to identify disparities and understand how their patient population mix is affecting their measure rates.

The risk-adjusted adherence measures were endorsed by the National Quality Forum (NQF) in the 2019 Spring cycle (NQF endorsed #0541). CMS will consider implementation of the PQA recommendations in the future for these Star Ratings measures (i.e., for the 2022 measurement year or beyond). Substantive measure changes must be proposed and finalized through rulemaking.

As discussed in the 2020 Call Letter and the April 17, 2019 HPMS memo, UPDATES - 2019 Medicare Part D Patient Safety and Overutilization Monitoring System Reports, CMS included stratifications by age, gender, dual eligibility/LIS status, and disability status in the Medication Adherence Patient Safety Reports to Part D sponsors for the 2019 measurement year.

Retired Display Measures for 2023

Osteoporosis Testing in Older Women (Part C). NCQA is retiring the Osteoporosis Testing in Older Women measure, which assesses if women 65 years and older have ever received a bone mineral density test to screen for osteoporosis. This current display page measure is fielded through the Medicare Health Outcomes Survey and assesses the number of eligible respondents who "ever had" a central dual-energy X-ray absorptiometry (DXA) of the back and hip to detect osteoporosis. During the last HEDIS reevaluation cycle, concerns about the validity of this survey measure and the ability of women to accurately recall their screening history spurred the

decision to retire the measure for measurement year 2020. This measure will be retired from the 2020 measurement year so it will be removed from the display page starting in 2023.

Potential New Measure Concepts

End-Stage Renal Disease (ESRD) Measures (Part C). The 21st Century Cures Act (CURES; P.L. 114-255) allows beneficiaries with End-Stage Renal Disease (ESRD) the option to start enrolling in MA plans in 2021. Most of the measures currently in the Part C & D Star Ratings capture the health care quality of beneficiaries with ESRD. NCQA is working to develop a new kidney health evaluation measure that may in the future replace the *Diabetes Care – Kidney Disease Monitoring* measure that is currently in the Star Ratings. The kidney health evaluation measure would assess whether adults who have diabetes received an annual kidney profile evaluation, defined by an estimated Glomerular Filtration Rate (eGFR) and a Urine Albumin-Creatinine Ratio (UACR). This new measure that is being tested aligns with recommendations from the American Diabetes Association and will provide critical information for screening and monitoring of kidney health for patients with diabetes. It may also be useful to add other new measures focused on ESRD and/or Chronic Kidney Disease. We are soliciting comments on ESRD measures that may be reliably measured at the contract level.

Prior Authorizations (Part C). CMS is beginning work to develop a measure for the display page related to prior authorizations and is considering proposing it in the future as a Star Ratings measure to support beneficiary access to necessary and reasonable care. Prior authorization is a critical aspect of plan performance since it affects how quickly plan enrollees can get needed care and services. Although prior authorization has proven to be an effective process for controlling improper payments and managing costs, CMS recognizes that when processes are not in place to quickly review and approve requests for tests, services and supplies that may be medically necessary for the beneficiary, this can affect access to needed patient care. We are also interested in feedback from stakeholders on any potential quality measures that could assess the performance of plans related to how well they administer and automate electronic prior authorizations.

HOS Measures (Part C). Patients are the ultimate source of information on patient outcomes. As we have previously stated, CMS is considering using new and more targeted patient-reported outcome measures to hold contracts accountable for the outcomes of care for their members. Longitudinal measures are key to assessing plans' success in improving or maintaining their members' functioning. CMS is proposing a new longitudinal measure from the Medicare Health Outcomes Survey (HOS) to complement the measurement of the physical health status of MA beneficiaries. CMS plans to post the longitudinal Physical Functioning Activities of Daily Living (PFADL) change measure on the 2021 and 2022 display pages. We may consider the measure for the Star Ratings in the future, pending rulemaking.

The PFADL scale combines two physical functioning (PF) questions (limitations in moderate activities and climbing stairs) with the six activities of daily living (ADL) questions to create a Likert-type scale (for more details about this measure, see https://www.hosonline.org/globalassets/hos-online/survey-results/mhos_pfadl_change_measure.pdf). PFADL scale scores are created from the baseline and the two-year follow up questions. The newly developed change measure can be interpreted as the percent of function retained by average MAO beneficiaries over two years compared to a maximum decline. In contrast to most HEDIS measures, the PFADL change measure for an MA contract would be its mean change score rather than the proportion passing the measure. The PFADL change score is positively correlated with both physical component summary (PCS) and mental component summary (MCS) scores. Please see https://www.hosonline.org/globalassets/hos-online/survey-results/mhos_pfadl_change_measure.pdf for a more detailed methodology used to score the PFADL change measure. We welcome stakeholder feedback about this new measure.

CMS also seeks comment on expanding the existing HOS measures (Improving or Maintaining Physical Health and Improving or Maintaining Mental Health) to the under 65 population. Currently, HOS measures are not calculated for beneficiaries under age 65, who are entitled to Medicare for reasons other than age (i.e., younger people with physical or mental disabilities, End-Stage Renal Disease (ESRD), and amyotrophic lateral sclerosis (ALS)). Enrollees under 65 are already included in the survey, so expanding analysis of the HOS measures to include the under 65 population would increase sample size for most contracts without increasing data collection costs.

Osteoporosis Screening (Part C). NCQA is exploring the feasibility and impact of a new osteoporosis screening measure for older women. Testing of a new potential measure will help determine if osteoporosis screening can be accurately identified in claims and clinical data. If developed and approved, the new measure would be included in HEDIS for measurement year 2020. CMS may consider this measure for the display page and Star Ratings in the future.

Cardiac Rehabilitation (Part C). NCQA is exploring a new measure assessing whether adults who had certain cardiac conditions (e.g., heart attack, coronary angioplasty, coronary artery bypass, heart transplant, heart valve repair or replacement) received evidence-based cardiac rehabilitation. This concept comes from discussions with the Million Hearts Campaign and the American Heart Association. As part of the national goal to increase cardiac rehabilitation participation rates, Million Hearts has proposed development of a plan-level HEDIS measure based on the American College of Cardiology/American Heart Association claims-based quality measure for cardiac rehabilitation participation. NCQA tested this measure in the fall of 2019. If approved, this measure would be included in HEDIS for measurement year 2020. CMS welcomes feedback on the feasibility and utility of this type of measure.

Diabetes Overtreatment (Part C). NCQA is exploring new measure concepts that will assess overtreatment in patients with type 2 diabetes. Several organizations, such as the American

Diabetes Association, have recommended relaxing glycemic control in diabetic older adults with comorbidities as they are less likely to benefit from intensive glycemic control and are at higher risk of adverse events such as hypoglycemia. NCQA is considering a measure that assesses whether clinically complex members with type 2 diabetes are being overtreated (as defined by HbA1c level and medications). NCQA is also investigating a potential outcome measure that focuses on the identification of hospitalizations, emergency department visits, and observation stays among diabetic adults due to hypoglycemia as an alternative way to assess diabetes overtreatment. NCQA plans to continue the work and investigation on which measures can be operationalized and will potentially begin testing the new measure in 2020. If developed and approved, the new measure would potentially be included in HEDIS for measurement year 2021. CMS welcomes feedback on the feasibility and utility of this type of measure.

Home Health Services (Part C). NCQA is exploring a new measure concept assessing the quality of care coordination for MA beneficiaries requiring home health services. Relative to other beneficiaries in the Medicare program, beneficiaries requiring home health are disproportionately older and manage five or more chronic conditions. Successful home health outcomes require care coordination before, during, and after the home health episode. Potential measure development is on an extended timeline to account for the complexity of changing referral pathways and diversity in service intent. If developed and approved, a new measure would potentially be included in HEDIS for measurement year 2021. CMS welcomes feedback on the feasibility and utility of this type of measure.

Generic Utilization (Part D). CMS plans to develop measures to assess generic and biosimilar utilization in the Medicare Part D program. CMS encourages Part D sponsors to leverage favorable tier placement and effective formulary management tools to incentivize beneficiaries to fill generic alternatives over branded products. Generic dispensing and generic substitution rates, 82% and 91% respectively in 2017, are high on average across the Part D program. However, the remaining branded prescription fills represent a significant opportunity to reduce Medicare expenditures and lower out-of-pocket costs for beneficiaries through the use of generic alternatives.

CMS is interested in comments on the following measure concepts:

1. Generic[14] Substitution Rate (higher is better): Total number of generic fills divided by the sum of brand and generic fills for drugs that had approved therapeutically equivalent generic products that were available on the market at the time of the fill.

2. Generic Therapeutic-Alternative Opportunity Rate (lower is better): Total number of brand fills divided by the sum of brand and generic fills within select drug classes or

[14] Brand and generic drugs, as defined in 42 CFR § 423.4.

subclasses where both brands and generics are available. Classes consisting of only brand National Drug Codes (NDCs) or only generic NDCs will be excluded from the measure.

3. Biosimilar Utilization Rate (higher is better): Total number of biosimilar fills divided by the sum of reference biologics and biosimilar fills for biologics that had approved biosimilars available on the market at the time of the fill.

We also seek input to help shape more detailed measure specifications, such as:

- What classification system should be used for the Generic Therapeutic-Alternative Opportunity Rate?
- What specific classes or subclasses (where both brands and generics are available) should be excluded, due to significant variability in the safety or effectiveness of the available generic(s) compared to the brand(s)?
- What are the current barriers to generic uptake?

We will continue to perform data analysis of current generic coverage, formulary placement, and generic utilization rates in Part D as well as consider the feedback on this measure concept. We will also work with measure developers to explore potential measure concepts. Our goal is to propose to adopt measures that reward sponsors for high rates of generic utilization.

Initial Opioid Prescribing (IOP) Measures (Part D). The PQA developed and endorsed three initial opioid prescribing (IOP) measures. These measures are aligned with the CDC Guideline for Prescribing Opioids for Chronic Pain. The new IOP measures, developed through a consensus process, will provide additional tools for Part D sponsors to monitor initial opioid prescriptions that increase risk for chronic opioid use and opioid use disorder.

- Initial Opioid Prescribing at High Dosage (IOP-HD): This measure assesses the percentage of individuals 18 years and older with one or more initial opioid prescriptions with an average daily morphine milligram equivalent (MME) of 50 or greater. To be included in the denominator, individuals would have filled one or more prescriptions for opioids, with a negative medication history for any opioid prescription claim during the lookback period. The opioid initiation period is the 7 day time period when the numerator is assessed and includes the date of the initial opioid prescription plus 6 days. A lower rate represents better performance.
- Initial Opioid Prescribing for Long Duration (IOP-LD): This measure assesses the percentage of individuals 18 years and older with one or more initial opioid prescriptions for more than 7 cumulative days' supply. To be included in the denominator, individuals would have filled one or more prescriptions for opioids, with a negative medication history for any opioid prescription claim during the lookback period. The opioid initiation

period is the 3 day time period when the numerator is assessed and includes the date of the initial opioid prescription plus 2 days. A lower rate represents better performance.

- Initial Opioid Prescribing for Long-Acting or Extended Release Opioids (IOP-LA): This measure assesses the percentage of individuals 18 years and older with one or more initial opioid prescriptions for long-acting or extended-release opioids. To be included in the denominator, individuals would have filled one or more prescriptions for opioids, with a negative medication history for any opioid prescription claim during the lookback period. The opioid initiation period is the 7 day time period when the numerator is assessed and includes the date of the initial opioid prescription plus 6 days. A lower rate represents better performance.

Like the other Part D patient safety measures, CMS would apply the member-years of enrollment adjustment to account for beneficiaries who are enrolled for only part of the contract year. The initial opioid prescription, as defined by the PQA, is the earliest date of service for an opioid prescription during the measurement year following a negative medication history. Beneficiaries may have multiple initial opioid prescriptions and therefore multiple opioid initiation periods during the measurement year. The lookback period is the period of 90 days prior to each opioid prescription; however, the lookback period is not part of the member-year calculation. Additionally, a negative medication history is defined as individuals with no prescription claims for opioids during the lookback period. Beneficiaries enrolled in hospice, with a cancer diagnosis, or with a sickle cell disease diagnosis during the measurement year or the 90 days prior to the earliest date of service for an opioid medication during the measurement year are excluded from all three IOP measures.

We tested the PQA specifications for these three measures using 2018 PDE data, adjusted the measure for member-years, and evaluated the number of contracts with greater than 30 member-years in the denominator. There were a total of 739 Part D contracts in year of service 2018; however, after adjusting the measure for member-years, 641 contracts met the eligibility requirements in the denominator. All three IOP measures had the same denominator population while the numerator population varied significantly based on the different numerator requirements for each IOP measure. The overall rates for all contract types for IOP-HD was approximately 13%, for IOP-LA was approximately 1%, and for IOP-LD was approximately 41%. The rate associated with the top 5% of PDP contracts for the IOP-HD was 25.01% while MA-PD contracts had a higher rate of 39.34%. The rate associated with the top 5% of PDP contracts for the IOP-LD was 63.64%, while MA-PD contracts had a higher rate of 86.58%. The rate associated with the top 5% of PDP contracts for the IOP-LA was 6.06% while MA-PD contracts had a higher rate of 11.50%.

Table 16: Distribution of Initial Opioid Prescribing Measure Rates by Medicare Part D Contract Type, 2018 Data

Part D Contracts			Percentiles							
Measure	**Type**	**Count**	**Mean**	**Min**	**10%**	**25%**	**50%**	**75%**	**95%**	**Max**
IOP-HD	All	641	11.94%	0.00%	4.95%	7.85%	11.47%	15.10%	22.54%	39.34%
	MA-PD	583	11.63%	0.00%	4.70%	7.59%	10.95%	14.80%	22.54%	39.34%
	PDP	58	15.09%	6.10%	9.66%	12.82%	14.95%	17.34%	23.50%	25.01%
IOP-LD	All	641	44.03%	14.06%	31.19%	36.71%	42.03%	49.81%	67.07%	86.58%
	MA-PD	583	44.41%	14.06%	31.01%	36.63%	42.56%	50.43%	67.60%	86.58%
	PDP	58	40.24%	28.53%	33.19%	37.24%	39.57%	42.44%	49.01%	63.64%
IOP-LA	All	641	1.07%	0.00%	0.22%	0.50%	0.79%	1.20%	2.90%	11.50%
	MA-PD	583	1.06%	0.00%	0.17%	0.48%	0.78%	1.18%	2.93%	11.50%
	PDP	58	1.14%	0.25%	0.46%	0.70%	0.99%	1.27%	2.20%	6.06%

CMS expects these rates may be lower for dates of service after 2018 due to Part D sponsor implementation of the opioid naïve point of sale (POS) edit in 2019.

CMS reviewed the IOP measures for potential inclusion in the Part D Patient Safety measure reporting. Of the three IOP measures, the IOP-LA and IOP-LD measures best align with the Medicare Part D opioid safety edit guidance. Although we found some variability within the contracts for all of the IOP measures, the overall rates for IOP-LA were low. In addition, the current Patient Safety measures based on the use of opioids from multiple providers and/or at high dosages (i.e., 90 MME) in persons without cancer and the Overutilization Monitoring System (OMS) monitors potential high-risk opioid use in the Part D program.

Therefore, CMS plans to begin reporting only the IOP-LD in the Patient Safety reports for the 2020 measurement year. We plan to add this measure to the display page for 2023 (2021 data) and 2024 (2022 data). We will consider adding the IOP-LD measure to the Star Ratings in the future pending rulemaking once we gain experience with the measure. However, CMS will perform additional analyses of the IOP-HD and IOP-LA measures internally and monitor any notable utilization trends in the future. As a reminder, the Patient Safety opioid measures and the Medicare Part D opioid-related policies are not intended as a means to implement prescribing limits which could have unintended consequences that adversely impact a beneficiary's access to medically necessary prescribed opioids. CMS is interested in stakeholder feedback on these new IOP measures.

Net Promoter Score. The Net Promoter Score (NPS) is a measure that focuses on the loyalty that exists between an organization and a consumer. To calculate an NPS score, the consumer

answers one question ("How likely is it that you would recommend [organization] to a friend or colleague?") using a 0-10 scale where the greater the value the more likely the consumer is to give a favorable recommendation. Respondents to this question are grouped as follows:

- **Promoters** (score 9-10) are loyal enthusiasts who will keep buying and refer others, fueling growth.
- **Passives** (score 7-8) are satisfied but unenthusiastic customers who are vulnerable to competitive offerings.
- **Detractors** (score 0-6) are unhappy customers who can damage a brand and impede growth through negative word-of-mouth.

The NPS is calculated by subtracting the percentage of Detractors from the percentage of Promoters, resulting in a score that can range from a low of -100 (if every respondent is a Detractor) to a high of 100 (if every respondent is a Promoter).

Advantages of the NPS measure include its simplicity, ease of use for organizations to help predict future growth, and that a single measure may create motivation in an organization. However, most companies that use this measure see this as a starting point for collecting additional information. Additionally, there are concerns that this type of measure may be more volatile and less reliable relative to other measures focused on patient experience. We are interested in feedback regarding potentially adding a question related to the NPS or customer loyalty to our MA and PDP CAHPS survey to use to develop a measure in the future for the Part C and D program. Health and drug plans are very complex and it is more difficult to understand why an enrollee may be loyal to their plan compared to a product that they may purchase at a store, so we would be interested in feedback on how such a measure would contribute to the program.

Attachment VI. Economic Information for Part II of the CY 2021 Advance Notice

Below, we provide the economic information for significant provisions in Advance Notice Part II. Provisions not specifically addressed below are intended to represent a continuation of the policies established for CY 2020 and, as a result, do not have an impact associated with them.

A. Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2021

1. Medicare Advantage and PACE non-ESRD Ratebook

The FFS growth percentage for the 2021 MA non-ESRD rates is estimated to be 2.57 percent, and the MA growth percentage for the 2021 non-ESRD rates is estimated to be 4.52 percent. As a result, the effective growth rate for 2021 MA non-ESRD rates is estimated to be 2.99 percent. The MA non-ESRD ratebook impact is calculated by comparing 2021 Part C expenditures reflecting these growth rate assumptions to the expected 2021 Part C expenditures assuming the MA non-ESRD ratebook remains unchanged from that finalized for 2020. The net impact on the Medicare Trust Funds for CY 2021 is expected to be $7.32 billion. This figure accounts for the impact of the benchmark rate cap, MA rebate, and MA EGWP policies, as well as the portion of the difference between benchmarks and bids that the government retains and the portion of the program costs covered by Part B premiums.

To calculate the CY 2021 PACE non-ESRD rates, CMS applies the MA growth percentage for the 2021 MA non-ESRD rates, estimated to be 4.52 percent, to the CY 2020 PACE rates. The PACE non-ESRD ratebook impact is calculated by comparing the 2021 PACE expenditures reflecting this growth rate assumption to the expected 2021 PACE expenditures assuming that the PACE non-ESRD ratebook remains unchanged from the CY 2020 PACE non-ESRD ratebook. The net impact on the Medicare Trust Funds for CY 2021 for the PACE ratebook change is expected to be $70 million. This figure accounts for the portion of the program costs covered by Part B premiums.

For the impact assessment for the exclusion of standardized costs for kidney acquisitions from MA benchmarks starting in 2021, see the CY 2021 proposed rule (CMS-4190-P) to codify the statutory requirement.

Note that outside of the exclusion of organ acquisition costs for kidney transplants from MA county rates, the methodology for calculating the CY 2021 MA and PACE rates remains unchanged from the methodology used for CY 2020.

2. Indirect Medical Education (IME) Phase Out

Section 161 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275) amended section 1853(k)(4) of the Act to require CMS to phase out indirect medical education (IME) amounts from MA capitation rates. Per statute, the maximum

incremental IME phase-out is 0.60 percent of the FFS rate per year. OACT estimated the impact of the IME phase-out change between 2020 and 2021. Since the maximum IME reduction is 6.6 percent in 2020 and 7.2 percent in 2021, we calculate the impact as the difference for those counties with IME percentages of at least 6.6 percent, with the maximum impact of 0.6 percent (i.e., the difference between 7.2 and 6.6 percent). Also, since the IME reduction to MA benchmarks is increasing, the impact is considered to be a net savings to the Medicare Trust Funds.

Only six counties in payment year 2021 have IME amounts greater than 6.6 percent of the FFS rate. All other counties have IME amounts less than 6.6 percent of their respective FFS rates and are not included in this analysis since their FFS rates, for purposes of the MA ratebook, are not impacted by the change in the IME phase-out percentage in 2021. For the ESRD ratebook, IME amounts are calculated at the state level, and all IME amounts aggregated at the state level are less than 6.6 percent of the FFS rate, so there is no impact from the IME phase-out change on the ESRD ratebook for 2021.

The results are a net savings of $13.90 million to the Medicare Trust Funds for CY 2021. This result takes into account the portion of the difference between benchmarks and bids that the government retains and the portion of the program costs covered by Part B premiums.

Note that the statutorily prescribed methodology for calculating the IME phase-out in 2021 is the same as that provided by statute for CY 2020; we are providing this impact assessment for informational purposes.

3. Medicare Advantage and PACE ESRD Ratebooks

The FFS growth percentage for the 2021 ESRD state rates is estimated to be 2.8 percent. The impact on the MA and PACE ESRD ratebooks is calculated by comparing projected 2021 Part C expenditures with this growth rate assumption to the expected 2021 Part C expenditures with the assumption that the MA and PACE ESRD ratebooks remain unchanged from that finalized for 2020. The net impact on the Medicare Trust Funds for CY 2021 is expected to be $400 million. This figure accounts for the portion of the program costs covered by Part B premiums.

Note that outside of the exclusion of organ acquisition costs for kidney transplants from non-PACE MA ESRD rates, the impact of which is addressed in the CY 2021 proposed rule, the methodology for calculating the CY 2021 ESRD rates remains unchanged from the methodology used for CY 2020.

4. ESRD Risk Adjustment Model for CY 2021

CMS is proposing to revise the blend of the risk scores calculated with the ESRD risk adjustment models for CY 2021 payments, with 75% of the risk score calculated with the 2020 ESRD model and 25% of the risk score calculated with the 2019 ESRD model. For CY 2020, CMS used a 50-

50% blend of the risk scores calculated with the 2020 and 2019 ESRD models. The impact of the ESRD risk adjustment model transition is the effect of the changes in the blend. The CY 2021 blended impact on ESRD risk scores of the transition to the 2020 ESRD model, relative to CY 2020, is 0.31% for ESRD (dialysis and post graft combined), which represents a $44 million net impact on the Medicare Trust Funds in 2021. This impact takes into account the portion of the program costs covered by Part B premiums.

5. Frailty Adjustment for FIDE SNPs

For CY 2021, CMS is proposing to calculate frailty scores for FIDE-SNPs by blending 75% of the frailty score using the frailty factors associated with the 2020 CMS-HCC risk adjustment model and 25% of the frailty score using the frailty factors associated with the 2017 risk adjustment CMS-HCC model. For CY 2020, CMS calculated the frailty scores as the sum of 50% of the frailty score using the 2020 CMS-HCC model frailty factors and 50% of the frailty score using the 2017 CMS-HCC model frailty factors. The impact of the frailty adjustment transition is the effect of changes in the blend of frailty scores calculated using the frailty factors associated with the 2017 CMS-HCC model and with the 2020 CMS-HCC model. The CY 2021 impact of transitioning to frailty scores calculated using the frailty factors associated with 2020 CMS-HCC model, relative to CY 2020, is a change in frailty scores of -8.6%, which represents a net savings of $10.1 million dollars to the Medicare Trust Funds in 2021. This impact takes into account the portion of the difference between benchmarks and bids that the government retains and the portion of the program costs covered by Part B premiums.

6. MA Coding Pattern Adjustment

For CY 2021, we are proposing the statutory minimum coding intensity adjustment (5.90%). There is no change in policy from CY 2020, and we applied the same factor for CY 2020, therefore the year-over-year impact is zero.

7. Normalization

The normalization factors serve to offset the trend in risk scores, and serves to maintain a 1.0 average FFS risk score. For CY 2021, CMS is proposing to apply the same methodology to calculate the normalization factors that was applied in CY 2020. To determine the CY 2021 normalization factors, we applied the CY 2020 methodology to the most current underlying data available, resulting in updated normalization factors. Since normalization is applied to risk scores to maintain the same level of the risk scores year-over-year, and there are no changes in the methodology being applied for CY 2021 from the prior year, the impact of normalization is zero.

B. Changes in the Payment Methodology for Medicare Part D for CY 2021

1. Encounter Data as a Diagnosis Source to Calculate Part D Risk Scores for CY 2021

The impact of the proposal to calculate Part D risk scores using the 2020 RxHCC model for CY 2021, by adding 75% of the risk score calculated with risk adjustment eligible diagnoses from encounter data (supplemented with RAPS inpatient records) and FFS claims with 25% of the risk score calculated using risk adjustment eligible diagnoses from RAPS data and FFS claims, is 0.00%. This impact is 0.00% because we project the differential between the RAPS-based risk score and the encounter data-based risk score to be 0.00%.

2. Annual Percentage Increase for Out-of-Pocket Threshold and Other Part D Parameters

The impact of the out-of-pocket threshold increase is the effect of implementing a statutorily required change in the methodology used to calculate the threshold. As required under section 1860D-2(b)(4) of the Act, the out-of-pocket threshold for 2021 and subsequent years is calculated by updating the previous year by the annual percentage increase in drug costs (API). In contrast, for 2020, the statutory methodology required that:

> (A) the previous year (2019) threshold first be recalculated as if thresholds for each of years 2014 through 2019 had been updated using the API,[15] and then
>
> (B) the recalculated prior year threshold be updated by the API.

If CMS were to apply the 2020 methodology for the out-of-pocket threshold increase for 2021, part (A) of the methodology would not have an impact on the calculations since the prior year (2020) threshold already accounts for the adjustment for 2014-2019, meaning only part (B) of the methodology – increase prior year threshold by API – would apply. Therefore, the 2020 and 2021 methodologies both result in the same 2020 threshold being increased by the API, and, thus, there is no impact for this provision.

The methodology for updating other Part D parameters for CY 2021 remains unchanged from that used for CY 2020. As a result, updating the other Part D parameters does not have an impact on the Medicare Trust Fund alone; the impact of such parameter updates is dependent on the behavior and bid assumptions of Part D plan sponsors.

[15] For 2014 and 2015, the Act required that the threshold be updated by the API minus 0.25 percentage point and that for contract years 2016-2019, the 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.