January 15, 2021

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

Announcement of Calendar Year (CY) 2022 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

In accordance with section 1853(b)(1) of the Social Security Act, we are notifying you of the annual capitation rate for each Medicare Advantage (MA) payment area for CY 2022 and the risk and other factors to be used in adjusting such rates.

CMS received many submissions in response to our request for comments on Part I of the Advance Notice of Methodological Changes for CY 2022 MA Capitation Rates and Part C and Part D Payment Policies (CY 2022 Advance Notice), published on September 14, 2020, and Part II of the CY 2022 Advance Notice, published on October 30, 2020. Commenters included professional organizations, MA and Part D sponsors, advocacy groups, state Medicaid agencies, pharmaceutical manufacturers, pharmacy benefit managers, pharmacies, and interested persons. After considering all comments received, we are finalizing a number of policies in the Announcement of CY 2022 MA Capitation Rates and Part C and Part D Payment Policies (CY 2022 Rate Announcement) that reflect CMS' continued commitment to providing MA organizations and Part D plan sponsors with the flexibility to develop and implement innovative approaches, as well as offer more affordable plan choices, to care for and empower Medicare beneficiaries. CMS is committed to exploring other avenues for simplifying and transforming the MA and Part D programs in order to encourage innovation and expand beneficiary choice, and is looking forward to working with stakeholders to achieve those shared goals.

The capitation rate tables for 2022 and supporting data are posted on the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html. The statutory component of the regional benchmarks, qualifying counties, and each county's applicable percentage are also posted on this section of the CMS website.

Attachment I of the Rate Announcement shows the final estimates of the National Per Capita MA Growth Percentage for 2022 and the National Medicare Fee-for-Service (FFS) Growth Percentage for 2022, used to calculate the 2022 capitation rates. As discussed in Attachment I, the final estimate of the National Per Capita MA Growth Percentage for combined aged and disabled beneficiaries is 6.30 percent, and the final estimate of the FFS Growth Percentage is 5.47 percent. Attachment II provides a set of tables that summarizes many of the key Medicare assumptions used in the calculation of the growth percentages.

Section 1853(b)(4) of the Social Security Act requires CMS to release county-specific per capita FFS expenditure information on an annual basis, beginning with March 1, 2001. In accordance

with this requirement, FFS data for CY 2019 were posted on the above website with Part II of the CY 2022 Advance Notice.

Attachment II details the key assumptions and financial information behind the growth percentages presented in Attachment I.

Attachment III presents responses to Part C payment-related comments on both Parts I and II of the CY 2022 Advance Notice.

Attachment IV presents responses to Part D payment-related comments on the CY 2022 Advance Notice.

Attachment V provides the final Part D benefit parameters and details how they are updated.

Attachment VI presents responses to comments on updates for MA and Part D Star Ratings.

Attachment VII contains economic information for significant provisions in the CY 2022 Rate Announcement.

Attachment VIII shows the RxHCC Risk Adjustment Factors.

We note that we received a number of comments, including those related to steps CMS could take regarding the potential negative impacts of the COVID-19 PHE on risk scores and medical loss ratio calculations, that we consider out of scope as they did not pertain to issues or policy options that are addressed through the Advance Notice/Rate Announcement process (e.g., suspension of RADV audits during the COVID-19 PHE). In general, as consistent with past practice, we have not summarized or addressed out-of-scope comments in this Rate Announcement.

COVID-19

The 2022 Rate Announcement does not catalog CMS' actions related to the 2019 Coronavirus Disease (COVID-19) public health emergency (PHE), but it does incorporate aspects of the impact of COVID-19 on health care costs in its estimates of prior and future Medicare spending. The health, safety, and welfare of America's patients and provider workforce in the face of the COVID-19 PHE is the top priority of the Trump Administration and CMS. CMS is working around the clock to equip the American healthcare system with maximum flexibility to respond to the COVID-19 PHE. An overview of some of the most significant actions CMS has taken in response to the PHE which relate to the waivers and flexibilities applicable to MA organizations and Part D plans is described in the CMS fact sheet "Medicare Advantage and Part D Plans: CMS Flexibilities to Fight COVID-19," (*available at*: https://www.cms.gov/files/document/covid-ma-and-part-d.pdf). The agency is also

communicating with stakeholders and developing further guidance, as needed, on issues related to the COVID-19 PHE.[1]

[1] CMS issued the Health Plan Management System (HPMS) memo, "Information Related to Coronavirus Disease 2019 – COVID-19" on March 10, 2020. In response to subsequent requests for additional guidance on CMS' expectations with respect to other MA and Part D policies, we issued updates of this memo on April 21 and May 22, 2020. *See* "Information Related to Coronavirus Disease 2019 – COVID-19" (March 10, 2020) (*available at*: https://www.cms.gov/files/document/hpms-memo-covid-information-plans.pdf); "Information Related to Coronavirus Disease 2019 – COVID-19" (rev. April 21, 2020) (*available at*: https://www.cms.gov/files/document/updated-guidance-ma-and-part-d-plan-sponsors-42120.pdf); and "Information Related to Coronavirus Disease 2019 – COVID-19" (rev. May 22, 2020) (*available at*: https://www.cms.gov/files/document/covid-19-updated-guidance-ma-and-part-d-plan-sponsors-52220.pdf).

Please note that the CMS Medicare Drug and Health Plan Contract Administration Group also issued guidance on these topics in two additional HPMS memos that respond to questions CMS received related to the above-mentioned memos. *See* "Updated Guidance for Medicare Advantage Organizations" (May 11, 2020) and "Updated Guidance for Medicare Advantage Organizations" (May 13, 2020) (*available at:* https://www.cms.gov/httpseditcmsgovresearch-statistics-data-and-systemscomputer-data-and-systemshpmshpms-memos-archive/hpms-memo-18).
For a more comprehensive listing of CMS' actions in response to the PHE, please refer to the Current Emergencies website (*available at*: https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page).

Key Updates from the Advance Notice

Growth Percentages: Attachment I provides the final estimates of the National Per Capita MA Growth Percentage and the FFS Growth Percentage, upon which the capitation rates are based, and information on deductibles for MSAs.

For the Announcement of CY 2022 MA Capitation Rates, the Secretary has directed the CMS Office of the Actuary to assume the current state of legal affairs concerning the Innovation Center's Most Favored Nation (MFN) Model Interim Final Rule with Comment Period (CMS-5528-IFC) will remain in place, and thus exclude the impact of the MFN model on the growth rate estimates used to calculate the 2022 MA capitation rates. Assuming the current state of legal affairs remains in place (including the current preliminary injunction) reflects the current best estimate of what expenditures will be in 2022.

Additionally, we note that we have updated our assumptions related to the COVID-19 public health emergency (PHE) between the Advance Notice and Rate Announcement specifically regarding when beneficiaries will receive care that they deferred as a result of the COVID-19 pandemic. Some of that care is now assumed to be deferred until a later date, and that deferred care is now expected to be more intensive than was assumed in the Advance Notice. As deferred care is now estimated to continue to return in 2022, 2022 FFS spending is estimated to be higher than estimated in the Advance Notice.

Calculation of FFS Costs: The Secretary has directed the CMS Office of the Actuary to adjust the FFS experience for beneficiaries enrolled in Puerto Rico to reflect the propensity of "zero–dollar" beneficiaries nationwide.

2022 RxHCC Normalization Factor: 1.043. CMS is finalizing the 2022 RxHCC normalization factor for the 2017/2018 RxHCC model calculated using the linear slope methodology with four years of data (2016-2019) instead of five years, as discussed below.

Medicare Part D Benefit Parameters – Annual Adjustments for Defined Standard Benefit in 2022: Attachment V provides the 2022 Part D benefit parameters for the defined standard benefit, low-income subsidy, and retiree drug subsidy.

Location of Network Areas for Private Fee-for-Service (PFFS) Plans in Plan Year 2023: The list of network areas for plan year 2023 will be provided in a separate announcement and made available on the CMS website by the first Monday in April.

Policies Adopted as Described

As in past years, policies in the Advance Notice that are not modified or retracted in the Rate Announcement become effective for the upcoming payment year. Clarifications in the Rate Announcement supersede information in the Advance Notice and prior Rate Announcements as they apply for payment year 2022.

CMS-Hierarchical Condition Categories (CMS-HCC) Risk Adjustment Model: For CY 2022, we will calculate risk scores as proposed in Part I of the CY 2022 Advance Notice. CMS will complete phasing in the model implemented in 2020, which meets the statutory requirements of the 21st Century Cures Act (Pub. L. 114-255). The 2020 CMS-HCC model (previously known as the alternative payment condition count (APCC) model) will be used with no blending for the risk score calculation. Specifically, 100 percent of the risk score will be calculated with the 2020 CMS-HCC model, using diagnoses from encounter data and FFS, as discussed in Attachment III, Sections G and M.

Final 2022 Part C and ESRD Normalization Factors:

2020 CMS-HCC Model: 1.118

2017 CMS-HCC Model: 1.128

CMS-HCC 2019 ESRD dialysis model & 2020 ESRD dialysis model: 1.077

CMS-HCC 2019 ESRD functioning graft model & 2020 ESRD functioning graft model: 1.126

Frailty Adjustment for Programs of All-Inclusive Care for the Elderly (PACE) organizations and FIDE SNPs: For PACE organizations, we will continue to use the frailty factors associated with the 2017 CMS-HCC model to calculate frailty scores for CY 2022. For FIDE SNPs, we will use the updated frailty factors for the 2020 CMS-HCC model to calculate frailty scores as proposed. These factors were recalibrated by non-dual, partial dual, and full-dual-eligible status consistent with the segments in the 2020 CMS-HCC model.

MA Benchmark, Quality Bonus Payments, and Rebate: We will continue to implement the methodology, as described in Part II of the CY 2022 Advance Notice, used to derive the benchmark county rates, how the qualifying bonus counties are identified, and the applicability of the Star Ratings.

Indirect Medical Education (IME) Phase Out: As described in Part II of the CY 2022 Advance Notice, we will continue phasing out IME amounts from the MA capitation rates. As noted on page 32 in Part II of the CY 2022 Advance Notice, section 1894(d)(3) of the Social Security Act provides that the IME payment phase-out does not apply to PACE capitation rates.

Organ Acquisition Costs for Kidney Transplants: The kidney acquisition cost carve-out factors for CY 2022, calculated using the methodology described in the Advance Notice, are published at https://www.cms.gov/Medicare/Health- Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html. As noted on pages 28-29 in Part II of the CY 2022 Advance Notice, CMS will continue to include the costs for kidney acquisitions in PACE payment rates.

End Stage Renal Disease (ESRD) State Rates: We will continue to determine the ESRD dialysis rates by state as described in Part II of the CY 2022 Advance Notice.

MA Employer Group Waiver Plans (EGWPs): We will continue to use the payment methodology as described in the Advance Notice, continuing for 2022 the payment methodology for MA EGWPs finalized in the CY 2021 Rate Announcement, including the enhancement to permit MA EGWPs to buy down Part B premiums. The bid-to-benchmark ratios applied in calculating 2022 MA EGWP Payment Rates are:

Applicable Percentage	Bid to Benchmark Ratio
0.95	83.0%
1	82.6%
1.075	82.6%
1.15	82.9%

ESRD Risk Adjustment Models: CMS is finalizing use of the ESRD dialysis and ESRD functioning graft risk adjustment models as proposed in Part II of the CY 2022 Advance Notice. Therefore, for CY 2022, CMS is fully phasing in the 2020 ESRD models. In addition to calculating 100 percent of the risk score using the 2020 ESRD models, CMS is finalizing the proposal to calculate risk scores for payment to MA organizations and certain demonstrations using only risk adjustment-eligible diagnoses from encounter data and FFS claims. For PACE organizations, CMS will continue to calculate ESRD risk scores for CY 2022 using the 2019 ESRD dialysis and ESRD functioning graft models as well as the 2019 transplant factors.

CMS-HCC Risk Adjustment Model Used for PACE Organizations: For CY 2022, non-ESRD PACE participant risk scores will be calculated using the 2017 CMS-HCC model.

Adjustment for MA Coding Pattern Differences: We will implement an MA coding pattern difference adjustment of 5.90 percent for CY 2022.

Risk Adjustment Sources of Diagnoses for 2022 (non-PACE): As proposed, we will end the blending of encounter data-based and RAPS-based risk scores and move to calculating 100 percent of the risk score using diagnoses from MA encounter data and FFS claims for CY 2022. In addition, for CY 2022 we will identify diagnoses for risk score calculation from FFS claims using HCPCS-based filtering logic and will no longer supplement encounter data-based scores with diagnoses from RAPS inpatient records for the following risk scores: Part C non-ESRD, ESRD dialysis and functioning graft, and Part D.

Risk Adjustment Sources of Diagnoses for 2022 (PACE): As proposed, we will continue the same method of calculating risk scores under the CMS-HCC, RxHCC, and ESRD models 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.

RxHCC Risk Adjustment Model: We are finalizing the use of the updated version of the RxHCC risk adjustment model to calculate Part D risk scores, as proposed in the CY 2022 Advance

Notice. The updated model uses diagnosis data from 2017 FFS claims and MA encounter data submissions, along with expenditure data from 2018 PDEs.

Part D Calendar Year Employer Group Waiver Plans: We are maintaining the Part D Calendar Year EGWP prospective reinsurance policy as discussed in the CY 2022 Advance Notice.

Part D Risk Sharing: As part of this CY 2022 Rate Announcement, we are not making changes to the 2022 threshold risk percentages and payment adjustments for Part D risk sharing.

/ s /
Demetrios L. 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 Rate Announcement. My opinion is limited to the following sections of this Rate Announcement: The growth percentages and United States per capita cost estimates provided and discussed in Attachments I, II and III; the qualifying county determination, calculations of Fee-for-Service cost, kidney acquisition cost carve-out, IME phase out, MA benchmarks, EGWP rates, and ESRD rates discussed in Attachment III; the Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2022 described in Attachments IV and V; and the economic information contained in Attachment VII.

/ s /
Jennifer Wuggazer Lazio, F.S.A., M.A.A.A.
Director
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Office of the Actuary

Attachments

2022 RATE ANNOUNCEMENT
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Introduction: Notice of Change in the Schedule for Publication of the Rate Announcement for CY 2022

Section 1853(b)(1)(B) of the Social Security Act (hereafter referred to as "the Act") mandates that we publish the Rate Announcement for a given year not later than the first Monday in April of the preceding year. At least 60 days before publishing the Rate Announcement for a given year, we must publish the Advance Notice of proposed methodological changes from the methodology and assumptions finalized in the previous year's announcement. We provide stakeholders no less than 30 days to comment on such proposed changes, pursuant to section 1853(b)(2) of the Act. As amended by the 21st Century Cures Act, section 1853(a)(1)(I)(iii) of the Act requires that we provide at least 60 days for public review and comment of proposed changes under section 1853(a)(1)(I) to the Part C risk adjustment model; we included this information in Part I of the Advance Notice.

We have customarily published the Rate Announcement in April, preceded by Part I of the Advance Notice in December or January (for those policies for which a longer comment period was required) and Part II in February, to comply with the aforementioned statutory deadlines set forth in the Act. However, for CY 2022, we are publishing the Rate Announcement earlier in 2021 in light of the challenges for MA organizations, PACE organizations, and Part D sponsors posed by the uncertainty associated with the COVID-19 pandemic. Accordingly, we published Part I of the CY 2022 Advance Notice in September 2020 and Part II in October 2020. We believe, and many commenters agreed, that MA organizations, Part D sponsors, and PACE organizations could potentially benefit from having information about capitation rates, risk adjustment factors, methodologies, benefit parameters, and assumptions earlier in the year. This gives MA organizations and Part D sponsors more time to prepare their bids, which must be submitted by the first Monday in June. We believe, and many commenters confirmed, that this change in timing to allow more certainty about MA and Part D payment policies earlier in the year is warranted in this unusual time when all stakeholders are grappling with additional uncertainties created by the COVID-19 pandemic. We note that the COVID-19 pandemic is a highly unusual situation, and we believe that the advantages of the additional time to prepare bids outweigh any downsides of potential changes to our calculations and methodologies, which commenters also largely confirmed.

Responses to Public Comments Regarding the Change in the Schedule for Publication of the Rate Announcement for CY 2022

Comment: Many commenters expressed appreciation for CMS' early release of the CY 2022 Advance Notice and indicated that the additional time was useful given the challenges posed by the COVID-19 pandemic. A few commenters supported the earlier release if there would be no negative effect on the rates. One commenter stated that an early release of policy changes would be of limited value without the rates being released at the same time.

Response: We appreciate the support. After consideration of the public comments we received, we have decided to publish the CY 2022 Rate Announcement earlier than in past years.

Comment: Several commenters were concerned that an earlier-than-normal release of the Advance Notice or Rate Announcement would not allow CMS to incorporate critical data and information, such as data from the fourth quarter of 2020.

Response: As noted in the CY 2022 Advance Notice, the accelerated schedule necessitates that we use an earlier baseline than would normally be used to develop the MA and FFS growth rates to determine the 2022 MA non-ESRD and ESRD capitation rates. The result is that the trend factors are based on one less quarter of data than under the normal methodology. Additionally, under the accelerated schedule, we were unable to incorporate some of the repricing adjustments typically applied to the historical FFS claims data to reflect the latest data available regarding episode savings/losses related to certain Innovation Center models. As discussed in Part II of the CY 2022 Advance Notice, under the accelerated schedule, we relied on earlier data to estimate kidney acquisition costs and calculate the EGWP bid-to-benchmark ratios.

The majority of the commenters believed the advantages of the early publication timeline and additional time between the release of the MA ratebook and the statutory bid submission deadline in June to prepare bids outweigh any downsides of changes to our calculations and methodologies. For the reasons identified in the Advance Notice, we are finalizing our proposal to use the accelerated timeline and the data sources associated with that schedule in Part II of the Advance Notice.

Comment: A couple of commenters advocated for a permanent change to an earlier timeline for publication of the Advance Notice and Rate Announcement. One commenter recommended a March release date as a timeframe that allows for the most accurate cost data and provides plans more time to prepare bids.

Response: We appreciate the commenters' suggestions. We will evaluate the need for an earlier release in future years, as necessary, to address extraordinary circumstances. We anticipate that such decisions will be based on balancing the advantages of an earlier release of information with the availability of more updated data. The statutory framework for the publication schedule of the Advance Notice and Rate Announcement as defined in section 1853(b) of the Act permits release of the Rate Announcement as late as the first Monday in April; we believe the statutory timeframe indicates the intent for the agency to use the most recent data possible in setting rates while permitting plans to have time to prepare bids.

Attachment I. Final Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2022

Table I-1 below shows the National Per Capita MA Growth Percentage (NPCMAGP) for 2022. An adjustment of -2.02 percent for the combined aged and disabled cohort is included in the NPCMAGP to account for corrections to prior years' estimates as required by section 1853(c)(6)(C). The combined aged and disabled change is used in the development of the ratebook.

Table I-1. Increase in the National Per Capita MA Growth Percentages (NPCMAGP) for 2022

	Prior increases	Current increases			NPCMAGP for 2022 with §1853(c)(6)(C) adjustment[1]
	2003 to 2021	2003 to 2021	2021 to 2022	2003 to 2022	
Aged + Disabled	87.910 %	84.113 %	8.494 %	99.752 %	6.30 %

[1] Current increases for 2003-2022 divided by the prior increases for 2003–2021.

Table I-2 below provides the change in the FFS United States Per Capita Cost (USPCC), which was used in the development of the county benchmarks. The percentage change in the FFS USPCC is shown as the current projected FFS USPCC for 2022 divided by projected FFS USPCC for 2021 as estimated in the 2021 Rate Announcement released on April 6, 2020.

Table I-2. FFS USPCC Growth Percentage for CY 2022

	Aged + Disabled	*Dialysis–only ESRD*
Current projected 2022 FFS USPCC	$1,028.38	$8,515.64
Prior projected 2021 FFS USPCC	975.06	8,110.21
Percent change	5.47 %	5.00 %

Table I-3 below shows the monthly actuarial value of the Medicare deductible and coinsurance for 2021 and 2022. In addition, for 2022, the actuarial value of deductibles and coinsurance is being shown for non-ESRD only, since MA plan bids for 2022 exclude costs for ESRD enrollees. These data were furnished by the Office of the Actuary.

Table I-3. Monthly Actuarial Value of Medicare Deductible and Coinsurance for 2021 and 2022

	2021	2022	Change	2022 non-ESRD
Part A Benefits	$36.31	$38.58	6.3%	$36.92
Part B Benefits[1]	145.31	150.66	3.7	141.45
Total Medicare	181.62	189.24	4.2	178.37

[1] Includes the amounts for outpatient psychiatric charges.

Medical Savings Account (MSA) Plans. The maximum deductible for MSA plans for 2022 is $15,050.

Attachment II. Key Assumptions and Financial Information

The USPCCs are the basis for the National Per Capita MA Growth Percentage. Attached is a table that compares last year's estimates of USPCCs with current estimates for 2003 to 2023. In addition, this table shows the current projections of the USPCCs through 2024. We are also providing an attached set of tables that summarize many of the key Medicare assumptions used in the calculation of the USPCCs. Most of the tables include information for the years 2003 through 2024.

Most of the tables in this attachment present combined aged and disabled non-ESRD data. The ESRD information presented is for the combined aged-ESRD, disabled-ESRD, and ESRD only.

All of the information provided in this attachment applies to the Medicare Part A and Part B programs. 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 Part D prescription drug benefit.

Comparison of Current & Previous Estimates of the Total USPCC – Non-ESRD

Calendar year	Part A		Part B		Part A + Part B		
	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	367.35	367.30	751.26	751.21	1.000
2010	383.93	383.94	376.12	376.12	760.05	760.06	1.000
2011	387.73	387.73	385.19	385.19	772.92	772.92	1.000
2012	377.37	377.40	391.82	391.84	769.19	769.24	1.000
2013	380.03	380.06	398.60	398.63	778.63	778.69	1.000
2014	370.40	370.41	418.40	418.19	788.80	788.60	1.000
2015	373.99	373.92	435.00	434.76	808.99	808.68	1.000
2016	377.98	378.01	444.17	443.91	822.15	821.92	1.000
2017	383.60	383.38	459.15	458.83	842.75	842.21	1.001
2018	388.62	387.29	489.65	488.29	878.27	875.58	1.003
2019	400.53	398.66	521.81	521.72	922.34	920.38	1.002
2020	400.32	419.53	523.63	558.89	923.95	978.42	0.944
2021	426.59	433.78	574.69	588.15	1,001.28	1,021.93	0.980
2022	458.19	449.17	628.14	616.15	1,086.33	1,065.32	1.020
2023	464.49	466.70	652.39	651.30	1,116.88	1,118.00	0.999
2024	482.83		689.40		1,172.23		

Comparison of Current & Previous Estimates of the FFS USPCC – Non-ESRD

Calendar year	Part A		Part B		Part A + Part B		
	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Current estimate	Last year's estimate	Ratio
2010	$371.20	$371.20	$373.99	$373.99	$745.19	$745.19	1.000
2011	371.15	371.15	383.01	383.01	754.16	754.16	1.000
2012	356.97	356.97	390.54	390.54	747.51	747.51	1.000
2013	363.75	363.75	394.32	394.32	758.07	758.07	1.000
2014	364.24	364.25	408.91	408.58	773.15	772.83	1.000
2015	369.36	369.16	427.79	427.33	797.15	796.49	1.001
2016	372.11	372.04	433.39	432.90	805.50	804.94	1.001
2017	374.66	374.27	448.16	447.62	822.82	821.89	1.001
2018	378.69	376.60	474.12	472.01	852.81	848.61	1.005
2019	383.40	385.10	500.57	501.41	883.97	886.51	0.997
2020	364.08	400.59	468.10	531.75	832.18	932.34	0.893
2021	397.12	415.36	532.57	559.70	929.69	975.06	0.953
2022	434.65	429.79	593.73	586.05	1,028.38	1,015.84	1.012
2023	440.27	446.16	616.33	618.89	1,056.60	1,065.05	0.992
2024	456.98		650.46		1,107.44		

Comparison of Current & Previous Estimates of the ESRD Dialysis-only FFS USPCC

Calendar year	Part A		Part B		Part A+Part B		
	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	2,952.21	2,952.21	4,526.09	4,526.09	7,478.30	7,478.30	1.000
2019	3,040.51	3,034.25	4,606.77	4,661.83	7,647.28	7,696.08	0.994
2020	2,876.72	3,163.25	4,491.12	4,747.62	7,367.84	7,910.87	0.931
2021	3,109.31	3,232.31	4,788.33	4,877.90	7,897.64	8,110.21	0.974
2022	3,407.39	3,317.94	5,108.25	4,999.52	8,515.64	8,317.46	1.024
2023	3,444.09	3,431.07	5,251.79	5,168.08	8,695.88	8,599.15	1.011
2024	3,579.68		5,445.43		9,025.11		

Basis for ESRD Dialysis-only FFS USPCC Trend

Calendar year	Part A			Part B			Part A & Part B		
	All ESRD cumulative FFS trend	Adjustment factor for dialysis-only	Adjusted dialysis-only cumulative trend	All ESRD cumulative FFS trend	Adjustment factor for dialysis-only	Adjusted dialysis-only cumulative trend	All ESRD cumulative FFS trend	Adjustment factor for dialysis-only	Adjusted dialysis-only cumulative trend
2020	0.94529	1.00089	0.94613	0.97597	0.99890	0.97490	0.96377	0.99968	0.96346
2021	1.02081	1.00178	1.02263	1.04170	0.99780	1.03941	1.03340	0.99936	1.03274
2022	1.11768	1.00267	1.12066	1.11252	0.99670	1.10886	1.11457	0.99908	1.11355
2023	1.12871	1.00357	1.13273	1.14505	0.99561	1.14002	1.13855	0.99874	1.13712
2024	1.17211	1.00446	1.17733	1.18857	0.99451	1.18205	1.18202	0.99843	1.18017

Summary of Key Projections

Part A[1]

Year	Calendar year CPI percent change	FY inpatient PPS update factor	FY Part A total reimbursement (incurred)
2003	2.2%	3.0%	3.5%
2004	2.6	3.4	8.4
2005	3.5	3.3	8.8
2006	3.2	3.7	5.9
2007	2.9	3.4	5.7
2008	4.1	2.7	7.6
2009	–0.7	2.7	6.7
2010	2.1	1.9	3.0
2011	3.6	−0.6	4.5
2012	2.1	−0.1	0.4
2013	1.4	2.8	4.7
2014	1.5	0.9	0.6
2015	–0.4	1.4	3.2
2016	1.0	0.9	4.3
2017	2.1	0.2	4.0
2018	2.5	1.8	4.0
2019	1.6	1.9	5.4
2020	2.2	3.1	1.7
2021	2.3	2.9	8.0
2022	2.3	2.8	8.7
2023	2.3	3.8	5.2
2024	2.3	3.2	6.5

Part B[2]

Calendar year	Physician fee schedule: Fees[3]	Physician fee schedule: Residual[4]	Outpatient hospital	ESRD dialysis update factor[5]	Total
2003	1.4%	4.5%	4.4%		6.8%
2004	3.8	5.9	11.1		9.8
2005	2.1	3.2	10.8		7.0
2006	0.2	4.6	5.1		6.1
2007	-1.4	3.5	8.2		4.3
2008	-0.3	4.0	6.3		4.8
2009	1.4	2.3	5.4		3.9
2010	2.3	2.1	6.6		2.4
2011	0.8	2.3	7.1	2.5%	2.3
2012	-1.2	0.8	7.2	2.1	1.7
2013	-0.1	0.2	7.2	2.3	0.8
2014	0.4	0.6	12.6	2.8	3.4
2015	-0.3	-0.3	7.4	0.0	2.7
2016	-0.4	-0.3	5.2	0.15	1.8
2017	0.1	1.1	7.4	0.55	2.8
2018	0.5	1.2	8.4	0.3	5.8
2019	1.2	2.8	5.3	1.3	5.8
2020	0.2	-12.3	-8.7	1.7	-1.4
2021	-0.3	9.8	18.6	1.6	8.0
2022	0.0	11.0	20.4	1.5	8.6
2023	0.0	-0.5	6.3	2.2	3.9
2024	0.0	2.7	8.2	2.2	5.5

[1] Percent change over prior year.

[2] Percent change in charges per aged Part B enrollee.

[3] Reflects the physician update and legislation affecting physician services—for example, the addition of new preventive services enacted in 1997, 2000, and 2010.

[4] Residual factors are factors other than price, including volume of services, intensity of services, and age/sex changes.

[5] The ESRD Prospective Payment System was implemented in 2011.

Medicare Enrollment Projections (In millions)

Non-ESRD Total

	Part A		Part B	
Calendar year	Aged	Disabled	Aged	Disabled
2003	34.437	5.961	33.038	5.215
2004	34.849	6.283	33.294	5.486
2005	35.257	6.610	33.621	5.776
2006	35.795	6.889	33.975	6.017
2007	36.447	7.167	34.465	6.245
2008	37.378	7.362	35.140	6.438
2009	38.257	7.574	35.832	6.664
2010	39.091	7.832	36.516	6.938
2011	39.950	8.171	37.247	7.254
2012	41.687	8.411	38.546	7.502
2013	43.087	8.629	39.779	7.732
2014	44.533	8.775	41.063	7.894
2015	45.911	8.853	42.311	7.977
2016	47.371	8.862	43.624	7.990
2017	48.878	8.940	44.945	8.008
2018	50.457	8.696	46.310	7.863
2019	52.126	8.513	47.767	7.732
2020	53.626	8.229	49.342	7.518
2021	55.253	7.995	50.865	7.289
2022	56.934	7.897	52.447	7.183
2023	58.598	7.879	54.021	7.150
2024	60.233	7.799	55.572	7.061

Non-ESRD Fee-for-Service

	Part A		Part B	
Calendar year	Aged	Disabled	Aged	Disabled
2003	29.593	5.628	28.097	4.875
2004	29.946	5.931	28.300	5.128
2005	30.014	6.178	28.287	5.339
2006	29.362	6.149	27.459	5.270
2007	28.838	6.225	26.782	5.297
2008	28.613	6.241	26.301	5.311
2009	28.563	6.288	26.071	5.374
2010	28.903	6.455	26.261	5.556
2011	29.210	6.659	26.440	5.736
2012	29.960	6.693	26.744	5.779
2013	30.330	6.691	26.948	5.790
2014	30.603	6.618	27.060	5.732
2015	30.947	6.490	27.274	5.610
2016	31.630	6.379	27.815	5.503
2017	31.901	6.300	27.882	5.362
2018	32.169	5.869	27.927	5.030
2019	32.473	5.450	28.019	4.665
2020	32.158	4.865	27.777	4.128
2021	31.913	4.397	27.411	3.684
2022	32.109	4.078	27.510	3.358
2023	32.739	3.942	28.051	3.207
2024	33.395	3.720	28.620	2.977

ESRD

	ESRD - Total		ESRD - Fee-for-Service	
Calendar year	Total Part A	Total Part B	Total Part A	Total Part B
2003	0.340	0.331	0.319	0.309
2004	0.353	0.342	0.332	0.321
2005	0.366	0.355	0.344	0.332
2006	0.382	0.370	0.353	0.340
2007	0.396	0.383	0.361	0.347
2008	0.411	0.397	0.367	0.353
2009	0.426	0.412	0.374	0.360
2010	0.442	0.428	0.388	0.373
2011	0.429	0.416	0.371	0.358
2012	0.441	0.429	0.379	0.366
2013	0.454	0.441	0.385	0.372
2014	0.469	0.456	0.390	0.377
2015	0.482	0.468	0.393	0.379
2016	0.496	0.481	0.400	0.384
2017	0.511	0.494	0.403	0.386
2018	0.523	0.506	0.404	0.386
2019	0.534	0.517	0.403	0.385
2020	0.545	0.521	0.400	0.376
2021	0.555	0.528	0.362	0.334
2022	0.567	0.538	0.341	0.311
2023	0.579	0.548	0.337	0.305
2024	0.589	0.557	0.335	0.301

Part A Projections for non-ESRD (Aged+Disabled)*

Calendar year	Inpatient hospital	SNF	Home health agency	Managed care	Hospice: Total reimbursement (in millions)
2003	2,594.78	370.63	124.28	457.87	5,733
2004	2,714.57	413.44	133.89	500.73	6,832
2005	2,818.21	450.54	140.87	602.29	8,016
2006	2,764.82	475.07	141.30	757.25	9,368
2007	2,707.49	504.24	143.72	905.74	10,518
2008	2,695.88	536.68	151.00	1,074.98	11,404
2009	2,651.47	551.67	153.86	1,246.02	12,274
2010	2,627.03	571.74	155.18	1,249.70	13,126
2011	2,585.95	623.31	138.31	1,299.28	13,897
2012	2,489.44	541.69	130.82	1,360.09	15,068
2013	2,485.37	540.47	128.47	1,399.69	15,263
2014	2,424.42	534.37	123.89	1,355.87	15,346
2015	2,408.18	530.99	126.08	1,417.01	16,159
2016	2,430.67	504.86	121.45	1,474.91	17,143
2017	2,410.56	484.86	117.39	1,586.53	18,260
2018	2,384.45	465.99	113.91	1,695.19	19,599
2019	2,339.59	444.76	108.56	1,910.12	21,186
2020	2,095.09	444.18	89.44	2,172.16	22,297
2021	2,200.22	450.10	100.18	2,365.35	23,890
2022	2,376.22	446.62	104.46	2,567.55	25,357
2023	2,353.60	462.12	115.96	2,638.66	27,273
2024	2,407.96	479.32	121.52	2,781.56	29,373

*Average reimbursement per enrollee on an incurred basis.

Part B Projections for non-ESRD (Aged+Disabled)*

Calendar year	Physician fee schedule	Outpatient hospital	Durable medical equipment
2003	1,226.51	364.77	196.96
2004	1,344.01	418.85	195.61
2005	1,397.43	477.65	196.83
2006	1,396.40	497.47	197.78
2007	1,368.35	526.92	195.68
2008	1,367.83	555.09	200.92
2009	1,386.03	587.64	183.61
2010	1,429.74	623.14	183.76
2011	1,459.64	663.06	175.84
2012	1,412.74	697.92	173.70
2013	1,369.67	735.39	152.53
2014	1,351.36	823.41	128.58
2015	1,336.30	876.10	132.78
2016	1,313.78	911.24	120.73
2017	1,293.73	953.07	112.38
2018	1,286.19	999.91	127.47
2019	1,302.41	1,017.57	130.11
2020	1,119.24	887.09	123.76
2021	1,189.91	1,006.74	113.44
2022	1,276.01	1,174.89	113.98
2023	1,241.48	1,234.10	116.66
2024	1,256.62	1,318.89	120.03

Calendar year	Carrier lab	Physician administered drugs	Other carrier	Intermediary lab
2003	73.73	182.58	147.21	75.18
2004	78.48	195.20	158.78	80.47
2005	82.71	178.77	184.02	84.16
2006	85.59	185.41	175.66	84.51
2007	90.65	186.97	176.55	84.38
2008	94.50	184.43	182.19	85.78
2009	101.60	196.19	176.69	79.19
2010	103.81	196.41	176.03	80.23
2011	103.85	209.50	177.27	83.31
2012	111.73	209.34	183.09	84.64
2013	111.79	216.91	174.96	81.74
2014	117.60	224.56	171.34	55.45
2015	113.99	252.11	172.69	55.26
2016	100.91	271.45	170.67	56.21
2017	100.68	280.54	175.18	54.99
2018	107.32	304.59	173.72	52.85
2019	108.66	327.07	171.74	49.41
2020	105.16	330.67	162.37	52.16
2021	116.68	364.10	162.74	54.29
2022	95.64	405.16	160.09	44.47
2023	100.68	430.52	163.70	45.56
2024	104.24	458.96	167.08	46.20

*Average reimbursement per enrollee on an incurred basis.

Calendar year	Other intermediary	Home health agency	Managed care
2003	113.99	136.75	421.40
2004	119.58	156.45	471.37
2005	139.78	179.44	560.31
2006	142.09	202.88	769.94
2007	151.16	232.33	931.18
2008	158.20	252.43	1,104.26
2009	187.44	282.09	1,203.79
2010	193.08	283.25	1,221.29
2011	198.15	255.13	1,276.29
2012	205.08	240.01	1,368.13
2013	194.43	234.72	1,497.49
2014	200.35	227.96	1,705.76
2015	210.13	225.27	1,831.21
2016	214.00	219.63	1,938.91
2017	220.91	209.51	2,097.24
2018	228.93	207.06	2,376.25
2019	236.77	202.73	2,704.91
2020	217.37	162.44	3,113.66
2021	235.78	182.53	3,459.45
2022	238.03	189.83	3,827.99
2023	246.54	210.54	4,026.87
2024	256.33	220.50	4,311.27

* Average reimbursement per enrollee on an incurred basis.

2022 Projections by Service Category for non-ESRD (Aged+Disabled)*

Service type	Current estimate	Last year's estimate	Ratio
Part A			
Inpatient hospital	$2,376.22	$2,439.23	0.974
SNF	446.62	479.31	0.932
Home health agency	104.46	116.38	0.898
Managed care	2,567.55	2,351.42	1.092
Part B			
Physician fee schedule	1,276.01	1,301.03	0.981
Outpatient hospital	1,174.89	1,236.26	0.950
Durable medical equipment	113.98	125.53	0.908
Carrier lab	95.64	109.32	0.875
Physician Administered Drugs	405.16	397.87	1.018
Other carrier	160.09	174.15	0.919
Intermediary lab	44.47	48.95	0.908
Other intermediary	238.03	260.39	0.914
Home health agency	189.83	208.93	0.909
Managed care	3,827.99	3,519.29	1.088

* Average reimbursement per enrollee on an incurred basis.

Claims Processing Costs as a Fraction of Benefits

Calendar year	Part A	Part B
2003	0.001849	0.011194
2004	0.001676	0.010542
2005	0.001515	0.009540
2006	0.001245	0.007126
2007	0.000968	0.006067
2008	0.000944	0.006414
2009	0.000844	0.005455
2010	0.000773	0.005055
2011	0.000749	0.004396
2012	0.001008	0.003288
2013	0.000994	0.002846
2014	0.001003	0.002884
2015	0.000952	0.002730
2016	0.000852	0.002348
2017	0.000833	0.002111
2018	0.000836	0.001953
2019	0.000699	0.001644
2020	0.000625	0.001536
2021	0.000625	0.001536
2022	0.000625	0.001536
2023	0.000625	0.001536
2024	0.000625	0.001536

Approximate Calculation of the USPCC, the National MA Growth Percentage for Combined (Aged+Disabled) Beneficiaries, and the FFS USPCC (Aged+Disabled)

The following procedure will approximate the actual calculation of the USPCCs from the underlying assumptions for the contract year for both Part A and Part B.

Part A: The Part A USPCC can be approximated by using the assumptions in the tables titled "Part A Projections for non-ESRD (Aged+Disabled)" and "Claims Processing Costs as a Fraction of Benefits." Information in the "Part A Projections" table is presented on a calendar year per capita basis. First, add the per capita amounts over all types of providers (excluding hospice). Next, multiply this amount by 1 plus the loading factor for administrative expenses from the "Claims Processing Costs" table. Then, divide by 12 to put this amount on a monthly basis.

Part B: The Part B USPCC can be approximated by using the assumptions in the tables titled "Part B Projections for non-ESRD (Aged+Disabled)" and "Claims Processing Costs as a Fraction of Benefits." Information in the "Part B Projections" table is presented on a calendar year per capita basis. First, add the per capita amounts over all types of providers. Next, multiply by 1 plus the loading factor for administrative expenses and divide by 12 to put this amount on a monthly basis.

The National Per Capita MA Growth Percentage: The National Per Capita MA Growth Percentage for 2022 (before adjusting for prior years' over/under estimates) is calculated by

adding the USPCCs for Part A and Part B for 2022 and then dividing by the sum of the current estimates of the USPCCs for Part A and Part B for 2021.

The FFS USPCC: The tables used to calculate the total USPCC can also be used to approximate the calculation of the FFS USPCC. The per capita data presented by type of provider in the projections tables for both Part A and Part B are based on total enrollment. To approximate the FFS USPCCs, first add the corresponding provider types under Part A and Part B separately. For the FFS calculations, do not include the managed care provider type. Next, rebase the sum of the per capita amounts for FFS enrollees, i.e., multiply the sum by total enrollees and divide by FFS enrollees. (The enrollment tables in this attachment now also include FFS enrollment). Then, multiply by 1 plus the loading factor for administrative expenses and divide by 12. The result will only be approximate because there is an additional adjustment to the FFS data which accounts for cost plan data which comes through the FFS data system. This cost plan data is in the total per capita amounts by type of provider, but it is removed for the FFS calculations.

Attachment III. Responses to Public Comments on Part C Payment Policy

In this attachment, we summarize public comments received and provide responses.

Section A. Estimates of the MA and FFS Growth Percentages for 2022

Comment: Many commenters recommended that CMS provide additional details regarding the sources of data and assumptions behind the agency's estimates, especially with regard to the COVID-19 pandemic. One commenter noted their belief that the level of details pertaining to the amounts and methodology of projected COVID-19 costs in the Advance Notice makes it difficult for plans to provide meaningful comment on projected costs for 2022. Several commenters recommended that CMS ensure the FFS growth percentages accounts for all COVID-19-related services, including COVID-19 vaccine administration, and release all data and assumptions so plans can confirm and provide detailed feedback

Specific requests from commenters:

- Several commenters requested that CMS provide additional detail regarding the deferred utilization of care and consider the long-term implications beyond CY 2021. One commenter noted that the impact of the COVID-19 pandemic will likely continue to disrupt the health care system due to deferred care and the currently unknown long-term effects of COVID-19 infection on individual health.
- One commenter cited a reduction in care in 2020, particularly in the second quarter, and CMS' expectation that 40-45 percent of care would be provided at the end of 2020 and in 2021. They requested additional information about the determination of the 40-45 percent estimate, including assumptions by service category, timing of the care and detailed calculations underlying the current estimates of 2020 and 2021 USPCCs.
- A few commenters requested that CMS release a quantitative summary of the expected changes in the utilization of health care services due to the COVID-19 pandemic reflected in the USPCCs for 2020, 2021, and 2022. The commenter recommended including costs that MA plans will be required to pay in 2022, such as vaccine administration, distribution and management costs, drugs, and treatment costs in benchmarks. One commenter encouraged CMS to ensure additional COVID-19 FFS costs for treatment and testing carry through to MA in 2022 and future rate setting processes.

Response: The growth percentages and USPCCs are based on CMS' best estimate of historical program experience and projected trend at the time those values are announced. We continue to consider it best practice to base the growth rates on the most recent data and assumptions at the time those values are announced. Therefore, for each release of the growth rates, CMS updates historical enrollment and claims, as well as projection factors, based on the most recent data. Section 1853 of the Act requires MA capitation rates to be based on FFS per capita costs, and therefore we make updates using the most current FFS data available and apply repricing

adjustments to reflect changes in FFS payment rules in order to best reflect program experience and develop appropriate projection factors.

We discussed in the CY 2022 Advance Notice Part II the methodology, sources of data, assumptions, and trends underlying the MA capitation rates at a level of detail consistent with past practice, which we believe to be sufficient for the public to understand and provide meaningful comments on the development of the MA capitation rates. In addition to the information provided in the CY 2022 Advance Notice Part II, CMS also shared detailed information about actuarial assumptions related to the impact of the COVID-19 pandemic and vaccine costs on growth rates in its Actuarial User Group call on November 12, 2020. Specifically, the call addressed actuarial assumptions about deferred care due to the COVID-19 PHE and cost and utilization of the COVID-19 vaccine. Participants of the call were invited to ask questions about assumptions supporting the CY 2022 Advance Notice growth rates. This call was widely attended by stakeholders, and the call's agenda and materials are available at https://www.cms.gov/files/document/user-group-call-agenda-2020-11-12.pdf.

Further, in Attachment II of this Rate Announcement and below, we also provide updated key economic assumptions underlying the USPCCs. Consistent with prior years, after the release of this Rate Announcement, we will publish additional information regarding trends for the prior five years that will be available at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Trends.html.We believe that this useful information in the CY 2022 Advance Notice and now the Rate Announcement provides the necessary support for understanding USPCC levels and trends that commenters are requesting. We will consider the comments regarding the timing and feasibility of data releases for future contract years.

Finally, we continue to monitor the emerging impacts of the COVID-19 pandemic and have updated the assumptions for the growth rates announced in Attachment I, as described briefly below.

Compared to the corresponding projections in the CY 2021 Rate Announcement, the current estimate of the CY 2020 non-ESRD FFS USPCC is down 10.7 percent. Most of the reduction is due to care that is projected to be forgone or deferred to CY 2021 or CY 2022 due to the effects of the COVID-19 pandemic.

Compared to the projections supporting the CY 2021 Rate Announcement, the projections supporting the CY 2022 Rate Announcement USPCCs for CY 2020 have changed as follows: inpatient: -9 percent; skilled nursing facility: -1 percent; home health: -25 percent; physician fee schedule: -13 percent; outpatient hospital: -17 percent; and physician administered drugs: -3 percent.

The current estimate of the CY 2021 FFS non-ESRD USPCC is down 4.7 percent relative to the corresponding projection supporting the CY 2021 Rate Announcement.

Compared to the projections supporting the CY 2021 Rate Announcement, the projections supporting the CY 2022 Rate Announcement USPCCs for CY 2021 have changed as follows: inpatient: -5 percent; skilled nursing facility: +0 percent; home health: -17 percent; physician fee schedule: -5 percent; outpatient hospital: -9 percent; and physician administered drugs: +2 percent.

The latest projections reflect the assumption that as a result of the COVID-19 pandemic, medical care for non-COVID services was reduced significantly. Some of that care is now assumed to be deferred until a later date, and that deferred care is now expected to be more intensive. As a result of the reduction in care in CY 2020 due to COVID-19, we estimate that 2020 FFS spending decreased by eight percent for Medicare Part A and 11 percent for Medicare Part B relative to the estimated costs supporting the CY 2021 Rate Announcement. With a large wave of the pandemic now expected for early 2021, non-COVID services are again expected to be lower-than-normal in 2021. This reduction is partially offset by some of the deferred care returning in 2021. The net impact is that 2021 FFS spending is now estimated to be roughly four percent lower than the estimates for both Part A and Part B supporting the CY 2021 Rate Announcement. As deferred care is now estimated to continue to return in 2022, 2022 FFS spending is estimated to be about two percent higher than estimates for both Part A and Part B supporting the CY 2021 Rate Announcement – this is also partially the reason for the difference between the 2022 FFS spending estimates in the CY 2022 Advance Notice Part II and this Rate Announcement.

Comment: Some commenters expressed concern about the absence of proposed policies or methodological changes that they believe are needed to address the COVID-19 PHE, the absence of which they argued would harm the stability of the MA program and adversely impact premiums and supplemental benefits for 2022 and future years.

A few of these commenters recommended that CMS consider ways to modify its traditional methodologies and payment factors to account for the extraordinary and uniquely disruptive nature of the COVID-19 PHE. The commenters requested that for CY 2023 and beyond, CMS consider applying a hold harmless provision or establish a floor to growth rates if there are large changes in growth rate estimates over the next few years driven by the COVID-19 PHE. They believe a hold harmless provision would ensure payment rates do not fall sharply if current estimates of growth prove inaccurate.

One commenter also requested CMS analyze how experience under the FFS and MA programs for CY 2020, 2021, and 2022 may be impacted differently during the pandemic. Several commenters are concerned that the 2022 FFS growth percentage is based on a FFS utilization trend that is lower than observed MA utilization trends. They recommended that CMS validate the accuracy of the FFS growth percentage, share additional information on the actuarial assumptions that underlie the calculation of the FFS growth percentage, and consider an adjustment to reflect the impact of the COVID-19 PHE on FFS vs. MA utilization.

Response: We appreciate the feedback provided by the commenters regarding payment policies for CY 2022 and beyond, and interest in the stability of payments year-over-year. We will take the commenters' concerns into account as we develop policies for future years. We note, however, that the statute prescribes the general approach to updating the USPCCs, and section 1853 requires that FFS per capita costs be used in developing MA rates. The statutory formula for developing MA rates does not consider MA-specific utilization and MA-specific costs.

Comment: Some commenters expressed concern regarding the underlying assumptions of the COVID-19 vaccine costs used in projecting the FFS growth percentage. They requested additional information and data sources underlying the assumptions for the costs associated with the vaccine administration. They are concerned that actual costs will be higher than projected costs without an appropriate adjustment to the benchmark. A commenter requested that CMS, to the extent possible, provide additional information about the assumptions used in developing MA rates regarding vaccine utilization, as to how the vaccine will impact COVID-19 prevalence and health care utilization by service category.

A few commenters noted CMS' use of the flu vaccine rate as the basis for estimating the COVID-19 vaccine rate. They cited research that suggested that significant effectiveness differences between the flu and COVID-19 vaccines and the significant death rate differences between the flu and COVID-19 would prompt greater public adoption of the COVID-19 vaccine relative to the flu vaccine.

Some commenters requested that CMS explain in more detail the assumptions, provided at the Fall Actuarial User Group Call on November 12, 2020, that 32 percent of FFS Medicare beneficiaries will receive a COVID-19 vaccine in 2021, that 52 percent of FFS beneficiaries will receive a COVID-19 vaccine in 2022, that there will be an average of two doses per utilizer, and the $88 average cost per dose. They are requesting CMS to clarify if it is projecting 84 percent or 52 percent cumulatively for the COVID-19 vaccination rate by the end of 2022. They believe if the projection has assumed only 52 percent by the end of 2022, then CMS should consider increasing this assumption.

A commenter expressed concern that vaccine ingredients and administrative costs could be significantly higher in 2022 than CMS estimated given uncertainty around the availability, clinical requirements, safety, efficacy, and prices of vaccines. Accordingly, stakeholders requested that they should be given the opportunity to identify any CMS projections they believe may be unrealistic and lead to inaccurate assumptions about utilization or costs. The commenter requested clarification regarding the share of the COVID-19 vaccine that CMS projects would be administered in 2022.

Response: We acknowledge the uncertain nature of the assumptions about the COVID-19 vaccine and the financial impact of the COVID-19 pandemic. The growth percentages, including

the assumptions related to COVID-19, are the current best estimates of the CMS Office of the Actuary.

The COVID-19 vaccine assumptions supporting the 2021 FFS USPCCs are: 60 percent of FFS beneficiaries will receive a COVID-19 vaccine during CY 2021, there will be an average of 2.2 doses per utilizer, and the average Medicare program cost per dose will be $28. The per-dose cost is based on estimated administration cost of $25 and vaccine cost of $3. The vaccine cost was developed under the assumption that most of the approved vaccines would be funded through Operation Warp Speed. Additionally, the COVID-19 vaccine assumption supporting the 2022 FFS USPCCs are: 52 percent of FFS beneficiaries will receive a COVID-19 vaccine during 2022, there will be an average of 2.0 doses per utilizer, and the average Medicare program cost per dose will be $88. The per-dose cost is based on estimated administration cost of $28 and vaccine cost of $60. We project vaccination rates to be similar over the next several years to take into account the potential need for beneficiaries to be vaccinated and have updates to their vaccinations at regular intervals. There is no explicit assumption for COVID-19 testing in the CY 2022 FFS USPCCs.

Comment: A commenter recommended that CMS continue to exclude the cost of the COVID-19 vaccines from MA capitation rates beyond CY 2021 and continue to pay for them under FFS. The commenter suggested that capitation is most appropriate for services with predictable costs and there exists too much uncertainty with respect to a COVID-19 vaccine so a capitated payment is likely to overpay or underpay health plans. The commenter cited concern that the variance in timing of vaccine production, distribution, or adoption could materially impact costs incurred in 2022.

Response: Section 1852(a)(5) of the Social Security Act and 42 CFR § 422.109 provide that if the projected cost of a National Coverage Determination (NCD) or a legislative change in benefits meets a significant cost threshold, coverage of the new benefit for beneficiaries enrolled in a Medicare Advantage (MA) plan will be provided through the FFS program until the MA capitation rates take the new significant cost into account. Given that the cost of the COVID vaccine was not reflected in the CY 2020 and CY 2021 MA ratebooks, the COVID-19 vaccines administered during CY 2020 and CY 2021 to MA beneficiaries will be made through the Medicare FFS program. The COVID-19 vaccine has been granted an emergency use authorization and is being distributed. Consistent with past practice as well as statutory and regulatory requirements, the estimated cost of the COVID-19 vaccines administered during CY 2022 is reflected in the 2022 capitation rates and benchmarks, and MA organizations must cover such costs beginning January 1, 2022.

Comment: One commenter stated that Special Needs Plans (SNPs) have not had significant COVID-19 pandemic-related declines in health care utilization among their populations, and that if CMS applies a trend using 2020 or 2021 as the baseline year, this disparity between SNPs' and FFS' delayed care could lead to inequitable rates. They recommended CMS analyze SNP

utilization in 2020 and determine if it would be more equitable to use 2019 FFS data as the baseline year since it is not impacted by the COVID-19 pandemic.

Response: We appreciate the recommendation provided by the commenter suggesting CMS use 2019 FFS data as the baseline year for setting SNP payment rates. The assumptions used in calculating FFS costs, which are compliant with rate setting requirements set forth in statute, are based on the most current economic forecasts, recent program experience, and other factors. The FFS growth rate used to update the ratebook reflects experience across the entire FFS Medicare program and, as required by statute, drives the overall change in MA benchmarks. CMS does not have authority to set rates by plan type or plan experience, but develops rates that reflect the costs of benefits for the average Medicare beneficiary. Other components of payment, including plan bids and risk adjustment, take into account plan-specific experience.

Key economic assumptions underlying the USPCCs are included in Attachment II of this Rate Announcement. Consistent with prior years, after the release of this Rate Announcement we will publish additional information regarding trends for the prior five years that will be available at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Trends.html.

We believe that this useful information provides the necessary support for understanding USPCC levels and trends that commenters are requesting.

Comment: A commenter noted that CMS issued guidance that the agency will not reimburse MAOs for implementing a payment increase for contracted inpatient hospitals, even though the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) increased the Inpatient Prospective Payment System weighting factor of the assigned Diagnosis-Related Group (DRG) by 20 percent for an individual diagnosed with COVID-19 discharged during the PHE. Since many MA contracts tie reimbursement to FFS rates, and many MA plans must pay the increased FFS rate for both contracted and non-contracted hospitals, they urged CMS account for the FFS payment increases in MA.

Response: We appreciate the recommendation provided by the commenter regarding adjustments to payment policy in response to the COVID-19 PHE. As noted above, section 1853 of the Act requires that MA rates be developed using FFS per capita costs. Therefore, whether the MA plan pays contracted providers the 20 percent increase does not affect the FFS costs supporting the MA capitation rates. The cost of increasing the DRG relative weight for COVID-19 discharges is built into the USPCCs and, consequently, included in the MA ratebook. The costs associated with such an increase in MA payments to providers could be included in CY 2022 bids. The assumptions used in calculating the updated FFS costs for CY 2020 and CY 2021 are based on the most current economic forecasts, recent program experience, and other factors.

Comment: Multiple commenters cited their concerns over what they characterize as the erratic nature of growth rate updates. They believe the unpredictability of the growth rates is exacerbated by the uncertainty of 2022 costs created by the COVID-19 pandemic. A commenter

urged CMS to provide details regarding the sources of input behind the agency's assumptions, as well as any variability in these assumptions and impacts on the USPCCs. A few commenters urged CMS to provide projections of potential variability of these assumptions on USPCC and rate setting for future years to assist with the development of accurate bids.

One commenter requested that CMS provide specific explanation of how each published forecast (Advance Notice, Rate Announcement) is developed, including the types/sources of data and methodologies used for each, and the differences between the forecasts. The commenter also requested an explanation of any methodological changes or data corrections that occurred between each immediately prior Rate Announcement and current Advance Notice, and if there are significant rate differences from one forecast to the next, an explanation of the changes observed in individual service categories (e.g., inpatient hospital, physician services) and which categories most strongly influenced the rate changes.

Response: For CY 2022 rate development, as for prior contract years, the Medicare fee-for-service (FFS) experience supporting the FFS USPCCs is based on benefit payments from the Medicare Part A and Part B Trust Funds plus claims processing costs. The benefit payments are made for specific episodes of care as reflected in the National Claims History file, Medicare Cost Report settlements, provider bonuses and penalties for participation in Medicare innovation models, and other sources. The expenditures are apportioned to the incurred year for purposes of the USPCC tabulations. Additionally, adjustments are made to the USPCC experience to account for benefit payments that have been incurred but not paid.

The USPCCs and growth rates are based on the most recent experience available at the time those values are released. For example, the 2022 MA ratebook FFS growth rates are based on expenditures through September 30, 2020.

The projected FFS USPCCs are based on historical incurred claims with growth factors for assumed changes in prices, utilization, and case mix. These assumptions are based on the most current economic forecasts, recent program experience, and other factors, and are developed consistent with actuarial standards of practice adopted by the Actuarial Standards Board.

CMS has, as required under section 1853(b)(3), included an explanation of the assumptions and changes in methodology used in the CY 2022 Rate Announcement; see the key economic assumptions underlying the USPCCs included in Attachment II of this Rate Announcement. Consistent with prior years, after the release of this Rate Announcement we will publish additional information regarding trends for the prior five years, which will be available at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Trends.html.

We note that the primary driver of the change in growth rates between the CY 2022 Advance Notice and CY 2022 Rate Announcement are changes in our assumptions related to COVID-19. As noted above, medical care for non-COVID services has been reduced significantly as a result of the COVID-19 pandemic. Some of that care is now assumed to be deferred until a later date,

and that deferred care is now expected to be more intensive. We now estimate that 2020 FFS spending decreased by eight percent for Medicare Part A and 11 percent for Medicare Part B relative to the estimated costs supporting the CY 2021 Rate Announcement. With a large wave of the pandemic now expected for early 2021, non-COVID services are again expected to be lower-than-normal in 2021. This reduction is partially offset by some of the deferred care returning in 2021. The net impact is that 2021 FFS spending is now estimated to be roughly four percent lower than the estimates for both Part A and Part B supporting the CY 2021 Rate Announcement. As deferred care is now estimated to continue to return in 2022, 2022 FFS spending is estimated to be about two percent higher than estimates for both Part A and Part B supporting the CY 2021 Rate Announcement.

We believe that this useful information provides the necessary support for understanding USPCC levels and trends that commenters are requesting.

Comment: A commenter noted that CMS does not discuss the extent to which its cost estimates reflect Medicare's Accelerated and Advance Payments Program, which provides advance funds to Medicare Part A and Part B providers and expanded dramatically in response to the COVID-19 PHE. They believe these payments have the potential to skew cost and growth expectations for 2020 and future years.

Response: Expenditures under the Medicare Accelerated and Advance Payments Program do not represent payments to providers for particular episodes of care and thus are not components of incurred costs for FFS utilization. CMS bases the FFS USPCCs and growth rates on incurred experience for specific services, regardless of when payment was made to the provider. Therefore, payments made under the Medicare Accelerated and Advance Payments Programs will only be reflected in the CY 2022 growth rates and the tabulation of USPCCs to the extent they cover costs for any incurred services in the experience data.

Comment: A commenter expressed that they are pleased to see a continued payment increase in MA over the past years.

Response: We appreciate the feedback of the commenter.

Comment: A commenter noted that the CY 2020 Total USPCC estimate in Table I-3 of the CY 2022 Advance Notice Part II decreased by approximately six percent in comparison to the CY 2020 Total USPCC estimate in the CY 2021 Rate Announcement. They also noted that Table I-4 indicated the CY 2020 FFS USPCC estimate decreased by approximately 12 percent between the CY 2021 Rate Announcement and the CY 2022 Advance Notice. They interpreted this as implying that the 2020 non-FFS USPCC increased by two percent compared to the previous estimate and requested that CMS explain the rationale for large difference between the FFS and non-FFS USPCCs.

Response: The MA portion of the estimate of the 2020 Total USPCC is based on the 2020 MA capitation payments made to plans. The 2020 MA capitation payments made to plans were not significantly restated. The 2020 MA capitation payments made to plans are not impacted by the COVID-19 pandemic since these payments were determined based on bids and benchmarks that were developed and finalized prior to the pandemic's onset (that is, CY 2020 ratebooks were finalized in April 2019, and CY 2020 bids were submitted in June 2019). The FFS portion of the estimate of the 2020 Total USPCC is based on incurred FFS costs based on utilization in the service year.

Comment: Some commenters cited that growth in the FFS dialysis-only ESRD USPCC lags that of the FFS non-ESRD USPCC. They noted that the FFS dialysis-only ESRD USPCC also appears to exhibit a higher degree of year-to-year volatility. One commenter's review of the comparison tables shows significant differences in current and previous FFS dialysis-only ESRD USPCCs for a given year. In addition, they cited that sizable changes have occurred between the FFS dialysis-only ESRD USPCC trends included in a given year's Advance Notice and Rate Announcement. They indicated that this volatility can challenge MA organizations' planning capabilities. The commenters believe CMS has not explained why the ESRD growth rate trends are often inconsistent with and much more volatile than the FFS growth rate trends.

The commenters requested that CMS release more data and be more transparent about the specific data and trends, underlying methodology, and other variables impacting the FFS ESRD USPCC. More specifically, a commenter requested that CMS provide detailed information that addresses the historic volatility of the ESRD growth rate over time. A commenter requested that CMS consider issuing a document outlining the FFS dialysis-only ESRD USPCC trends along with a narrative description of its components, similar to the materials that CMS prepares and releases on the FFS non-ESRD USPCC.

A commenter urged CMS to explore policy options to avoid making material negative revisions between the Advance Notice and Final Announcement and smooth out large year-to-year fluctuations. They believe such a policy could be imperative given the impact of the COVID-19 pandemic and the impact these circumstances may have on developing and announcing MA rates on an accelerated timeline.

A few commenters noted that the ESRD growth percentage is developed based on the most recent calendar year of data available, trended to the upcoming year, leading to large swings and volatility in ESRD payment. The commenters believed that to improve accuracy and better align with the FFS non-ESRD USPCC, CMS should modify the methodology for the ESRD growth percentage to use five years of FFS claims data, rather than just one year.

Response: We appreciate the feedback submitted by the commenters. As discussed in past Rate Announcements, we believe it is important to update the FFS per capita cost estimates using the most current FFS data available at the time those values are announced and apply repricing

adjustments to reflect changes in FFS payment rules. Similar to prior Rate Announcements, the method for calculating the county level non-ESRD rates and the state level ESRD rates includes a five-year rolling average of historical claims experience, which provides some measure of stability in the rates. We continue to refine and improve our data and methodology used in the projection of the ESRD dialysis growth percentage. However, there are often unforeseen changes in trends stemming from factors such as finalization of regulations, changes in statute, and aberrations in utilization.

Both the non-ESRD and ESRD ratebook AGAs are based on five years of historical data. Further, the FFS non-ESRD USPCCs are tabulated directly from the baseline projection model. The ESRD dialysis USPCCs also are derived from the total ESRD USPCC baseline but are adjusted for recent trend differences between the total ESRD and dialysis ESRD populations. Thus, the ESRD dialysis USPCCs are projected using a base year USPCC, CY 2019 for the 2022 dialysis ESRD ratebook, trended from 2019 to 2022 using total ESRD growth with an "adjustment factor for dialysis only." The utilization and intensity assumptions supporting the ESRD trends are based on multiple years of historical experience. The applicable trends are found in the Attachment II table, "Basis for ESRD Dialysis-only FFS USPCC Trend."

Comment: One commenter asked to confirm the percentage increase applied to PACE rates.

Response: The PACE county rates are established using the applicable amount as determined under section 1853(k)(1) without excluding indirect medical education amounts or organ acquisition costs for kidney transplants, as discussed in Attachment II, Sections C and D of the CY 2022 Advance Notice Part II. In a rebasing year such as CY 2022, the applicable amount is the greater of the county's FFS costs or the previous year's applicable amount increased by the MA growth percentage. As discussed in Attachment I of this document, the MA growth percentage for CY 2022 is 6.30 percent.

Comment: A few commenters believe the Most Favored Nation Model Interim Final Rule with Comment Period (CMS-5528-IFC) (85 FR 76180), referenced throughout this document as the MFN IFC, will negatively affect 2022 bids because significantly lower MFN Model rates may not be attainable in the MA program but will be incorporated into MA benchmarks. Commenters cited that in the MFN IFC, CMS Office of the Actuary (OACT) estimated that payments to MA plans would be reduced between $28.5 billion and $49.6 billion over seven years due to reduced FFS spending. The commenters are concerned the MFN Model will affect costs and projected growth rates for 2022 and, in turn, negatively impact bids, premiums, and supplemental benefits. They encouraged CMS to make an adjustment to MA ratebook calculations to ensure the Model will not undermine the stability of the MA and Part D programs and result in higher overall costs, less benefits, and fewer plan offerings for MA beneficiaries.

A few commenters, citing concerns over expected legal challenges to the MFN IFC, urged CMS to consider the implications of the model on the overall rate setting process and to coordinate

with plan actuaries well in advance of the bid cycle. The commenters recommended full transparency in upcoming bid guidance, methods for making adjustments to the model for future contract years, and potential model recalibrations to adjust for the extraordinary impacts to the MA program. A commenter recommended CMS share information with plans as soon as possible to ensure plans have an opportunity to analyze the data and assess the impacts in preparation for bids. This commenter also suggested CMS provide in advance details on how the MFN IFC will be accounted for in AGA and benchmark calculations for CY 2022.

Response: As stated in the "Key Updates from the Advance Notice" section of this document, for the Announcement of CY 2022 MA Capitation Rates, the Secretary has directed the CMS Office of the Actuary to assume the current state of legal affairs concerning the Innovation Center's MFN IFC will remain in place, and thus exclude the impact of the MFN Model on the growth rate estimates used to calculate the 2022 MA capitation rates. Assuming the current state of legal affairs remains in place (including the current preliminary injunction) reflects the current best estimate of what expenditures will be in 2022.

Also, consistent with prior years, CMS did not propose to reprice Part B drugs in the CY 2022 Advance Notice, and we have not developed the data and systems to support such repricing. Therefore, we would not reprice Part B drugs to account for the MFN IFC as part of our adjustments to the AGAs irrespective of the Secretarial direction related to the treatment of the MFN IFC.

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

Comment: Several commenters expressed concern that the pre-ACA rate cap diminishes incentives for high performing plans to continuously improve quality. Commenters believed that the inclusion of the quality bonus in the rate cap calculation harms beneficiaries by undermining value-based care and reducing benefits to enrollees in high quality plans. One commenter expressed concern that the cap is inconsistent with Congressional intent and is contrary to ensuring that seniors receive the highest possible quality of care.

Commenters suggested that we review our options for exercising discretionary, regulatory, and/or demonstration authority to eliminate the cap or to remove quality bonuses from the cap calculation and reward high performing plans. Two commenters referred to legal analyses provided to CMS in previous years regarding this issue that showed that they believed such changes were legally permissible.

Response: As we have stated in response to similar comments in prior Rate Announcements, while we appreciate the commenters' concerns, there is no discretion under section 1853(n)(4) of the Act to eliminate application of the pre-ACA rate cap or exclude the bonus payment from the cap calculation.

Given this lack of discretion, we note that the Fiscal Year 2021 President's Budget included a legislative proposal to remove the cap on MA benchmarks and also to remove the doubling of quality bonus payments in qualifying counties.[2]

Comment: Two commenters noted that CMS changed the definition of a "new MA plan" in the regulations at § 422.252 for the 2022 quality bonus payments (QBPs) only. For 2022 only, a "new MA plan" means an MA contract offered by a parent organization that has not had another MA contract in the previous four years, a change from the prior three-year requirement, which affects new contracts that started in 2019. With this change, new plans started in 2019 will continue to be considered new in 2022 and receive the 3.5 percent QBP. One commenter supported this change, while the other commenter pointed out that this could result in lower or higher payments from CMS depending on the Star Rating a plan would have had for CY 2022 if it had been measured; the commenter believes that this policy should be a net positive for MA plans.

Response: We appreciate the feedback submitted by the commenters. As we stated on page 16 of the CY 2022 Advance Notice Part II, we finalized this modification to the definition of "new MA plan" in the regulations at § 422.252 for the 2022 QBPs only (see the Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency Interim Final Rule (CMS-1744-IFC) (85 FR 19269–19275)). As explained in the IFC, this change was necessary because the CAHPS and HEDIS data that would otherwise be used for the 2021 Star Ratings for a new MA plan that started in 2019 is not available because we eliminated the requirement to submit those CAHPS and HEDIS data. (85 FR 19275). The change to the definition of "new MA plan" is limited to the 2021 Star Ratings (and therefore, the 2022 QBPs) only.

Comment: One commenter expressed support for treating low enrollment contracts as qualifying contracts for QBP purposes. The commenter further requested that low enrollment contracts also be treated as new contracts under an existing parent organization that has had a contract in the preceding three-year period (or four-year period for 2022 QBP ratings), and receive an enrollment-weighted average of the Star Ratings earned by the parent organization's existing MA contracts.

Response: We appreciate the suggestion submitted by the commenter. As we stated on Page 17 of the CY 2022 Advance Notice Part II, section 1853(o)(3)(A)(ii)(II) of the Act, as implemented in the regulation at 42 C.F.R. § 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 an increase in payment under section 1853(o). The statute does not address the amount of the increase for low enrollment contracts. We intend to continue the

[2] https://www.whitehouse.gov/wp-content/uploads/2020/02/msar_fy21.pdf

longstanding policy of treating low enrollment contracts as qualifying contracts that receive the QBP of 3.5 percentage points, similar to the QBP percentage increase applied to new MA plans.

Comment: One commenter suggested that CMS work with Congress to change the current bonus and rebate retention structure from a "cliff" to a smoother payment scale/structure.

Response: We appreciate the feedback submitted by the commenter. The statutory requirements regarding quality bonus payments and rebates are prescribed in sections 1853(o) and 1854(c) of the Act, respectively.

Comment: One commenter expressed support for our determination that some of the counties in Puerto Rico will be eligible for the Qualifying County Bonus Payment in 2022. The commenter further requested that we review the remaining counties in Puerto Rico that are not classified as qualifying counties, suggesting that the 2004 Urban Floor criteria should be based on the entire territory and that Metropolitan Statistical Area delineations may be modified by the agency based on an OMB Bulletin dated February 28, 2013.

Response: As noted in Part II of the CY 2022 Advance Notice, section 1853(o)(3)(B) of the Act sets forth the criteria for determining a qualifying county for purposes of the QBP. We do not have discretion to classify a county as a qualifying county if it does not meet the statutory criteria. The counties in Puerto Rico that are not classified as qualifying counties do not meet the criterion that a qualifying county's MA capitation rate for 2004 was based on the amount specified in section 1853(c)(1)(B) of the Act for a Metropolitan Statistical Area with a population of more than 250,000.

Section C. Calculation of Fee-for-Service Costs

Comment: One commenter suggested that we consider releasing information regarding methodologies, adjustments, assumptions, and other rate calculations at more frequent intervals throughout the year or earlier in the year. Two commenters suggested that we release FFS data more frequently in order to give plans insight into year-over-year changes, which may be helpful as MA plans structure provider contracts and allow plans to anticipate changes in county rates.

Response: We appreciate the suggestions submitted by the commenters regarding ratebook releases for future contract years. We will consider these comments regarding the timing and feasibility of data releases. We intend to continue to release the Advance Notice (which includes proposed changes to be made in the methodology and assumptions from the previous Rate Announcement) for future years in a timely manner that is consistent with the timeframe in section 1853(b) of the Act.

Comment: One commenter requested that CMS consider removing 2020 data from any future FFS cost rebasing, given the uncertainty related to the COVID-19 pandemic. The commenter suggested that the 2020 data might not be stable enough to include in future rebasing. Another

commenter requested that we consider ways to maintain stability of the MA market in the coming years as the potentially disruptive impact of the COVID-19 pandemic reaches the data streams that flow into the MA benchmarks and other payment factors.

One commenter suggested that we announce how the 2020-2021 experience will be used in the calculation of future growth rates and benchmarks, in particular the five-year rolling average of data used to calculate the AGAs as the 2020–2021 experience would impact this aspect of ratebook development for years after the COVID-19 pandemic is over.

Response: We appreciate the feedback submitted by the commenters regarding ratebook calculations for future contract years, a topic which is out of the scope of the CY 2022 Rate Announcement. We will consider and address the impact of the COVID-19 pandemic on rate development for future years when appropriate, in future Advance Notices and Rate Announcements.

Comment: Several commenters expressed concern regarding the magnitude and variability of COVID-19 impacts across counties, as well as year-to-year fluctuations in rates, and expressed concern regarding the county-level rebasing adjustments. Two of the commenters suggested that we pause rebasing for the CY 2022 ratebook and not update the AGAs since they thought that this would minimize the impact of potential variation of COVID-19-related costs on the county rates, so CMS could develop how COVID-19 pandemic experience might be accounted for in future AGA updates, and also encouraged us to communicate the rebasing schedule with plans in advance.

Three of the commenters requested that we follow a rebasing schedule that is more closely aligned with the statutory minimum of once every three years, rather than annually, for consistency and stability.

One commenter appreciated that the historical county-level costs would not include 2020 FFS data, and thus the impact of the COVID-19 pandemic, in the AGA calculation of the CY 2022 rates, but the commenter may have misinterpreted this to mean that we had proposed to not rebase the rates.

Response: We appreciate the feedback submitted by the commenters and appreciate concerns about stability in rates. We note, however, that rebasing for CY 2022 will not be affected by COVID-19 costs because the five-year rolling average of historical data used in the AGA calculation for CY 2022 rates is based on 2015–2019 data, which was not impacted by the COVID-19 pandemic. As discussed in past Rate Announcements, given that MA county rates are based on FFS costs, we believe it is important to update the FFS per capita cost estimates using the most current FFS data available and apply repricing adjustments to reflect changes in FFS payment rules. We have stated in previous Rate Announcements that we anticipate rebasing the rates each year. We have also previously discussed how the method for calculating the county

level rates includes a five-year rolling average of historical claims experience, which provides a measure of stability in the rates. We are finalizing the proposal to rebase the CY 2022 rates.

We will consider the comments regarding the timing and frequency of rebasing and how to address the impact of the COVID-19 pandemic on the data used for AGAs as we plan for developing rates for 2023 and future years.

Comment: Two commenters stated that in some cases, the effect of rebasing county rates nearly offsets the effect of the growth rate, which they recommended CMS should take steps to avoid.

Response: While we appreciate the suggestion of the commenter, we do not find the suggestion that we restrict the impact of rebasing so that it does not exceed the impact of the growth rate to be consistent with the statutory requirements for rebasing. As discussed on page 13 of Part II of the CY 2022 Advance Notice, section 1853(c)(1)(D)(ii) of the Act requires CMS to rebase the county FFS rates periodically, which entails updating the estimate of each county's FFS costs using more current FFS claims information. In addition, as discussed in Part II of the CY 2022 Advance Notice, the growth rates are used in the calculation of MA rates, per section 1853(k) and (n) of the Act.

Comment: Many commenters requested that we calculate FFS spending using only claims and utilization data for beneficiaries enrolled in both Part A and Part B (rather than based on such data for beneficiaries in Part A and/or Part B, as is the practice today) because they believed that would be a more accurate, reasonable, appropriate, and/or equitable methodology. Many commenters cited MedPAC's support of benchmarks calculated based on FFS data for beneficiaries with both Part A and Part B.

Many commenters pointed out that in order to enroll in an MA plan, beneficiaries are required to be enrolled in both Part A and Part B. Several commenters expressed that the MA benchmark can only represent what an MA enrollee would cost in Medicare FFS, as required, if based on the Medicare FFS costs of only beneficiaries eligible for enrollment in MA. Two commenters suggested that the current approach is inconsistent with actuarial principles because the MA rates reflect Medicare FFS beneficiaries who are ineligible to enroll in MA. One commenter indicated that excluding Part A-only and Part B-only beneficiaries (i.e., beneficiaries not eligible to enroll in MA plans) would make the comparison of the MA bids to benchmarks a more reasonable comparison.

Two commenters stated that, over time, as a higher percentage of beneficiaries join MA plans, a higher percentage of beneficiaries remaining in FFS do not enroll in Part B. Many commenters noted that beneficiaries enrolled only in Part A had utilization and cost patterns that differ from beneficiaries enrolled in both Part A and Part B, and requested excluding Part A-only beneficiaries from the methodology to ensure rate adequacy. Three commenters noted that Part A-only enrollment varies by county, whereby certain counties are disproportionately impacted, and expressed concern regarding the changes in MA penetration and Part A only enrollment over

time. One of the commenters expressed concern that increasing MA penetration leaves fewer, and a less representative population of, beneficiaries on which to calculate FFS spending.

Two commenters stated that the risk adjustment models are calibrated with FFS beneficiaries enrolled in Part A and Part B, and recommended that risk adjustment and payment rates be based on the same population.

Three commenters expressed support for continuing our policy of basing benchmarks in Puerto Rico on Medicare costs for beneficiaries with both Part A and Part B coverage. One of the commenters requested that we apply a uniform approach in all counties to calculate benchmarks, pointing to the methodology used by CMS for Puerto Rico rates. Another commenter noted we have not, to date, provided further analysis regarding this topic.

One commenter stated that, similar to their belief that the adjustment made to per capita costs for Medicare beneficiaries who are dually eligible for benefits through the Department of Veterans Affairs and the Department of Defense (i.e., the VA/DoD adjustment) is needed because these beneficiaries are not enrolled in MA, a similar adjustment should be made for Part A-only and Part B-only beneficiaries who are not enrolled in MA (because they are not eligible to enroll).

Many commenters supported the notion that CMS issue a separate Request for Information (RFI) on revising the MA ratebook for future years such that benchmarks are based on information for beneficiaries with both Part A and Part B only instead of those with Part A and/or Part B. One of the commenters suggested that we adopt such a revision to the ratebook for 2022 rather than for a future year as would be contemplated in an RFI.

Response: We refer commenters to the detailed response that we provided in the CY 2020 Rate Announcement regarding use of FFS data for costs of all Medicare beneficiaries, whereby CMS concluded that it finds the current ratebook methodology (our longstanding policy of considering costs of beneficiaries with Part A and/or Part B) is within our authority under the statute. We continue to believe that it is not necessary to change the methodology at this time, nor is it required, as the statutory language clearly permits CMS to include Medicare beneficiaries who have Part A or Part B only. While we recognize that calculating rates based on data that excludes beneficiaries entitled only to Part A would yield different results than calculating rates based on our current methodology, that fact alone does not determine which methodology should be employed.

While we consider our long standing approach appropriate for 2022, the question of whether the methodology to calculate MA capitation rates for future years (2023 and/or beyond) should be revised in ratesetting or rulemaking to include FFS spending data only for beneficiaries enrolled in both Part A and Part B is one we may further consider, particularly in a situation where we consider possible future changes to the MA coding pattern adjustment and whether such a change in that policy, if any, should be considered in tandem and implemented on the same

timeline. However, we decline to adopt such a revision at this time but may consider soliciting further comment on those matters in the future.

Further, section 1853(c)(1)(D)(iii) of the Act explicitly requires an adjustment to the estimate of the FFS per capita cost for individuals dually eligible for benefits through the Department of Veterans Affairs and the Department of Defense. There is no statutory requirement for excluding cost data for beneficiaries with coverage for Part A only or Part B only from the information used to develop the FFS per capita cost estimate.

We have discussed in past Advance Notices and Rate Announcements that 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. As a result, we believe it is appropriate to adjust the FFS rate calculation for Puerto Rico used to determine MA rates so that it is based only on the Medicare costs for beneficiaries with both Part A and Part B. Our exercise in discretion for the data used to develop the estimate for one geographic area, based on circumstances unique to that area, illustrates how there is more than one way to develop a reasonable and reliable adjusted average per capita cost estimate for purposes of the MA statute.

We appreciate the suggestions submitted by commenters, and we will continue to analyze this issue and consider whether any adjustments to the methodology on this point may be warranted in future years. For 2022, we will continue to calculate FFS spending for the purpose of establishing MA benchmarks using FFS claims and utilization data for beneficiaries in Part A and/or Part B.

Comment: One commenter requested information regarding the perceived disparate impact of rebasing on Florida relative to other states. The commenter requested additional details to explain what is driving such a negative trend in Florida and the magnitude of the impact of each driver.

Response: As stated on page 33 of the CY 2021 Rate Announcement, there are several factors that affect the impact of rebasing and repricing in each county, including the rolling forward of the experience period, repricing of historical FFS claims, and changes in risk scores. Stakeholders can conduct a county-level analysis of the impact of changes in these factors on the FFS rate using the published spreadsheets “Medicare FFS County 2021 Web.xlsx” and “Medicare FFS County 2022 Web.xlsx” available at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data.

It appears that the primary influence on rebasing in Florida counties is the rolling forward of the experience period. The CY 2021 rates included historical experience for 2014 through 2018, and the CY 2022 rates are based on experience for 2015 through 2019. For example, for Broward County, Florida (one of the largest counties in Florida in terms of the number of FFS beneficiaries), the 2014 standardized geographic adjustment used in the AGA calculation for rates in the 2021 non-ESRD ratebook was 1.26281, which was the county’s highest standardized

geographic adjustment for the experience period of 2014 through 2018. This was replaced with a 2019 standardized geographic adjustment of 1.19240 in the 2022 non-ESRD ratebook, which is slightly lower than the range of the county's standardized geographic adjustments for the years 2015 through 2018. The standardized geographic adjustment reflects the relative costs for the county compared to the nationwide average; Broward County's relative costs compared to the nationwide average were higher in 2014 than in 2019.

Comment: One commenter expressed concern with our proposal to limit our adjustment of the AGAs for Innovation Center payment and service delivery models to those listed in Table B1-1 of the Advance Notice, and with the proposed exclusion of certain payments under those models (e.g., care management fees) that are funded through the Innovation Center rather than the Medicare Part A or Part B Trust Funds. The commenter stated that they were unaware of any statutory basis for excluding these payments from the MA benchmarks and that the exclusion of these funds means CMS is not determining the cost of providing a benefit to MA enrollees that is comparable to what it would be if the benefit were provided to such enrollees under the FFS program. The commenter recommended that we reconsider our policy of excluding model payments from our adjustment of the AGAs to the extent the model payments are funded through the Innovation Center.

Response: As explained on pages 25-26 of Part II of the CY 2022 Advance Notice, we considered 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 2015-2019 period. However, in 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 Part A or Part B Trust Funds.

As we discussed on page 20 of the CY 2018 Advance Notice, the fees paid from administrative accounts authorized by section 1115A of the Act are not from the Part A and Part B Trust Funds, from which Medicare claims are disbursed, so we do not consider those payments to be part of FFS costs. Section 1853(f) of the Act indicates that payments to MA organizations shall be made from the Trust Funds "in such proportion as the Secretary determines reflects the relative weight that benefits under Part A and under Part B represents of the actuarial value of the total benefits under this title." Section 1876(a)(4) indicates that FFS costs used for MA rates are based on the estimated amount that would be payable for services covered under Part A and Part B, and types of expenses otherwise reimbursable under Part A and Part B (including administrative costs incurred by organizations described in sections 1816 and 1842). As these costs described in section 1876(a)(4) of the Act are paid from the Trust Funds, excluding costs paid from another appropriation is appropriate to determine FFS costs. See sections 1817(h) and 1841(g) of the Act.

Accordingly, there will be not be any adjustment to historical FFS claims to account for payments made from the funds appropriated under section 1115A.

Comment: The CY 2022 Advance Notice sought public comment on the possibility of adjusting FFS experience in Puerto Rico to reflect the propensity of zero dollar beneficiaries nationwide. Several commenters supported the use of an adjustment to the Puerto Rico MA rates to reflect the prevalence of zero-dollar beneficiaries nationwide. The commenters believed that such an adjustment is appropriate because the number of zero claimants in the Puerto Rico FFS population is a significantly greater proportion of the population relative to the rest of the United States.

Response: The Secretary has directed OACT to adjust the FFS experience for beneficiaries in Puerto Rico to reflect the propensity of zero-dollar beneficiaries nationwide. For purposes of making this adjustment, consistent with the Secretary's instructions, OACT evaluated experience exclusively for beneficiaries that are enrolled in both Part A and Part B and are not also eligible for VA coverage.

The updated study analyzed experience for calendar years 2015 through 2019, using the cohort of FFS beneficiaries enrolled mid-year (i.e., enrolled in both Part A and Part B as of the mid-year dates used for the study) to approximate the average enrollment for the year. On average, 15.0 percent of Puerto Rico FFS beneficiaries with both Part A and Part B 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. These results were applied to the Puerto Rico FFS experience by adjusting the weighting of the enrollment and risk scores for the zero-claim cohort to reflect the nationwide proportion of zero-claim beneficiaries. The resulting impact was an average increase in the standardized FFS costs in Puerto Rico of 4.6 percent for 2015 through 2019. Accordingly, a 4.6 percent adjustment was applied to the pre-standardized Puerto Rico FFS rates supporting the CY 2022 ratebook development.

Comment: Commenters expressed concern regarding the disparity between payment rates in Puerto Rico and payment rates in the mainland. Commenters urged us to explore all potential options to increase MA benchmark rates in Puerto Rico, to achieve greater parity with rates on the mainland.

One commenter suggested that we make additional adjustments to MA payments in Puerto Rico to account for unique dynamics of the local FFS and MA markets and to ensure payments are adequate. Another commenter urged CMS to address Puerto Rico funding levels to prevent deterioration of the Puerto Rico health care infrastructure, given the very high MA penetration rate and correspondingly low FFS enrollment.

One commenter expressed support for the proposed use of five years of FFS experience to mitigate any annual fluctuations and anomalies in the data. Two commenters requested that we consider additional rate adjustments for Puerto Rico, including establishing an AGA minimum/floor (e.g., applying an AGA of 0.70) or applying a hold harmless minimum benchmark. One of the commenters noted a correlation between geography-specific FFS GPCI

factors used to determine provider payment rates and MA benchmark rates, except for Puerto Rico where the weighted GPCI factor is near the national average but the MA benchmark rate is 39.6 percent below the national average. The commenter believes that an AGA floor would help slow provider migration from Puerto Rico due to provider funding issues that result in access issues for beneficiaries.

One commenter recommended that we adjust the MA benchmarks in Puerto Rico to account for the proportion of dually eligible beneficiaries in Puerto Rico. The commenter stated that the difference in the proportion of dually eligible beneficiaries in the MA and FFS populations in Puerto Rico is so large that risk scores alone cannot correct the large discrepancy that exists between the two populations without an adjustment at the base rates.

Response: We appreciate the concerns and recommendations commenters have raised regarding Puerto Rico. We will continue to analyze these issues and consider whether any refinements to the methodology may be warranted in future years. As discussed in the CY 2017 Advance Notice, the law requires that MA benchmarks be based on a county's average Medicare FFS per-capita costs, 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 MA benchmarks. Note that, as discussed on pages 20-21 in Part II of the CY 2022 Advance Notice, the repricing adjustments reflect the applicable GPCI and wage indices used in Medicare FFS, and, therefore, these factors are reflected in the development of the MA rates. As we stated in the CY 2017 and 2018 Rate Announcements, we believe that the FFS data in Puerto Rico is sufficient for establishing accurate MA benchmarks. Finally, we continue to believe that the use of a rolling five years of data to establish the AGAs is appropriate for all counties and acts to mitigate any annual fluctuations or anomalies in the data; we are continuing this policy in developing the MA rates for 2022.

Section D. Organ Acquisition Costs for Kidney Transplants

Comment: One commenter expressed appreciation for the detailed information that CMS provided throughout Section C (Organ Acquisition Costs for Kidney Transplants), pages 28-31, in Part II of the CY 2022 Advance Notice. Another commenter specifically expressed appreciation for the explanation CMS provided regarding the proposal to change the order of application of the kidney acquisition cost (KAC) adjustment.

Response: We appreciate the support.

Comment: Several commenters requested additional transparency and data regarding the KAC carve-out methodology. A few commenters requested that CMS provide a supplemental file illustrating the step-by-step numerical development of each county-specific KAC carve-out amount when the final CY 2022 MA benchmarks are released. Two of these commenters stated that the supplemental information would help plans understand the county-level adjustments. One of the commenters requesting the supplemental file explained that the county-level

adjustments for their plan's small geographic service area varied widely for 2021, and that it would be helpful to understand how these differences arise from the data CMS uses to calculate the carve-outs.

Response: The KAC carve-out factors are included as part of the rate calculation data for 2022, which can be accessed by navigating to the following page: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data. Additionally, the steps used to develop the 2022 KAC carve-out factors are identified in steps 1 through 9 on pages 29-30 of the CY 2022 Advance Notice. Steps 1 through 6 describe the methodology for development of the "pass-through" kidney acquisition costs for the five-year historical period, 2015-2019. The corresponding cost report files can be accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports and by selecting "Cost Reports by Fiscal Year" (https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Cost-Reports-by-Fiscal-Year). The documentation corresponding to the cost report data is in the file "HOSPITAL2010–DOCUMENATION (ZIP)" from this web page: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Hospital-2010-form. This cost report data reflects the most recent updates and may not match the data used in the ratebook development. Additionally, the claims data referenced in step 7 are included in the spreadsheets FFSyy.xlsx, under the link "FFS Data 2015-2019" from this web page: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats.

Note that the KACs can vary between two counties if the Medicare beneficiaries in one of the counties have more discharges (transplant and non-transplant) in a kidney transplant center than Medicare beneficiaries in the other county.

Comment: A few commenters expressed concern about the magnitude of the estimated KACs, contending that the estimates do not accurately reflect MA organizations' costs for kidney acquisitions. One commenter pointed to their organization's internal analysis as the reason for their concern that CMS is overestimating the KACs and making too large of an exclusion for these costs from the benchmark. Two commenters noted that excluding costs that are artificially high could exacerbate current issues of payment inadequacy in the ESRD state rates. Commenters requested that CMS reevaluate the estimates and consider MA plans' actual data and experience before excluding the costs from MA benchmarks.

Two commenters expressed concern that a misalignment between the number of Medicare discharges, as reported in the Cost Reports, and the number of Medicare inpatient stays, as reported in the claims data, is inflating the total estimated organ acquisition costs and resulting in an inflated carve-out from the MA payments.

Response: Section 1853(k) and (n)(2) of the Act require that CMS carve out an estimate of the standardized costs for payments for FFS kidney acquisitions from the MA capitation rates and benchmarks. Accordingly, consistent with the statute, the KAC carve-out methodology yields our best estimate of the FFS spending on KACs, even if that might not reflect the MA organization's own cost experience. Additionally, discharges in the Cost Reports and the number of Medicare discharge claims are consistent with each other – Medicare Administrative Contractors ensure consistency as part of the reporting and settlement process. We extracted Medicare's share of KACs and the number of Medicare discharges from the Cost Reports (number of Medicare discharges includes both kidney transplant discharges and discharges not related to kidney transplants) in order to calculate KAC per discharge. To calculate the pass-through amount, we multiplied the KAC per discharge by the number of Medicare discharges in the transplant center's FFS inpatient claims. We found that these calculated amounts closely matched the total KAC on the Cost Reports.

Comment: Some commenters expressed concern that the carve-out would negatively impact MA rates. Two commenters noted that, due to the greater proportion of kidney transplant patients included in FFS data compared to individual MA organizations, they were concerned about the disproportionate impact the reduction would have with minimal or no claims reductions to offset the loss of revenue. One commenter expressed concern that the KAC carve-out will impose disproportionate reductions for benchmarks in Puerto Rico. This commenter also noted that the carve-out would exacerbate the disparity in payment rates between Puerto Rico and the mainland, citing low FFS expenditures for Puerto Rico, which serve as the basis for MA benchmarks, and significant rate cuts for Puerto Rico put into place by the Affordable Care Act.

Response: We appreciate the concerns submitted by commenters, but we must comply with the statutory requirement (in section 1853(k) and (n)(2) of the Act) to carve out the KAC amount from the MA benchmarks developed based on FFS cost experience. Additionally, as we stated in the CY 2018 Rate Announcement, we believe the FFS data in Puerto Rico is sufficient for establishing accurate MA rates. Our approach to the KAC factor is consistent with that analysis and the statutory requirements. We note that section 1852(a)(1)(B) of the Act does provide that MA plans are not responsible for covering the cost of kidney acquisitions for kidney transplants beginning with the same year (2021) that the KAC carve out is applied to MA rates.

Comment: In the event of an early Rate Announcement, one commenter urged CMS to consider the potential need for future adjustments to the per member-per month KAC carve-out factors should analyses based on more complete data produce markedly different estimates.

Response: We appreciate the feedback provided by the commenter and will continue to analyze the issue as additional data emerges. We looked at computed CY 2018 KAC per discharge for kidney acquisition centers and compared the changes through updates to the Hospital Cost Report Information System (HCRIS). We found that the KAC per discharge increased by 0.11 percent from the third quarter 2019 update to the fourth quarter 2019 update. The corresponding

increase from the fourth quarter 2019 to the first quarter 2020 update was 0.16 percent. We expected a similar pattern for CY 2019. Since these changes are so small, we expect minimal impact on the KAC carve-out factors for 2022. We do not expect that incorporating changes from future HCRIS updates would have produced significantly different estimates.

Comment: One commenter requested that CMS monitor the impact of the carve-out on MA enrollees' access to kidney transplants.

Response: We appreciate the feedback regarding this issue.

Section E. ESRD Rates

Comment: One commenter expressed appreciation for CMS' description of the data sources used to develop the ESRD rates as well as the enhancements made to the derivation of the AGAs.

Response: We appreciate the support.

Comment: The majority of commenters expressed concern that ESRD state rates are not sufficient to cover the cost of care of ESRD beneficiaries, and requested that CMS reexamine the methodology to improve the accuracy of MA ESRD benchmarks and payment, especially given that ESRD beneficiaries will be able to directly enroll in MA plans beginning in 2021. Many of these commenters highlighted potential consequences of inadequate rates, including the adoption of less attractive network and benefit designs to discourage ESRD beneficiaries' enrollment, inhibited ability to deliver high quality care and services, increased premiums, and reduced benefits. Some commenters also expressed disappointment in CMS' decision not to make significant changes to the ESRD payment rates for CY 2022.

Two commenters also noted that the potential for increased kidney damage as a result of COVID-19 necessitates another review of the current benchmarks.

Response: We appreciate the concerns commenters have raised. We will continue to analyze these issues and consider whether, consistent with the statutory requirements for setting ESRD rates in section 1853(a)(1)(H) of the Act, any refinements to the methodology may be warranted in future years to ensure appropriate ESRD payment rates.

We also note that MA organizations must maintain a network of contracted providers that is sufficient to provide adequate access to covered services to meet the needs of populations served and is consistent with the prevailing community pattern of health care delivery in the areas where the network is being offered. In accordance with the beneficiary protections under section 1852(b) and at § 422.112(a), we expect that MA plans will continue to ensure that their plan designs allow for adequate access to services. CMS will continue to monitor and investigate complaints related to plan coverage, and, as warranted, may take compliance or enforcement actions against an MA organization for failing to meet any contract requirements, such as providing adequate access to medically necessary services.

Comment: A number of commenters requested that we study the development of ESRD rates on a smaller geographic basis to better reflect cost differences across local areas. Some commenters offered specific recommendations, such as implementing an urban/non-urban adjustment based on grouping together similar-cost areas across states and using credibility adjustments for geographic areas with small ESRD FFS enrollment. Another commenter suggested that CMS model the implications of setting ESRD rates at the metropolitan level, rather than at the state level, and allow stakeholders to comment on the new approach.

Several commenters cited results from studies conducted by other organizations to underscore the concern that ESRD state rates may not adequately reflect cost variations of serving ESRD beneficiaries within a state.

One commenter noted that the 21st Century Cures Act requires that by December 31, 2023, the Secretary submit a report to Congress that includes an analysis of enrollment and spending for beneficiaries with ESRD across the FFS and MA programs, as well as an assessment of the sufficiency of the amount of data pertaining to ESRD beneficiaries under FFS for the purposes of determining rates for ESRD beneficiaries in MA. The commenter stated that this report should include an analysis of geographic variation in costs of providing care to ESRD beneficiaries, and should consider the differences in costs and benchmarks in rural and urban areas.

Response: We appreciate the feedback regarding geographic variation in the costs of care within a state. We will continue to analyze this issue and consider whether, consistent with the statutory requirements for setting ESRD rates in section 1853(a)(1)(H) of the Act, any refinements to the methodology may be warranted in future years regarding the geographic level of ESRD rates. Further, we believe that significant changes to the current methodology, especially of the magnitude described by the commenters, should be fully examined and included in the Advance Notice and subject to notice and comment before they are adopted. We also appreciate the feedback regarding suggested content for the report to Congress.

Comment: Commenters provided additional suggestions for revisions to ESRD benchmarks and payment.

Three commenters indicated that quality bonus payments should be applied to ESRD rates, with one commenter recommending that we apply FFS quartile adjustments to the ESRD rates like those applied for non-ESRD rates. One of the commenters believed that the statute directs us to apply quality bonuses at the contract/plan level, and therefore the quality bonuses should be applied to the entire contract/plan rather than only to non-ESRD beneficiaries.

Numerous commenters suggested that we adjust MA rates for ESRD dialysis beneficiaries to reflect the impact of maximum out-of-pocket (MOOP) cost requirements in MA.

One commenter suggested that MA plans should be compensated for ESRD beneficiaries' supplemental benefits via MA rebates paid to plans for their ESRD beneficiaries.

Response: While we appreciate the suggestions of commenters, we do not find these specific suggestions to be consistent with our interpretation of section 1853 of the Act as a whole — that the legislative intent is for us to more closely align MA payment rates with FFS costs — and the statutory requirements for ESRD rate calculation. Section 1853(o) of the Act is clear that the quality bonus payment is applied to the applicable percentage used to calculate the applicable amount under section 1853(n) of the Act, while ESRD rates are set pursuant to section 1853(a)(1)(H) of the Act (that is, not subsection (n)). Further, section 1854 of the Act is clear that beneficiary rebates are set based on the amount by which the benchmark exceeds the MA plan's bid; as MA plans do not incorporate ESRD experience into Part C bids, there is no authority to calculate and pay rebates with ESRD rates.

Comment: Commenters suggested that the underlying ESRD Prospective Payment System (PPS) does not adequately cover the costs of care for beneficiaries and leads to the development of inadequate MA ESRD rates, citing analyses of the PPS by MedPAC and another outside organization. One commenter expressed concern that the smaller updates to the FFS dialysis-only ESRD USPCC relative to those for the FFS non-ESRD USPCC are driven largely by policies that inappropriately constrain reimbursement under the ESRD PPS. The commenter cited examples such as application of an expanded set of case-mix adjusters, an outlier payment pool that has not achieved parity, and limitations on bad debt recoveries that they believe have resulted in inadequate payments. This commenter noted that underpayments resulting from ESRD PPS policies flow directly into the MA rate setting process, undermining the adequacy of plan payments for beneficiaries with ESRD.

Response: We appreciate the feedback provided by commenters regarding the ESRD PPS and its relationship to the development of the MA ESRD rates. Section 1853(a)(1)(H) requires that CMS establish "separate rates of payment" with respect to ESRD beneficiaries enrolled in MA plans. In accordance with the authority provided under section 1853(a)(1)(H), and in keeping with CMS' interpretation of the legislative intent of the Affordable Care Act to more closely align MA payment rates with FFS costs, the ESRD state rates are based on FFS costs. We encourage commenters to review and respond to the appropriate rulemaking for the ESRD PPS for the Medicare FFS program.

Comment: Numerous commenters expressed concern about the highly-concentrated nature of the dialysis provider market, citing the small number of organizations operating most of the dialysis stations in the United States. These commenters indicated that the concentration of dialysis providers and network adequacy requirements affect an MA organization's ability to negotiate reasonable reimbursement for dialysis services. Several commenters cited a MedPAC analysis indicating that, on average, MA contracts are paying more than the Medicare FFS rate for dialysis treatments.

Response: We appreciate the feedback provided by commenters regarding this issue. Please refer to the CY 2021 final rule (CMS-4190-F), which addresses concerns regarding dialysis provider

concentration, network adequacy requirements, and the challenges MA organizations face in negotiating reasonable reimbursement for dialysis services. In the final rule, we explain that our decision not to set quantitative standards for network adequacy for dialysis will bring greater competition, which we believe will drive down plan and patient costs for dialysis services. We also note that CMS is prohibited from setting the payment arrangements between MA plans and their contracted providers. For services furnished by a non-contracted provider, sections 1852(k)(1) and 1866(a)(1)(O) of the Act require health care providers to accept what would be paid by the FFS Medicare program for Medicare-covered services.

Comment: Two commenters urged CMS to ensure that payment for new and innovative products is incorporated in the MA rates in a timely fashion. One commenter noted that the MA rates should be updated at the same time the ESRD PPS incorporates new products through the Transitional Drug Add-on Payment Adjustment (TDAPA) and the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES). This commenter also mentioned that 2021 may be a year in which important innovative products become available to patients.

Response: We appreciate the commenters' feedback regarding this issue. The CY 2022 dialysis-only ESRD USPCC reflects our best estimate of the national per-capita cost, including changes to the ESRD PPS bundled payments.

Comment: Two commenters expressed concern that we underrepresent the actual costs for dialysis in Puerto Rico in the ESRD rates. One commenter cited decreases in the ESRD rates in Puerto Rico, which the commenter indicated results in funding inadequacies for ESRD beneficiaries.

One commenter provided suggestions for rate adjustments that we should consider, such as establishing an AGA floor or using a proxy benchmark.

Another commenter expressed concern with the wage index data used in the ESRD PPS for Puerto Rico.

Response: We appreciate the concerns and suggestions that commenters have raised regarding ESRD rates in Puerto Rico. We will continue to analyze these issues and consider whether, consistent with the statutory requirements for setting ESRD rates in section 1853(a)(1)(H) of the Act, any refinements to the methodology may be warranted in future years. As we stated in the CY 2018 Rate Announcement, we believe that the FFS data in Puerto Rico is sufficient for establishing accurate MA rates, as well as consistent with the statutory requirements. Finally, the development of the ESRD PPS is outside of the scope of this document and we encourage commenters to review and respond to the appropriate rulemaking for that payment system.

Section F. MA Employer Group Waiver Plans

The bid-to-benchmark ratios applied in calculating MA EGWP Payment Rates for 2022 are:

Applicable Percentage	Bid-to-Benchmark Ratio
0.95	83.0%
1	82.6%
1.075	82.6%
1.15	82.9%

We will continue to use the steps in the payment methodology for 2022, as well as the applicable rules, as described in Part II of the CY 2022 Advance Notice. Consistent with our proposal in that document, due to the early release of the CY 2022 Rate Announcement, we have used January 2021 enrollment data weight the bid-to-benchmark ratios.

Comment: The majority of commenters expressed support for the proposal to continue the 2021 payment methodology that differentiates between PPO and HMO EGWP and individual market plans. The commenters also expressed support for the proposal to modify the enrollment data used to weight the bid-to-benchmark ratios based on the timing of the release of the CY 2022 Rate Announcement.

The majority of commenters expressed support for the proposal to continue the 2021 payment methodology enhancement to permit EGWPs to buy-down the Part B premium for their enrollees.

Response: We thank the commenters for their support.

Comment: A commenter recommended a refinement to the proposed implementation of the Part B premium buy-down whereby we would establish segment IDs that correspond to different Part B premium buy-down amounts in the plan benefit package (PBP) to reduce the number of EGWP PBPs submitted for various Part B premium buy-down amounts.

Response: As described in the CY 2022 Advance Notice, when an individual market MA organization submits a plan bid to us, the MA organization is permitted to use MA rebates to buy-down a portion of the Part B premiums for its enrollees in each plan by identifying the buy-down amount in the Bid Pricing Tool as its use of the beneficiary rebate. We then retain that rebate amount specified by the MA organization for each plan and coordinate directly with the Social Security Administration (SSA) to ensure that each beneficiary's Part B premium (taking into account the buy-down amount) is appropriately calculated and withheld from the beneficiary's Social Security check or billed to the beneficiary. Implementing the bidding waiver as described in the Advance Notice facilitates the communication of this information from CMS to SSA by maintaining an operational structure that is similar to the one that exists for individual market MA organizations. For this reason, we decline to make the recommended changes, but

we appreciate the commenter's thoughts on this issue and will continue to analyze and explore suggestions for refinements to this policy in the future.

Comment: A couple of commenters requested that we clarify the applicable requirements and limitations on the use of funds that EGWPs receive from CMS. One commenter observed that whereas in prior years the Advance Notice stated that we were waiving "the requirement that MA EGWPs allocate rebate dollars to any specific purpose," the CY 2022 Advance Notice instead stated that we would "continue to waive the requirement that MA EGWPs must specify how they are allocating MA rebate dollars in CY 2022," followed by a new sentence which stated, "However, the limits in § 422.266 on how the MA rebate may be used have not been waived and therefore continue to apply for EGWPs." A couple of commenters asked that we clarify whether our statement that we had not waived the limits on use of rebates in § 422.266 should be understood to mean that MA EGWPs are prohibited from using funds received from CMS to make payments to employer groups under so-called "gainshare" arrangements. The commenters also requested that we identify the specific statutory and regulatory provisions that we have waived.

Response: Under our MA EGWP payment methodology, MA EGWPs receive a monthly payment for each enrollee that consists of two components: (1) the base county payment rate, which represents the amount CMS pays for basic benefits, and (2) a county-level rebate (for local EGWPs) or regional rebate (for RPPO EGWPs). To calculate the specific payment amount for each enrollee, CMS adds these two components together and multiplies the sum by the enrollee's risk score to produce a single payment amount; the portions that represent the base county payment rate and the rebate are not subsequently broken out. Because MA EGWPs are unable to identify the amount of their payment that is the rebate payment, since CY 2017, we have waived the requirement in § 422.254(d) for MA organizations to inform CMS how they will distribute amounts paid as rebates among the options at § 422.266(b). However, the limits on using rebate amounts in § 422.266(b) have not been waived, so MAOs are not permitted to use enrollee/beneficiary rebates for a different purpose. *See* section 1854(b) of the Act and § 422.266(a) for calculation of the rebate amount.

Our statement in the CY 2022 Advance Notice that we have not waived the limits in § 422.266 on how the MA rebate can be used means that any amounts that an MA EGWP rebates to enrollees must be provided in a form and manner that is consistent with § 422.266. As explained further in the next response to a public comment, we have waived the requirement in section 1854(b)(1)(C)(i) of the Act and § 422.266(a) that EGWPs rebate to their enrollees a specific percentage of the average per capita savings. Under section 1854(b)(1)(C)(i) and § 422.266(a), non-EGWP MA plans receive a percentage of the amount by which the applicable benchmark exceeds the plan bid, which such plans must rebate to their enrollees in one or more of the forms specified by § 422.266(b). By contrast, because EGWPs do not submit plan bids, we have waived the requirement that they rebate to their enrollees a percentage of the amount by which the applicable benchmark exceeds the plan bid; however, if an MA EGWP chooses to rebate part

of the payment it receives from CMS to its enrollees, it must do using one of the options in § 422.266(b). Thus, an EGWP could issue no rebates, or it could use the rebate to pay for *mandatory* supplemental benefits in accordance with § 422.266(b)(2); however, the EGWP could not issue rebates for *optional* supplemental benefits, as this is prohibited under § 422.266(b)(2).

Finally, in regard to the commenters' questions about whether (by stating that we had not waived the limits on the use of waivers under § 422.266) CMS had implied a broader restriction on how MA organizations use *any* funds they receive from CMS, we note that the limits on the use of rebates at § 422.266 would not apply to the entire MA EGWP monthly payment, as rebates only represent a portion of the total amount that we pay to EGWPs for their enrollees (as noted above, our payments to EGWPs consist of an amount paid for basic benefits in addition to the amount paid rebates). We appreciate that this point might not seem particularly meaningful given that our EGWP payment methodology does not distinguish between amounts paid for basic benefits and amounts paid for rebates; however, we believe it may be helpful for us to clarify that we do not regard the regulation at § 422.266, which governs the use of beneficiary rebates, as restricting how the EGWP can use the entire payment it receives from CMS, particularly its own gain/loss margin.

Comment: One commenter requested that we confirm whether we have waived the requirements of section 1854(b)(1)(C)(i) of the Act (42 U.S.C. § 1395w), which provides that "[t] he MA plan shall provide to the enrollee a monthly rebate" equal to a percentage of the average per capita savings.

Response: As explained in the previous response, because we have we have waived the bidding requirement for MA EGWPs, we have also waived the requirement at section 1854(b)(1)(C)(i) of the Act and § 422.266(a) for EGWPs to rebate to enrollees a specific percentage of the average per capita savings, which are calculated as the amount by which the applicable benchmark exceeds the plan bid. Furthermore, we believe that requiring EGWPs to provide enrollees with a specific percentage of the amount paid for rebates (which are funded with average per capita savings) as required by section 1854(b)(1)(C)(i) of the Act and § 422.266(a) would be inconsistent with the rationale for waiving the requirement at § 422.254(d) that MA organizations must inform CMS of how they will distribute the beneficiary rebate to their enrollees; that specific waiver was included in our waiver of the bidding requirements for MA EGWPs because under the payment policy we devised as a condition of the waiver of the requirement to submit a bid, MA EGWPs are unable to distinguish the portion of their monthly payments that represents the amount paid for rebates (from the amount paid for basic benefits).

Section G. CMS-HCC Risk Adjustment Model for CY 2022

Comment: Most commenters expressed support for the 2020 CMS-HCC risk adjustment model (previously known as the Alternative Payment Condition Count, or APCC, model) as proposed for CY 2022. They noted its improved accuracy in predicting costs for beneficiaries with

multiple chronic diseases and indicated that a full phase-in of the 2020 model would reduce the complexity and administrative burden of having two models. The majority of commenters were in support of finalizing the phase-in of the 2020 CMS-HCC risk adjustment model, with a weight of 100 percent for CY 2022.

Response: We thank the commenters for their support of fully phasing in the 2020 CMS-HCC risk adjustment model, which meets the requirements of the 21st Century Cures Act. It includes additional HCCs for dementia and pressure ulcers, as well as variables that account for the number of conditions a beneficiary may have, making an adjustment as the number of conditions increase. For CY 2022, we are finalizing the full phase-in of the 2020 CMS-HCC model as proposed: 100 percent of the risk score will be calculated with the 2020 CMS-HCC model.

Comment: A couple of commenters expressed concern about the accuracy of the 2020 CMS-HCC risk adjustment model for predicting costs, particularly for medically complex beneficiaries, those affected by social determinants of health, and beneficiaries dually eligible for Medicare and Medicaid. These commenters requested that CMS review the predictive accuracy of the model for dually eligible beneficiaries and consider other indicators of cost for inclusion in the model, such as social determinants of health.

Response: CMS is committed to monitoring and improving the accuracy of the risk adjustment model for predicting costs across subgroups. For example, a 2017 major model revision was implemented specifically to improve the prediction of dually eligible beneficiaries. More recently, updates made to the model were aimed at improving the accuracy of predicted costs across subgroups of beneficiaries in the program, including beneficiaries with dementia and pressure ulcers, who as a group are a medically complex, high cost population, and those with multiple chronic conditions; these model improvements were made in response to the 21st Century Cures Act. We appreciate comments regarding the predictability of the 2020 CMS-HCC model for certain demographic subgroups and will continue to assess cost prediction for medically complex beneficiaries including those who are dually eligible for Medicare and Medicaid.

Comment: One commenter questioned CMS' interpretation of the 21st Century Cures Act regarding the condition count, given that the model is already additive.

Response: Section 1853(a)(1)(I)(i)(I) of the Act, as added by the 21st Century Cures Act, requires that our MA risk adjustment "shall make an additional adjustment … as the number of diseases or conditions of an individual increases." We interpret this 21st Century Cures Act amendment to section 1853(a)(1) to require that a specific adjustment for the number of conditions that a beneficiary has be included in the model and that this adjustment be fully phased-in by 2022. The CY 2019 Advance Notice, Part I details the analytic work conducted by CMS to implement the statutorily-required adjustment for condition count, and sought comment on different approaches to implementing this requirement to include a count of conditions in the

CMS-HCC model.[3] The count variables in the 2020 model count the number of conditions that a beneficiary has, among those that are included in that model for payment. Including a count of payment conditions in the model (most of which are chronic conditions) improves the accuracy of prediction by count of payment conditions (the predictive ratios are closer to 1.0).

We will continue to evaluate models and explore options for improving their accuracy for subgroups of beneficiaries.

Comment: Some commenters recommended different methods for updating the CMS-HCC risk adjustment model, including recalibration based on the most current diagnostic data available to include ICD-10 codes, making updates on an annual basis, use of more sources of data (e.g., home health and SNF), calibration of the model using encounter data, and considering a concurrent/prospective hybrid model – meaning that concurrent diagnoses (those received in the payment year) are used for acute conditions while prospective diagnoses (those received in the prior year) are used for chronic conditions.

Response: We appreciate commenters' suggestions on updating the CMS-HCC risk adjustment model. As discussed in the 2018 Report to Congress: Risk Adjustment in Medicare Advantage,[4] calibrating a model with ICD-10 diagnoses will be one of our primary considerations moving forward. We will take commenters' suggestions into consideration as we develop models and methodological changes for future years.

Comment: A few commenters stated they would like to see increased transparency in the methodology used to update the model, and the release of sufficient details and data for plans to adequately assess model revisions. Commenters also expressed a desire for increased collaboration and engagement with stakeholders, with requests that we work with stakeholders to design and develop a model for use in future payment years. Commenters expressed appreciation for the 60-day review and comment period, urging us to continue our efforts to enhance transparency and engagement with stakeholders by providing at least 60 days for stakeholders to comment on future risk adjustment proposals.

Response: We will consider additional ways in which we can engage with stakeholders as we consider changes to the CMS-HCC risk adjustment model for future years, and appreciate commenter support. As amended by the 21st Century Cures Act, section 1853(a)(1)(I)(iii) of the Social Security Act requires that we provide at least 60 days for public review and comment of proposed changes under section 1853(a)(1)(I) to the Part C risk adjustment model.

Comment: Many commenters requested that CMS take steps to address what they believe will be a negative impact of the COVID-19 pandemic on risk scores. These commenters believed that

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[3] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2019Part1.pdf

[4] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/RTC-Dec2018.pdf

2022 risk scores would be too low to predict the level of costs plans will experience in 2022 as a result of fewer medical encounters in 2021 and a concomitant reduction in the number of diagnoses collected. There were various recommendations put forward for addressing the impact of the COVID-19 pandemic. Some commenters requested a hybrid model, meaning that concurrent diagnoses (those from dates of service in the payment year) are used for acute conditions while prospective diagnoses (those for dates of service in the prior year) are used for chronic conditions, while others recommended that CMS apply an adjuster to the risk adjustment model, or to payment itself, to increase payment. Other suggestions included using two years of diagnosis data, using different (or more) sources of data, and allowing chronic condition diagnoses from previous years. Some commenters recommended that CMS add the COVID-19 diagnosis code to an existing HCC in the risk adjustment models and/or develop a standalone COVID-19 HCC. One commenter asked CMS to develop a hold harmless COVID-19 adjustment for plans for their 2022 plan bids, and possibly also for future years depending on the course of the ongoing pandemic.

Response: We appreciate commenters' concerns about the impact of the COVID-19 pandemic on utilization and diagnoses submission, and the potential effects on risk adjusted payments. CMS does not think that it is possible at this time to take into account any potential impact that the COVID-19 pandemic may have on CY 2022 risk scores (which are based on 2021 diagnoses). Data needed for such an analysis does not yet exist, and there is a potential scenario where CY 2022 risk scores increase with increasing utilization in 2021. We note that a risk adjustment eligible diagnosis only has to be submitted and accepted once for it to count in a beneficiary's risk score calculation. We believe that a policy change adopted in this Rate Announcement (to address possible impacts of the COVID-19 PHE on CY 2022 risk scores) without a description in the Advance Notice and developed without data to inform such a policy change is likely inconsistent with our authority under section 1853 of the Act; in addition, such a change has the potential to result in inaccurate payments to plans.

Section H. ESRD Risk Adjustment Model for CY 2022

For CY 2022, CMS is finalizing its proposal and will fully phase in the 2020 ESRD models (ESRD dialysis, ESRD functioning graft, and transplant) for non-PACE organizations. For PACE organizations, CMS will continue to calculate ESRD risk scores for CY 2022 using the 2019 ESRD dialysis and ESRD functioning graft models, as well as the 2019 transplant factors.[5]

Comment: A few commenters supported CMS' proposal to fully transition to the 2020 ESRD models to calculate ESRD risk scores. A few commenters also applauded CMS for its recent

[5] Part II of the 2019 Advance Notice, which describes the 2019 ESRD models, and the 2019 Rate Announcement, which includes the 2019 ESRD model relative factors, are available on the CMS website here: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html

work to improve the ESRD risk adjustment models and facilitate a more seamless implementation process for changes to the models.

Response: CMS appreciates the comments. For CY 2022, we will calculate risk scores for payment of ESRD beneficiaries in MA plans and certain demonstrations by continuing to use the ESRD models implemented in 2020 as proposed in Part II of the CY 2022 Advance Notice. Specifically, we will calculate 100 percent of the risk score with the 2020 ESRD models for non-PACE organizations.

Comment: Some commenters requested specific modifications to the ESRD risk adjustment models, including that we:

- consider the adequacy of risk scores for new MA enrollees and make adjustments where appropriate, possibly in the form of an upward adjustment in per member-per month payments to account for these new MA enrollees, and
- move enrollees with a reported dialysis diagnosis into the ESRD payment and risk adjustment segment automatically.

A few commenters requested that CMS continue its efforts to evaluate costs and further refine the ESRD risk adjustment models to provide consistency and predictability and avoid year-to-year fluctuation of the MA ESRD payment rates for clinically complex patients with ESRD, particularly in light of the 21st Century Cures Act permitting broader enrollment of ESRD beneficiaries in MA plans in 2021.

Response: CMS appreciates the comments and recommendations for updates to the ESRD risk adjustment models. CMS is not implementing these commenters' recommendations for the ESRD models used for risk adjusted payments in CY 2022 because we believe that the existing 2020 ESRD models will improve risk adjustment payments for beneficiaries with ESRD. Specifically, the 2020 ESRD models are calibrated on more recent data, are calibrated using diagnoses filtered based on the same approach used to filter encounter data, and include adjustments to correct for the under-prediction and over-prediction of costs for small subpopulations. CMS will continue to evaluate the ESRD risk adjustment models in the future and consider whether any refinements to the methodology for the ESRD model calibration may be warranted in future years.

We would also like to clarify that the dialysis new enrollee relative factors are applied in payment only to enrollees who do not have 12 months of Part B enrollment in the data collection period. Enrollees who are newly enrolled in an MA plan, or who are newly on dialysis, but who have 12 months of Part B enrollment in the data collection period, are "continuing enrollees" for the purpose of risk adjustment and we calculate their risk scores using the continuing enrollee dialysis segment, which includes HCCs. CMS calibrates the continuing enrollee dialysis component of the ESRD model using diagnoses and expenditure data for beneficiaries in FFS who are in dialysis status and have 12 months of Part B in the data collection period.

Comment: A few commenters requested that future updates to the ESRD risk adjustment models be communicated with a longer timeline, with some commenters asking for 60 days to review and submit comments, such as for the recent changes to the CMS-HCC model. Commenters recommended that CMS continue to engage with stakeholders and ensure model updates are developed collaboratively and transparently to facilitate a more seamless implementation process. One commenter recommended that fundamental changes to the model should include even more time for engagement and comment, recommending that any changes in how the ESRD risk adjustment models are developed be proposed with no less than two years of lead time and a comment period of 180 days for robust analysis and thoughtful consideration of the potential impacts. This commenter also recommended consideration of a budget neutrality adjustment during any transition to a new model.

Response: CMS appreciates the comments and will consider ways to engage with stakeholders, share additional information, and provide sufficient time for public feedback for model changes as we continue to explore ways to improve ESRD risk adjustment.

CMS notes that the Cures Act amendment to the Medicare statute requires a 60-day comment period for changes to the CMS-HCC model that are being fully phased-in in 2022.

Section I. CMS-HCC Risk Adjustment Used for PACE Organizations in CY 2022

Comment: Commenters supported CMS' proposal to utilize the 2017 CMS-HCC model for PACE payment for CY 2022, acknowledging that the 2017 CMS-HCC model is an improvement over the prior model applied to PACE. However, commenters also expressed concern that the model excludes dementia and other chronic conditions (such as pressure ulcer, moderate chronic kidney disease, and mental health and substance use disorders) that are prevalent in the PACE population. Commenters requested that the 2020 CMS-HCC model, which includes dementia HCCs, be used for PACE enrollees as expeditiously as possible.

Response: We appreciate the support for use of the 2017 CMS-HCC model for PACE payment for CY 2022, which will be a continuation of the 2020 and 2021 risk adjustment policy. While we acknowledge concerns from commenters that the 2017 CMS-HCC model does not include the dementia HCCs and the request by some commenters to expeditiously implement the 2020 CMS-HCC model for payment to PACE organizations, we note the 2017 CMS-HCC model is an improvement in predicting costs relative to the model previously used for payment to PACE organizations: it is based on more current data years and, in particular, improves the predictive accuracy of risk scores for dually eligible beneficiaries. In more recent years, we have made additional improvements to the CMS-HCC risk adjustment model and we reiterate our intention to use this more recently updated model to pay PACE organizations as soon as it is practicable. The 2020 CMS-HCC model is calibrated using the same approach to identify risk adjustment eligible diagnoses as is used to identify diagnoses on encounter data records. As such, the 2020 model is intended to calculate risk scores using diagnoses submitted on encounter data records.

Since we are not calculating PACE beneficiary risk scores using diagnoses solely from encounter data and FFS claims as we are for non-PACE organizations for CY 2022, we cannot implement the 2020 CMS-HCC model for PACE at this time. CMS will continue to work closely with PACE organizations to develop further guidance and provide technical assistance with regard to encounter data submissions in anticipation of implementing the risk adjustment model used for MA for PACE payment in the future.

Section J. Frailty Adjustment for PACE Organizations and FIDE SNPs

Comment: Commenters expressed concern that the frailty factors associated with the 2017 CMS-HCC risk adjustment model do not fully account for the level of dementia diagnosed in PACE participants and the costs associated with their care. Commenters also believed that the frailty factors are not representative of the PACE population because response rates to the Modified Health Outcomes Survey (HOS-M) are low among PACE participants and are likely even lower among participants with dementia. To this end, the commenters requested flexibility in the administration of the HOS-M survey for patients with dementia if the 2020 CMS-HCC model cannot be implemented for PACE enrollees in 2022. Commenters requested that CMS allow PACE organizations to proactively offer their participants with dementia assistance in completing the survey.

Response: Because the CMS-HCC risk adjustment model predicts total expenditures for Part A and Part B benefits, for beneficiaries with conditions such as dementia that are not directly incorporated in the 2017 CMS-HCC model, the associated costs can be predicted by comorbid conditions and demographic factors that are included in the model. To the extent that these costs are not predicted by the model, they are likely to be reflected in the frailty factors. CMS estimates frailty factors to explain 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, on counts of activities of daily living (ADLs).[6] Although total costs are included in the calibration of the 2017 CMS-HCC risk adjustment model, and the associated frailty factors help predict overall costs where diagnoses are not fully predictive, results for individual organizations may differ due to differences between the sample used for model calibration and the populations enrolled in individual plans.

CMS acknowledges the concerns related to the response rates for the HOS-M for PACE participants, particularly among participants with dementia. The responses from this survey are used to determine a beneficiary's limitations in activities of daily living (ADLs) that are accounted for in the calculation of a contract's frailty score. We collect survey data in a consistent manner for all PACE organizations, as this helps to ensure equitable frailty results for payment. Permitting variation in how the survey is administered for participants with specific conditions may disproportionately affect frailty scores for certain organizations, depending on

[6] https://www.cms.gov/files/document/2022-advance-notice-part-ii.pdf

what proportion of an organization's participants has that condition. For the HOS-M, a proxy response will remain at the discretion of the beneficiary, but PACE staff may check with a family member or caregiver to determine if participants with dementia need assistance completing the survey.

Section K. Medicare Advantage Coding Pattern Adjustment

Comment: The majority of commenters supported CMS' proposed 5.90 percent 2022 coding pattern adjustment.

Response: CMS appreciates the support of the commenters. CMS is finalizing the proposed adjustment of 5.90 percent for CY 2022.

Comment: A few commenters indicated they are concerned that CMS is considering a different approach, as noted in the News Alert for the CY 2022 Advance Notice, Part II,[7] regarding coding pattern adjustments in 2023 and beyond and stated that the information provided in previous Notices for contemplated coding pattern adjustment methodology updates is now outdated, insufficient, or both. The commenters recommended that CMS avoid potential changes to the coding pattern adjustment methodology until at least 2024, after providing significantly more details and transparency about any updates, including potential impacts, and a meaningful opportunity for MA plans to evaluate and comment on updates to the methodology.

A few commenters noted that changes in enrollment, demographics, standards of care, treatment patterns, payment policies, and even legislation must be considered in, first, determining the relevance of the coding pattern adjustment and then, if appropriate, the level of the adjustment. These commenters requested that CMS keep the following considerations and concerns in mind if it will consider updating the coding pattern adjustment methodology in the future:

- which cohorts and data should be the basis of the adjustment,
- changing enrollment patterns or disproportionate geographic dispersion,
- other downward adjustments that already impact risk scores (e.g., normalization, etc.),
- the impact of model recalibrations and medical record review,
- prospective versus retroactive application,
- the impact of ICD-10 and integrated care coordination,
- the impact of passive enrollment,
- adjustments for benefit difference between MA and FFS to allow for equitable coding comparisons, medical record review,
- the application of the adjustment as a uniform industry-wide adjustment,
- the potential difference in risk score growth due to demographics and morbidity in MA versus FFS,

[7] The CY 2022 Advance Notice Part II press release is available here: https://www.cms.gov/newsroom/press-releases/news-alert-october-30-2020-cms-releases-part-ii-2022-medicare-advantage-and-part-d-advance-notice

- future model calibration using MA data and the impact of payment and reform model on coding incentives.

Some commenters also provided alternative recommendations to the proposed statutory minimum coding pattern adjustment. One commenter, who acknowledged CMS' limitations due to statutory restraints regarding the minimum adjustment, requested that CMS work in conjunction with Congress to reevaluate the formula for the coding pattern adjustment. Another commenter indicated that coding patterns across the MA landscape were very heterogeneous and that failure to recognize these differences across plans by applying an across-the-board coding pattern adjustment could result in an inequitable outcome regardless of the method used to calculate the adjustment. The commenter suggested a segmented approach to coding pattern adjustments that recognizes different levels of coding patterns among plans, such that the lowest coding factor is applied to lower coding plans while the highest factor is applied to higher coding plans. One commenter stated that the statutory minimum of 5.90 percent is too high and recommended that CMS eliminate the coding pattern adjustment immediately by moving towards using MA data to recalibrate the models. Another commenter indicated that an across-the-board coding pattern adjustment disproportionately penalizes physician organizations and recommended that CMS reconsider the application of the mandatory coding pattern adjustment. The commenter noted that the difference in coding patterns between the Medicare FFS and MA programs has been narrowing and also suggested that CMS consider an appropriate method for the identification of chronic conditions, which suggested they thought that such coding should not be taken into account when measuring coding differences between MA and FFS.

Response: We appreciate commenters' feedback. CMS continually works to develop an understanding of coding trends and makes an assessment for each payment year regarding the appropriate adjustment based on specific considerations of both coding trends and other market changes.

Section 1853(a)(1)(C)(ii) of the Act requires application of a minimum MA coding pattern adjustment to risk scores; CMS believes that using a uniform adjustment is an appropriate and efficient approach to achieving the requirements of the statute and that the statutory minimum adjustment level provides an equitable approach for CY 2022 payments. No future changes were contemplated in the Advance Notice.

While we consider our long standing approach appropriate for 2022, the question of whether the methodology to calculate MA capitation rates for future years (2023 and/or beyond) should be revised in ratesetting or rulemaking to include FFS spending data only for beneficiaries enrolled in both Part A and Part B is one we may further consider, particularly in a situation where we consider possible future changes to the MA coding pattern adjustment and whether such a change in that policy, if any, should be considered in tandem and implemented on the same timeline. However, we decline to adopt such a revision at this time but may consider soliciting further comment on those matters in the future.

Comment: A few commenters believed that it is fundamentally incorrect to assume any observed coding differentials between the FFS and MA populations are driven by inappropriate coding on the part of MA plans and requested that CMS recognize that higher coding does not necessarily equate to wrong coding. One commenter stated that the coding pattern adjustment should recognize the MA program and health plan or group efforts to prevent fraudulent coding practices, such as RADV's, retrospective deletions submitted by plans and financial takebacks.

Response: The MA coding pattern adjustment is not intended to adjust for inaccurate coding in a particular instance, but it is intended to account for program-wide differences in coding patterns between MA and FFS. As required by statute, CMS applies the MA coding pattern adjustment to adjust for the impact on MA risk scores of coding patterns that differ from FFS coding, which is the basis of the CMS-HCC model. Congress continued to increase the coding pattern adjustment and ultimately set the adjustment for 2019 and each subsequent year so as to reduce all MA risk scores by 5.90 percent.

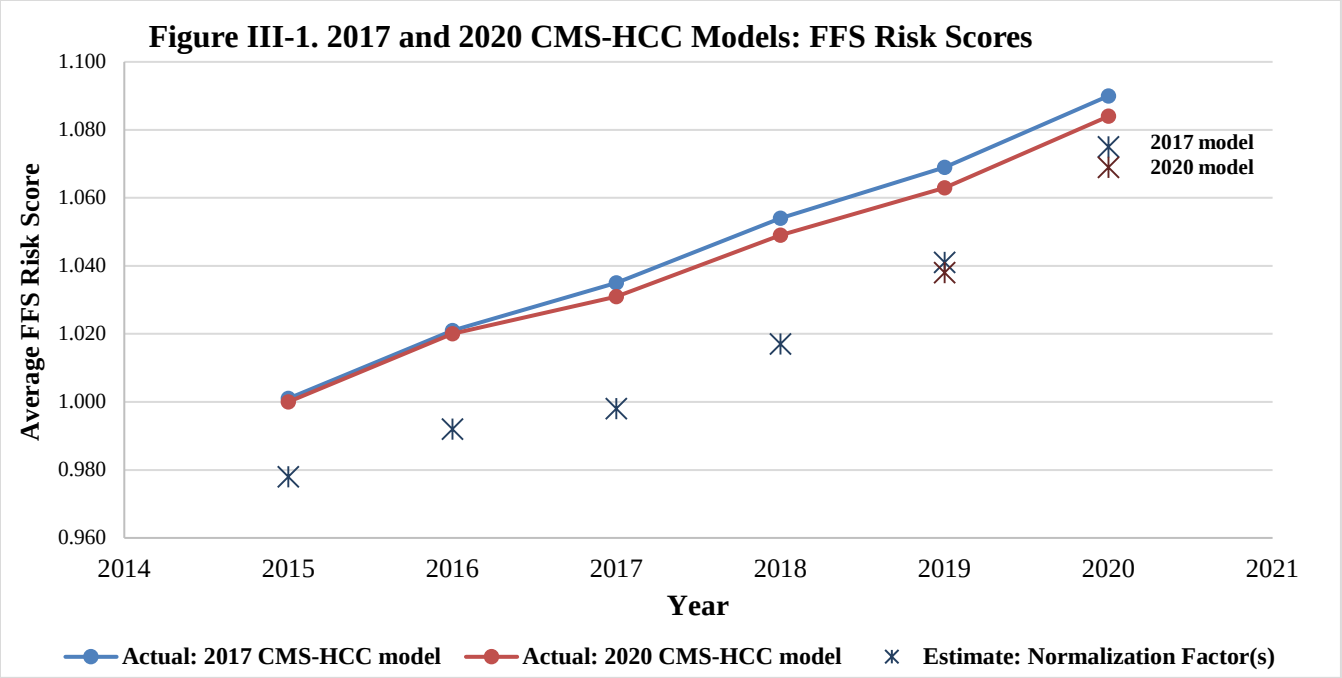
Section L. Normalization Factors

Comment: Several commenters suggested we make an adjustment to how we apply the current methodology for calculating the normalization factor, and a couple of commenters suggested we make a change to our methodology. Commenters generally believed that the proposed methodology resulted in an increase in the normalization factor that was artificially high due to the implementation of ICD-10, and questioned the reasoning behind CMS' previous statement that the impact of ICD-10 on the FFS risk score trend would stabilize over time. Commenters provided a number of options for how CMS could adjust for the increasing trend, including adding more or less years of data to the calculation of the slope, adjusting the underlying data for the effect of ICD-10, recalibrating the model with more recent data, and applying the linear trend additively rather than multiplicatively.

Numerous commenters expressed concern that the impact of the COVID-19 pandemic is not reflected in CMS' projection of FFS risk scores for normalization and recommended CMS adjust the normalization factor. Commenters noted that service utilization in FFS has decreased in 2020, citing a study done by Wakely, MedPAC, and ASPE, and may continue to decrease into 2021. They stated their belief that decreased utilization will result in a significant underestimate of the health status of the MA population in 2021 and 2022, resulting in substantial underpayment for MA plans. One commenter suggested that CMS compare emerging 2020 diagnoses data to data for prior years to estimate a 2021 risk score impact and adjust the expected trend and normalization factors accordingly.

Response: We are finalizing the normalization methodology for the Part C and ESRD models as proposed. We believe that the proposed methodology – using a linear approach with five years of data – will produce an appropriate estimate of the applicable 2022 average risk score for Part C and ESRD models. The goal of the normalization factor is to accurately predict the FFS risk

score in the payment year, thereby maintaining an average FFS risk score of 1.0. Updating the normalization factors annually stabilizes payment both year-over-year and between model calibrations. In addition, we have regularly used five years of historical data when calculating normalization factors with the linear slope methodology. While there is inherent uncertainty with any prediction of future values, using five years of data to calculate the slope provides a smoothing effect. We acknowledge concerns regarding the increasing normalization factor, however, as Figure III-1 shows, CMS' projection of the FFS risk score in the payment year (i.e., the normalization factor) has underestimated the actual FFS risk score since 2015 by an average of 2.40%. As stated in the CY 2022 Advance Notice, our analysis indicates there are multiple factors contributing to the recent increase in average FFS risk scores, and of those, the implementation of ICD-10 is one that we expect to stabilize moving forward as providers have more experience using the ICD-10 code set and establish their coding practices. However, as we also noted, we do not expect the average Medicare FFS risk score to decrease. Instead, we believe that other factors, such as more complete reporting of diagnosis codes – for example, as a result of the changing incentives due to the implementation of alternative payment models in Medicare FFS and a changing case-mix – will continue to put upward pressure on the FFS risk score. We do not yet know what impact, if any, the COVID pandemic will have on 2022 risk scores. Also, we do not think that it is possible to take into account any potential impact that the COVID pandemic may have on 2022 FFS risk scores (2021 diagnoses) because the data needed for such analysis does not yet exist. In addition, there is a potential scenario where 2022 risk scores do increase with increasing utilization, for instance, to make up for deferred care that is furnished in 2021. We again note that our normalization factors are projections of the payment year FFS risk scores, and any projection can be imprecise; our projections over the last several years have proven to be too low. We believe that a reduction in the 2022 normalization factor without adequate data has the potential to result in under normalization for 2022, and that continuing to use a five-year rolling average will smooth effects of changing trends in FFS risk scores.



Comment: A number of commenters requested that CMS provide more information and supporting data on the methodology for developing the normalization factor and requested that there be more transparency regarding why more recent years' risk scores were increasing. Many commenters specifically requested that we provide more granular detail on the factors driving the increase in the Part C normalization factor, including quantifying the impact of demographics, reported health status of the FFS Medicare population, alternative payment models, and ICD-10 implementation. One commenter expressed a belief that the change from a single community segment to six community segments based on dual and aged/disabled status and making Medicaid concurrent in for payment year 2017) further inflated the normalization factors. There was a general concern over the increase in the Part C normalization factor and that the aforementioned drivers are inflating the factor. Several commenters made suggestions to address their concerns, including that CMS analyze the FFS normalization factors in relation to the FFS growth rate, that CMS recalibrate the model with ICD-10 diagnoses, and that CMS make an adjustment for one-time events, like the implementation of ICD-10 on October 1, 2015 and later dates of service, and the separation of the model into more refined community segments for payment year 2017. One commenter expressed concern regarding transparency with the Part D normalization factor calculation and requested that the data used for its calculation be made available to allow plans to incorporate the information into their own modeling and planning to inform 2022 bids. A few commenters recommend that CMS seek outside council to address FFS normalization and model recalibration through stakeholder engagement or establishment of a TEP.

Response: The normalization factor for each model is an estimate of the average applicable risk score in the payment year. We project the normalization factors from a set of historical annual

average risk scores, with each year's risk score calculated using the risk adjustment model that will be used in the payment year, thereby removing any effect on the risk score trend that could be model driven. For Part C, PACE, and ESRD post-graft, the historical risk score for each year is calculated as the average FFS risk score for all beneficiaries who are entitled to Part A and enrolled in Part B, and not in ESRD or hospice status. These beneficiaries include those who are new enrollees (i.e., do not have 12 months of Part B in the data collection year and, therefore, have a risk score calculated with the new enrollee segment of the applicable model) and those who are full risk (i.e., beneficiaries who have 12 months of Part B enrollment during the data collection period and have a risk score calculated using the appropriate full risk segment of the applicable model).[8] We then compute the trend over five years by calculating the slope in risk scores from the beginning to the end of the historical period, then applying the average annual change from the denominator year (1.0) to the payment year. In determining the ESRD dialysis normalization factor, we follow the same method, except we use the population of beneficiaries in dialysis status to calculate the historical dialysis risk scores.

Under any model, the average risk score can change from year to year for a number of reasons, including changes in demographics, disease prevalence, coding practices, and utilization. Our analysis continues to suggest that the increase in the average FFS risk score is driven by an increase in the disease component of the risk score (HCCs and interactions) that is not being offset by a relatively small decrease in the demographic component of the risk score. We believe that there are multiple aspects to the implementation of the ICD-10 that could drive the increase in the disease component of the risk score, including concept changes, greater availability of codes to report, differences between how the model is calibrated and risk scores are calculated.

Further, we believe that there are incentives to report more diagnosis codes in the alternative payment models implemented in FFS. However, we cannot distinguish the individual impacts of these factors. We note that, because MA risk scores are calculated with the same ICD-10 – to – HCC mappings used to calculate FFS risk scores, that similar increases are likely to be reflected in MA risk scores.

Comment: Several commenters expressed support for using an alternative approach to calculate the RxHCC normalization factor for CY 2022 and most of those were in support of projecting the slope based on four years of data (2016–2019) rather than the proposal to use five years. This alternative approach was the preferred method of these commenters because it would remove the influence of a year where nine months of diagnosis data used ICD-9 coding and three months used ICD-10 coding, as well as mitigate the impact of increased encounter data reporting.

Response: CMS appreciates the feedback received from commenters on the alternative approaches to calculating the RxHCC normalization factor for CY 2022. Given the feedback,

[8] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf

CMS will calculate the 2022 RxHCC normalization factor using the linear slope methodology with four years of data (2016–2019) instead of five years, as previously proposed. The normalization factor produced under the four-year method is comparable to the factor that would have been produced by the proposed method of calculating the linear slope using five years of data had there not been the more pronounced increase in encounter data-based risk scores between 2015-2016, which we believe to be in part a result of increased reporting when encounter data was first incorporated into risk score calculation.

Comment: One commenter was concerned that the Part D RxHCC model and normalization factor proposed for CY 2022 are not developed consistent with the HHS Office of Inspector General's (OIG) final rule, which appeared in the November 30, 2020 Federal Register, on "Fraud and Abuse; Removal of Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees" (85 FR 76666). They further recommend that CMS adjust the Part D RxHCC model and normalization factor to reflect this change in Part D plan costs.

Response: CMS appreciates the commenters' concern and suggestions. The OIG rule was released after the 2022 Advance Notice was proposed, but we will take it into consideration for the future. CMS believes that any policy changes that CMS considers making in response to the OIG's new rule should be made after evaluating its impact on Part D plan liability and would benefit from being proposed and subject to comment from stakeholders. See also our response in Attachment IV, Section A below to similar comments regarding the Part D RxHCC model.

Section M. Sources of Diagnoses for Risk Score Calculations for CY 2022

Comment: The majority of commenters supported the proposal to end the blending of encounter data-based and RAPS-based risk scores and move to using 100% of the risk score calculated using diagnoses from MA encounter data and FFS claims for CY 2022. Some commenters stated their understanding that the transition to using 100% of the risk score calculated using diagnoses from MA encounter data and FFS claims was necessary given the statutory requirement to transition to the 2020 CMS-HCC model by 2022. One commenter noted that encounter data will continue to provide CMS with greater insight into cost, utilization, risk, and quality metrics for all MA organizations, will provide a single source of data for MA benchmarks and risk score calibration, and will ensure that uniform, CMS-identified filtration logic will be applied for risk adjustment purposes across all MA organizations. A few commenters did not support the proposal, citing either operational concerns with encounter data processing or concerns that encounter data disproportionally impacts risk scores of plans who serve a large number of members with complex conditions and diagnoses, or who are dual eligible beneficiaries.

Some commenters mentioned the FFS filtering change, but no commenters expressed an opinion on the proposed update to the filtering. One commenter noted their belief that until CMS reruns final payments for years 2017–2019 to correct risk adjusted payments due to corrections that

were made to the encounter data system,[9] they do not believe it is accurate to state that the impact of transitioning to encounter data-based risk scores is zero. Some commenters requested that CMS include the industry in developing data monitoring standards as we complete the transition to 100% encounter data-based risk scores. Commenters also recommended that CMS improve timely communication and maintain transparency with stakeholders, and look to calibrating a new risk adjustment model based on encounter data.

Several commenters expressed concern over the proposal to exclude diagnoses from inpatient RAPS records from the risk score calculations. A few of those with reservations noted that they were uncertain what the encounter data submissions would look like given COVID's impact on healthcare utilization and thought it was not the best time to exclude RAPS inpatient data as a diagnostic source. Others had more general operational concerns about inpatient submission in encounter data. Some pointed to a Wakely study, noting that while there may not be a negative impact across all plans, there could be a negative impact for some. A handful of commenters believed that CMS had extensive edits on inpatient encounter data which resulted in many inpatient encounters being rejected. However, a number of commenters that directly commented on the policy supported the proposal to discontinue use of RAPS inpatient data to supplement encounter data-based risk scores. Some of these commenters noted that discontinuing the RAPS inpatient supplementation, along with no longer blending two models, would alleviate the complexities of the current risk score calculations. One commenter suggested that plans should have the option of including RAPS inpatient data as a supplement to encounter data. Commenters also requested clarity on whether or not they would be required to continue to submit RAPS data if the proposal were accepted.

Regardless of position on the proposals, many commenters noted that while CMS has worked to improve issues with submissions and processing in the encounter data system, the need exists for continued work on operational issues, technical support to plans, and more frequent reporting out of the encounter data system.

Response: We appreciate the support for the proposal to end the blending of encounter data-based and RAPS-based risk scores and move to calculating 100 percent of the risk score using diagnoses from MA encounter data and FFS claims for CY 2022, and for the understanding that this transition aligns with CMS finalizing the full phase-in of the 2020 CMS-HCC model, secondary to the statutory requirement mandated by the 21st Century Cures Act.

While we understand that some commenters remain concerned about their inpatient encounter data submissions and would prefer the continued supplementation with RAPS inpatient, these reservations are not widespread and appear to be linked to plan-specific submission challenges. CMS continues to observe that the overall impact of the supplementation with RAPS inpatient

[9] CMS has issued HPMS memos over the last few years notifying MA organizations that in the future CMS will rerun final reconciliation of multiple payment years as the result of system updates that could affect payment.

data is small and is expected to be zero by 2022, but we will provide more in depth and targeted technical assistance to those plans experiencing challenges by holding User Group Calls to address specific areas that the commenters identified as challenges and continuing one-on-one calls with plans. In addition, we will look into the specific edits these organizations believe may be contributing to their difficulties in successfully submitting their encounter data and consider solutions, and address these specifically in the one-on-one calls with plans. We believe that providing a targeted technical assistance approach to help resolve plan-specific submission challenges is the best path forward, given the variety of concerns among a subset of plans.

In addition, as was explained in the CY 2021 Rate Announcement, CMS developed and implemented an MA encounter data integrity plan, which includes a range of activities aimed at improving the completeness and validity of encounter data. Core activities include submission outreach, technical assistance, data analysis, and monitoring. These activities continue to improve the completeness and validity of encounter data. Furthermore, in conversations with MA organizations, CMS has asked whether the encounter data system prevents MA organizations from successfully submitting data and the magnitude of the problem. The feedback continues to be positive: as both CMS' and MA organizations' encounter data systems have matured and stabilized, MA organizations have stated that they are able to successfully submit 99 percent of data to the MA encounter data system. We take this feedback into account as we develop additional technical assistance efforts. As CMS fully implements the use of encounter data in risk-adjusted payment, we remain committed to our partnership with the industry in our continued work on complete, valid, and accurate encounter data submissions.

CMS continues to see evidence in the data that the efforts by the agency and MA organizations to improve the accuracy and completeness of encounter data are working, and we believe that improvements will continue to be made to both CMS and plan systems to increase the accuracy and completeness of encounter data. Therefore, CMS is finalizing the proposal to end the blending of encounter data-based and RAPS-based risk scores and move to using 100 percent of the risk score calculated using diagnoses from MA encounter data and FFS claims for CY 2022 without inpatient RAPS supplementation. Given that no RAPS data will be included in the calculation of MA risk scores for CY 2022, MA plans (that is, non-PACE plans) will not be required to submit data with 2021 dates of service to RAPS. However, RAPS will remain available for the submission of data for CY 2020 and CY 2021 payment, and the correction of data from prior payment years.

Comment: Several commenters expressed support for the continued methodology for PACE wherein encounter data is an additional source of data for the calculation of risk scores, along with RAPS and FFS claims. These commenters also requested that CMS address PACE's unique needs and challenges with submitting encounter data and the impact of full reliance on encounter data for their risk score calculation in the future.

Response: We appreciate the support and for CY 2022 are finalizing the proposal to pool risk adjustment-eligible diagnoses from the following sources to calculate a single risk score for each PACE participant (with no weighting): (1) encounter data, (2) RAPS data, and (3) FFS claims. This approach will apply to risk scores calculated for PACE participants using the CMS-HCC risk adjustment model (i.e., the risk adjusted payments for the Part A and B services), ESRD models, and the RxHCC model. For CY 2022, we will continue to use the 2019 ESRD models to calculate risk scores for PACE participants with ESRD, and the 2020 RxHCC model to calculate Part D risk scores for PACE participants. Non-ESRD PACE participant risk scores will be calculated using the 2017 CMS-HCC model. We understand PACE organizations' concerns regarding their unique submission issues with encounter data, and are committed to working closely with these organizations to provide the technical assistance and guidance to allow them to successfully submit the necessary data.

Given that RAPS data will still be used in the calculation of PACE risk scores for CY 2022 using pooled sources of data as first finalized in the 2015 Rate Announcement,[10] PACE organizations should still submit data to RAPS in CY 2021.

[10] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf

Attachment IV. Responses to Public Comments on Part D Payment Policy

Section A. RxHCC Risk Adjustment Model

Comment: The majority of commenters supported the proposed recalibration of the RxHCC risk adjustment model. Commenters stated the importance of including updated data to ensure more accurate risk adjusted payments to Part D plans.

Response: We appreciate support from the commenters for the proposed recalibration of the RxHCC risk adjustment model, which is developed with more current data. For CY 2022, CMS is finalizing the policy to calculate non-PACE Part D risk scores using the recalibrated 2017/2018 RxHCC model.

Comment: A few commenters expressed concern that the recalibrated model does not account for the impact of the OIG's final rule on the "Fraud and Abuse; Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees," which was published in the Federal Register on November 30, 2020 (85 FR 76666). One commenter believed that, due to the time lag in recalibration, there will be multiple years where the RxHCC model may not reflect new cost and utilization patterns that could result from changes that apply manufacturer rebates at the point-of-sale. They therefore suggested CMS work with plan actuaries to make potential interim adjustments, noting a previous adjustment applied to the RxHCC on chronic Hepatitis C in 2016, and recalibrate the model with PDEs once they reflect manufacturer rebates applied at the point-of-sale. Another commenter suggested delaying implementation of the proposed recalibrated model for a similar reason that the model does not account for the application of manufacturer rebates at the point of sale.

Response: We recognize the commenters' concern that the recalibrated model does not account for potential impacts of this final rule, which removes protection under the existing discount safe harbor for drug manufacturer discounts on Part D drugs beginning January 1, 2022, and establishes new safe harbor protection for such discounts when their full value is provided to the dispensing pharmacy and completely reflected in the price at the point of sale to the beneficiary . Given that the final rule was issued recently in November 2020, there was neither sufficient time nor information available to analyze the potential impact of the rule on Part D expenditures and, in particular, plan liability, used to calibrate the RxHCC model. Therefore, without adequate information about the impacts on plan liability for different beneficiaries, it is not clear how we could recalibrate the RxHCC model to reflect the impact of the final OIG rule before the changes made in the rule are reflected in the PDE data. We note that the adjustment made to the RxHCC for chronic Hepatitis C was a unique circumstance only applicable to one RxHCC rather than having the potential to impact each RxHCC in the model.

Regarding the comment that we delay implementation of the proposed model since it does not reflect the impacts of the final OIG rule, we note that neither the current RxHCC risk adjustment model nor the recalibrated RxHCC model being finalized for CY 2022 consider manufacturer rebates in estimating the prescription drug plan liability, and believe that the updated RxHCC model improves accuracy by using more recent cost and utilization data. We will take commenters' recommendations to further improve the model into consideration for future model updates, as additional information regarding the impact of the rule change on Part D expenditures becomes available.

Comment: One commenter suggested that CMS consider developing a hybrid prospective-concurrent RxHCC model where the markers for drug classes are measured and applied concurrently, similar to the HHS-HCC risk adjustment model. The commenter believed including data markers for drug classes and specific drugs in a concurrent manner could improve the model's accuracy in predicting relative costs, by distinguishing enrollees who were prescribed certain medications from others with the same medical condition who were not, and enhancing the predictive power of the model overall and for specific diseases.

Response: We appreciate the commenter's suggestion and understand that in certain programs where a combined medical and drug model is utilized, there may be methodological differences in the approach for predicting relative costs that are population specific. 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 MA-Part D plans (MA-PDs). By using a separate RxHCC model from the CMS-HCC model that is used to predict medical costs, the RxHCC model accounts for differences in predicted plan liability for prescription drugs among distinct subgroups of Part D eligible beneficiaries. We appreciate and will take suggestions to improve the model into consideration for future model updates.

Comment: One commenter questioned why CY 2019 PDEs were not used for recalibration, and what lag times can be expected between reconciliation and the use of reconciled PDEs for the various payment methodologies.

Response: The RxHCC model calibrations are typically based on the most recent finalized data available at the time of model calibration. At the time that we recalibrated the updated RxHCC model, 2017 diagnoses and 2018 PDEs provided the most current and complete diagnostic and prescription drug cost profiles. The model coefficients are estimated and then the relative factors are determined by dividing each coefficient by the average predicted per capita expenditure. At the time the 2019 denominator was estimated, the 2018 diagnoses were complete. As required in section 1860D-15(c)(1)(D) of the Act, RxHCC model update proposals and the publication of the associated model relative factors must be announced by the first Monday in April prior to the start of the payment year, in accordance with section 1853(b)(1)(B)(i)(II). This necessitates lags in data used for model calibration.

Comment: One commenter requested clarification on the use of both MA-PD and FFS members in the proposed RxHCC model recalibration, and whether this was a departure from previous versions of the model.

Response: While, in the early years of the Part D program, CMS calibrated the RxHCC model using data from FFS beneficiaries only, starting in 2016, CMS has used an RxHCC model that incorporates data from beneficiaries enrolled in both MA-PD and PDP plans. This model uses 2012/2013 data and is calibrated using diagnostic data from FFS claims and MA-PD RAPS data, and cost data from PDEs submitted by both standalone PDPs and MA-PDs, to predict plan liability for prescription drugs under the Medicare Part D drug benefit. The RxHCC model that we are finalizing for CY 2022 uses 2017/2018 data and is calibrated using the same sources for diagnostic and cost data as this previous model, except the source of diagnoses for MA-PDs was updated from RAPS data submissions to encounter data submissions. We also note that, starting in 2011, we have set the 1.0 in Part D across the entire program (i.e., across Part D enrollees in both MA-PDs and PDPs) by developing a model denominator using beneficiaries in both MA-PDs and PDPs, and including beneficiaries in both MA-PDs and PDPs in the RxHCC normalization factor.

Section B. Risk Adjustment Sources of Diagnoses for 2022 (RxHCC Section)

Please refer to Section M in Attachment III, above, for comments and responses on the sources of diagnoses for risk score calculation for CY 2022.

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

Comment: One commenter supported our policy of paying prospective reinsurance amounts to Part D EGWPs and recommended that CMS add a trend adjustment to the methodology so that prospective reinsurance payments take into account the amount by which reinsurance is projected to increase in the current payment year relative to the most recently reconciled payment year.

Response: We thank the commenter for their support and recommendation. We do not believe it is appropriate that we adjust prospective reinsurance payments for CY 2022 by a trend factor when we did not propose to do so in the Advance Notice. Although we decline to add a trend factor at this time, we will consider this recommendation as we continue to refine our methodology for future years.

Section D. Part D Risk Sharing

Comment: One commenter expressed support for the policy on Part D risk sharing outlined in the Advance Notice.

Response: We thank the commenter for their support.

Comment: One commenter expressed concern that if recent congressional proposals to redesign Part D become law, they will create more pricing and payment uncertainty, particularly with respect to rebates. The commenter recommended that CMS explore adjustments to risk sharing (e.g., tighter risk corridors during implementation or for key subpopulations such as LIS individuals) to mitigate problems if legislative changes are enacted.

Response: We appreciate the concern raised by the commenter. We will monitor and analyze legislative changes to the Part D program and consider whether any adjustments within our discretion and authority may be warranted.

Section E. Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2022

Comment: Many commenters noted that estimates of the 2022 benefit parameters were not included in the Advance Notice and urged that, at a minimum, CMS publish the parameters before the Rate Announcement's statutory deadline. A few commenters requested that CMS publish the parameters as soon as they can be calculated. A few commenters urged CMS to publish the Rate Announcement with the parameters by mid-January to provide Part D sponsors sufficient time to develop 2022 bids.

Response: We thank the commenters for their input. We have provided the Part D benefit parameters for 2022 in Attachment V of this document.

Comment: A couple commenters requested that we clarify whether we intended to change our longstanding policy and exclude Part D drug costs paid on behalf of the beneficiary by any person or organization (other than insurers, group health plans, or similar third party payers) from counting toward the beneficiary's TrOOP expense. The commenters noted that, after identifying several third party arrangements[11] that contribute to both TrOOP and the total gross covered prescription drug cost estimate, the Advance Notice stated, "Any spending on covered Part D drugs under any other third-party arrangement does not count toward TrOOP but is captured in the total gross covered prescription drug cost estimate." The commenters were concerned that this might be interpreted as excluding certain third-party payments that CMS has in the past indicated would count toward TrOOP, such as payments of beneficiaries' Part D drug costs by family members or charitable foundations.

Response: We appreciate the commenters' concerns and confirm that we did not change our policy regarding the types of payments made on behalf of a beneficiary by other persons or organizations that count toward TrOOP.

[11] The Advance Notice identified the following third party arrangements as counting toward TrOOP and the total gross covered prescription drug cost estimate: LIS cost-sharing support, State Pharmacy Assistance Programs, Indian Health Service and certain other Native American organizations, AIDS Drug Assistance Program, or by a manufacturer as payment under the Medicare Coverage Gap Discount Program.

We clarify that payments made by family members or charitable organizations on behalf of the beneficiary will continue to be treated as “incurred costs” for purposes of calculating the beneficiary’s TrOOP expense, as discussed in the January 28, 2005 final rule implementing the Part D program (70 FR 4194, 4239). However, as noted in that final rule, any arrangement under which a charitable organization pays a Medicare beneficiary’s cost-sharing obligations must comply with all applicable fraud and abuse laws, including, where applicable, the anti-kickback statute at section 1128B(b) of the Act, as well as the civil monetary penalty provision prohibiting inducements to beneficiaries at section 1128A(a)(5).

Attachment V. Final Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy, and Retiree Drug Subsidy

Table V-1. Updated API and CPI for 2022

	Annual percentage trend for 2021	Prior year revisions	Annual percentage increase for 2022
API	5.36%	1.85%	7.31%
September CPI (all items, U.S. city average) (1)	2.19%	-1.04%	1.12%

Note: Percentages are multiplicative, not additive.

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

Table V-2. Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy, and Retiree Drug Subsidy

	2021	2022
Standard Benefit		
Deductible	$445	$480
Initial Coverage Limit	$4,130	$4,430
Out-of-Pocket Threshold	$6,550	$7,050
Total Covered Part D Spending at Out-of-Pocket Threshold for Non-Applicable Beneficiaries (1)	$9,313.75	$10,012.50
Estimated Total Covered Part D Spending for Applicable Beneficiaries (2)	$10,048.39	$10,690.20
Minimum Cost-Sharing in Catastrophic Coverage Portion of the Benefit		
Generic/Preferred Multi-Source Drug	$3.70	$3.95
Other	$9.20	$9.85
Full Subsidy-Full Benefit Dual Eligible (FBDE) Individuals (3)		
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	$1.35
Other (5)	$4.00	$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	$3.70	$3.95
Other	$9.20	$9.85

	2021	2022
Above Out-of-Pocket Threshold	$0.00	$0.00
Full Subsidy-Non-FBDE Individuals (3)		
Applied or eligible for QMB/SLMB/QI or SSI, income at or below 135% FPL and resources ≤ $9,470 (individuals, 2021) or ≤ $14,960 (couples, 2021) [category code 1] (6)		
Deductible	$0.00	$0.00
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.70	$3.95
Other	$9.20	$9.85
Maximum Copayments above Out-of-Pocket Threshold	$0.00	$0.00
Partial Subsidy (3)		
Applied and income below 150% FPL and resources below $14,790 (individual, 2021) or $29,520 (couples, 2021) [category code 4] (5)		
Deductible (5)	$92.00	$99.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.70	$3.95
Other	$9.20	$9.85
Retiree Drug Subsidy Amounts		
Cost Threshold	$445	$480
Cost Limit	$9,200	$9,850

(1) For a beneficiary who is not considered an "applicable beneficiary," as defined at section 1860D-14A(g)(1) of the Act, and is not eligible for the Medicare 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.

(2) For a beneficiary who is an "applicable beneficiary," as defined at section 1860D-14A(g)(1) of the Act, and is eligible for the Medicare 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.

(3) The LIS eligibility categories and corresponding cost-sharing benefits are sometimes referred to using category codes as follows:

- Category Code 1 – Non-institutionalized FBDE individuals with incomes above 100% of the FPL and full-subsidy-non-FBDE individuals.
- Category Code 2 – Non-institutionalized FBDE individuals with incomes below or up to 100% of the FPL.
- Category Code 3 – FBDE individuals who are institutionalized or would be institutionalized if they were not receiving home and community-based services.
- Category Code 4 – Partial subsidy individuals.

(4) Per section 1860D-14(a)(1)(D)(i) of the Act, full-benefit dual eligible beneficiaries who are receiving home and community based services qualify for zero cost-sharing if the individuals (or couple) would have been institutionalized otherwise.

(5) The partial LIS deductible is increased from the unrounded 2021 value of $447.40. Increases to the maximum copayments for non-institutionalized FBDE individuals with incomes no greater than 100% of the FPL are applied to the unrounded 2021 values of $3.70 for generic/preferred multi-source drugs and $9.21 for all other drugs.
(6) These resource limit figures will be updated for CY 2022. Additionally, these amounts include $1,500 per person for burial expenses.

Section A. 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 $4.00 for all other drugs in 2021 and rounded to the nearest multiple of $0.05 and $0.10 respectively.[12]

Section B. 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 2022 benefit parameters, Part D program data is used to calculate the annual percentage trend as follows:

$$\frac{August\ 2020\text{–}July\ 2021}{August\ 2019\text{–}July\ 2020} = \frac{\$4{,}331.98}{\$4{,}111.54} = 1.0536$$

In the formula, the average per capita cost for August 2019 – July 2020 ($4,111.54) is calculated from actual Part D PDE data, and the average per capita cost for August 2020 – July 2021 ($4,331.98) is calculated based on actual Part D PDE data incurred from August 2020 – November 2020 and projected through July 2021.

The 2022 benefit parameters reflect the 2021 annual percentage trend, as well as an update for revision to prior year estimates for API. Based on updated NHE prescription drug per capita

[12] Per section 1860D-14(a)(4)(A) of the Act, the copayments are increased from the unrounded 2021 values of $1.32 for multi-source generic or preferred drugs, and $3.97 for all other drugs.

costs and PDE data, the annual percentage increases are now calculated as summarized by Table V-3.

Table V-3. 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%	9.89%
2017	3.99%	4.02%
2018	1.89%	1.88%
2019	4.08%	4.06%
2020	4.94%	4.92%
2021	3.16%	5.09%

Accordingly, the 2022 benefit parameters reflect a multiplicative update of 1.85 percent for prior year revisions. In summary, the 2021 parameters outlined in Section A are updated by 7.31 percent for 2022, as summarized by Table V-4.

Table V-4. Annual Percentage Increase

Annual percentage trend for July 2021	5.36%
Prior year revisions	1.85%
Annual percentage increase for 2022	7.31%

Note: Percentages are multiplicative, not additive. Values are carried to additional decimal places and may differ slightly from 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 2021 threshold value of $6,550 as our starting point. To calculate the 2022 value, we applied the 2022 API described above and rounded to the nearest $50. The resulting 2022 out-of-pocket threshold value is $7,050.

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 2021, an estimate of the September 2021 CPI based on projections from the President's FY 2022 Budget.

The September 2020 value is from the Bureau of Labor Statistics. The annual percentage trend in the September CPI for contract year 2022 is calculated as follows:

$$\frac{\text{Projected September 2021 CPI}}{\text{Actual September 2020 CPI}} \; or \; \frac{266.0}{260.3} = 1.0219$$

(Source: President's FY2022 Budget and Bureau of Labor Statistics, Department of Labor)

The 2022 benefit parameters reflect the 2021 annual percentage trend in the September CPI of 2.19 percent, as well as a revision to the prior estimate for the 2020 CPI increase over the 12-month period ending in September 2020. Based on the actual reported CPI for September 2020, the September 2020 CPI increase is now estimated to be 1.37 percent. Accordingly, the 2022 update reflects a -1.04 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 1.12 percent for 2022, as summarized by Table V-5.

Table V-5. Cumulative Annual Percentage Increase in September CPI

Annual percentage trend for September 2021	2.19%
Prior year revisions	-1.04%
Annual percentage increase for 2022	1.12%

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

Section C. 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 $445 in 2021 and rounded to the nearest multiple of $5.

Initial Coverage Limit: From $4,130 in 2021 and rounded to the nearest multiple of $10.

Out-of-Pocket Threshold: From $6,550 in 2021 and rounded to the nearest multiple of $50.

Minimum Cost-Sharing after the Out-of-Pocket Threshold (i.e., in the catastrophic phase): From $3.70 per generic or preferred drug that is a multi-source drug and $9.20 for all other drugs in 2021, 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 $3.70 per generic, preferred drug that is a multi-source drug, or biosimilar and $9.20 for all other drugs in 2021, rounded to the nearest multiple of $0.05.

Deductible for Low Income (Partial) Subsidy Eligible Enrollees: From $92.00[13] in 2021 and rounded to the nearest $1.

Maximum Copayments above the Out-of-Pocket Threshold for Low Income (Partial) Subsidy Eligible Enrollees: From $3.70 per generic, preferred drug that is a multi-source drug, or biosimilar and $9.20 for all other drugs in 2021, rounded to the nearest multiple of $0.05.

[13] 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 2021 value of $92.04.

Table V-6. Part D Benefit Parameters for Defined Standard Benefit for 2021 and 2022 for Non-LIS Beneficiaries

	2021		2022	
Deductible Phase	Cost-sharing: 100%		Cost-sharing: 100%	
	Deductible: $445		Deductible: $480	
Initial Coverage Phase	Cost-sharing: 25%		Cost-sharing: 25%	
	Initial Coverage Limit: $4,130		Initial Coverage Limit: $4,430	
Coverage Gap	Applicable Drugs Cost-sharing: 25% (1)	Non-applicable Drugs Cost-sharing: 25%	Applicable Drugs Cost-sharing: 25% (1)	Non-applicable Drugs Cost-sharing: 25%
	Out-of-Pocket Threshold: $6,550		Out-of-Pocket Threshold: $7,050	
Catastrophic Coverage	Cost-sharing: Greater of 5% or $3.70 (Generic/Preferred Multi-Source Drug) / $9.20 (Other)		Cost-sharing: Greater of 5% or $3.95 (Generic/Preferred Multi-Source Drug) / $9.85 (Other)	

(1) The 25% coinsurance for applicable drugs for non-LIS beneficiaries during the coverage gap reflects the application of the 70% Medicare Coverage Gap Discount Program discount.

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

For 2022, the estimated total covered Part D spending at out-of-pocket threshold for applicable beneficiaries is $10,690.20. 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 0.085 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 0.060 percent to 94.940 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:

$$\text{ICL} + \frac{\text{100\% beneficiary cost sharing in the gap}}{\text{weighted gap coinsurance factor}} \; \textit{or} \; \$4{,}430 + \frac{\$5{,}582.50}{89.1745\%} = \$10{,}690.20$$

- *ICL* is the Initial Coverage Limit equal to $4,430.
- *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* $7,050 − $1,467.50 = $5,582.50

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

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

  or

  (91.76% × 94.940%) + (8.24% × 25%) = 89.1745%

  - *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 2020 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

      94.940% = [(99.915% × 95%) + (0.085% × 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 2020PDEs.

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.

Table V-6. Updated Total Gross Covered Drug Costs at the Out-of-Pocket Threshold for Applicable and Non-Applicable Beneficiaries in 2022

	2021	2022
Total Gross Covered Drug Costs at Out-of-Pocket Threshold for Non-Applicable Beneficiaries (1)	$9,313.75	$10,012.50
Estimated Total Gross Covered Drug Costs for Applicable Beneficiaries (2)	$10,048.39	$10,690.20

(1) For a beneficiary who is not an "applicable beneficiary," as defined at section 1860D-14A(g)(1) of the Act, and is not eligible for the Medicare 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.

(2) For a beneficiary who is an "applicable beneficiary," as defined at section 1860D-14A(g)(1) of the Act, and is eligible for the Medicare 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.

Section E. 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 $435 and $8,950, respectively, for plans that end in 2020, and as $445 and $9,200 for plans that end in 2021. For 2022, the cost threshold is $480 and the cost limit is $9,850.

Table V-7. Updated Retiree Drug Subsidy Amounts in 2022

	2021	2022
Cost Threshold	$445	$480
Cost Limit	$9,200	$9,850

Attachment VI. 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 Medicare Part C and D Final Rule, published in April 2018, for performance periods beginning with 2019; that final rule lays out the methodology for the 2021 Star Ratings and beyond. In the COVID-19 interim final rule (IFC) (CMS-1744-IFC) issued on March 31, 2020 (the "March 31, 2020 COVID-19 IFC"), CMS adopted a series of changes for the 2022 Star Ratings in recognition of the impact on health plan and provider operations posed by the COVID-19 pandemic (85 FR 19269–75). The March 31, 2020 COVID-19 IFC removes guardrails for the 2022 Star Ratings by delaying their application until the 2023 Star Ratings and expands the existing hold harmless provision for the Part C and D Improvement measures to include all contracts for the 2022 Star Ratings. Additionally, in order to address how the 2021 Star Ratings are based in part on data for the 2018 performance period, the March 31, 2020 COVID-19 IFC revises the definition of "new MA plan" so that for purposes of 2022 quality bonus payments based on 2021 Star Ratings only, new MA plan means an MA contract offered by a parent organization that has not had another MA contract in the previous 4 years. The COVID-19 IFC (CMS-3401-IFC) issued on August 25, 2020 (the "August 25, 2020 COVID-19 IFC") modifies the application of the extreme and uncontrollable circumstances policy for calculation of the 2022 Part C and D Star Ratings to address the effects of the public health emergency (PHE) due to the COVID-19 pandemic (85 FR 54844–47). Please see these IFCs for further information on these changes for the 2021 and 2022 Star Ratings.

In the Advance Notice, we provided information and updates in accordance with §§ 422.164, 422.166, 423.184, and 423.186. We appreciate the feedback we received on potential future measures and concepts for the Star Ratings. We reviewed the comments and will consider them for future rulemaking, as necessary.

Reminders for 2022 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 that issues can be resolved prior to the first plan preview period. As described at § 422.164(h)(1), CMS must annually set and announce a deadline for MA organizations 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, 2021, for all contracts to make their requests for review of the 2022 Star Rating appeals and CTM measure data. Commenters expressed support for this deadline. Sponsoring organizations can view their Part C appeals data on the website medicareappeal.com/AppealSearch 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 2022 Star Ratings

Improvement Measures (Part C & D). Under §§ 422.164(f) and 423.184(f), improvement measures are calculated using performance measures that meet specific conditions. The measures that will be used to calculate the 2022 Star Ratings are listed in Table VI-1. As stated in §§ 422.164(f)(4)(i) and 423.184(f)(4)(i), CMS will only include measures at the contract level if numeric value scores are available for both the current and prior years.

Table VI-1: 2022 Star Ratings Improvement Measures[a]

Part C or D	Measure	Measure Type	Weight	Improvement Measure	Included in the 2022 CAI Values
C	Breast Cancer Screening	Process Measure	1	Yes	Yes
C	Colorectal Cancer Screening	Process Measure	1	Yes	Yes
C	Annual Flu Vaccine	Process Measure	1	Yes	Yes
C	Improving or Maintaining Physical Health	Outcome Measure	3	No	No
C	Improving or Maintaining Mental Health	Outcome Measure	3	No	No
C	Monitoring Physical Activity	Process Measure	1	Yes	Yes
C	Special Needs Plan (SNP) Care Management	Process Measure	1	Yes	No
C	Care for Older Adults – Medication Review	Process Measure	1	Yes	No
C	Care for Older Adults – Pain Assessment	Process Measure	1	Yes	No
C	Osteoporosis Management in Women who had a Fracture	Process Measure	1	Yes	Yes
C	Diabetes Care – Eye Exam	Process Measure	1	Yes	Yes
C	Diabetes Care – Kidney Disease Monitoring	Process Measure	1	Yes	Yes
C	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3	Yes	Yes
C	Rheumatoid Arthritis Management	Process Measure	1	Yes	Yes
C	Reducing the Risk of Falling	Process Measure	1	Yes	Yes
C	Improving Bladder Control	Process Measure	1	Yes	Yes

Part C or D	Measure	Measure Type	Weight	Improvement Measure	Included in the 2022 CAI Values
C	Medication Reconciliation Post-Discharge	Process Measure	1	Yes	Yes
C	Getting Needed Care	Patients' Experience and Complaints Measure	2	Yes	No
C	Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	2	Yes	No
C	Customer Service	Patients' Experience and Complaints Measure	2	Yes	No
C	Rating of Health Care Quality	Patients' Experience and Complaints Measure	2	Yes	No
C	Rating of Health Plan	Patients' Experience and Complaints Measure	2	Yes	No
C	Care Coordination	Patients' Experience and Complaints Measure	2	Yes	No
C	Complaints about the Health Plan	Patients' Experience and Complaints Measure	2	Yes	No
C	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2	Yes	No
C	Health Plan Quality Improvement	Improvement Measure	5	No	No
C	Plan Makes Timely Decisions about Appeals	Measures Capturing Access	2	Yes	No
C	Reviewing Appeals Decisions	Measures Capturing Access	2	Yes	No
C	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2	Yes	No
C	Statin Therapy for Patients with Cardiovascular Disease	Process Measure	1	Yes	Yes
D	Call Center – Foreign Language Interpreter and TTY Availability	Measures Capturing Access	2	Yes	No
D	Complaints about the Drug Plan	Patients' Experience and Complaints Measure	2	Yes	No
D	Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	2	Yes	No
D	Drug Plan Quality Improvement	Improvement Measure	5	No	No
D	Rating of Drug Plan	Patients' Experience and Complaints Measure	2	Yes	No
D	Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	2	Yes	No
D	MPF Price Accuracy	Process Measure	1	No	No
D	Medication Adherence for Diabetes Medications	Intermediate Outcome Measure	3	Yes	Yes
D	Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measure	3	Yes	Yes
D	Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measure	3	Yes	Yes
D	MTM Program Completion Rate for CMR	Process Measure	1	Yes	Yes
D	Statin Use in Persons with Diabetes	Intermediate Outcome Measure	3	Yes	Yes

[a] Care for Older Adults – Functional Status Assessment was inadvertently included in this table in the Advance Notice. As noted in the 2021 Rate Announcement (https://www.cms.gov/files/document/2021-announcement.pdf, page 92), this measure is being moved to the display page for the 2022 Star Ratings due to a substantive measure specification.

2022 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) and 423.186(f)(2), all measures identified as candidate measures are included in the determination of the 2022 CAI values. The measure set for the 2022 CAI (for both Part C and Part D) is identified in Table IV-1.

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 with the 2022 CAI values at https://go.cms.gov/partcanddstarratings.

Most commenters supported continuing the CAI, but would also like CMS to work towards a longer-term solution that more fully accounts for the impact of socioeconomic factors on the Star Ratings, with several commenters asking CMS to consider options from the Assistant Secretary for Planning and Evaluation (ASPE) Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program Second Report to Congress released in March 2020 (https://aspe.hhs.gov/system/files/pdf/263676/Second-IMPACT-SES-Report-to-Congress.pdf). A few commenters focused on concerns about the ASPE recommendations, adding more social risk factors to the CAI, and eliminating the negative CAI adjustments. CMS is reviewing the ASPE recommendations, exploring additional options to account for differences in within- contract performance across different social risk factors, and investigating the feasibility of adding additional social risk factors to the CAI or alternative methodologies. As this work progresses, we will share it with stakeholders for their input.

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. For the 2020 measurement period with the COVID-19 pandemic, most MA and Part D contracts qualify for the disaster adjustments finalized in the CY 2020 Final Rule, published in the Federal Register on April 16, 2019 (84 FR 15830–31). An affected contract is identified based on whether its service area is within an “emergency area” during an “emergency period” as defined in section 1135 of the Act and within a geographic areas designated in a major disaster declaration under the Stafford Act and the Secretary exercised authority under section 1135 of the Act based on the same triggering event(s). The August 25, 2020 COVID-19 IFC modifies the calculation of the 2022 Part C and D

Star Ratings to address the application of the extreme and uncontrollable circumstances policy for the PHE for COVID-19. Specifically, for the 2022 Star Ratings, CMS will not exclude the numeric values (that is, the performance data) for affected contracts with 60 percent or more of their enrollees in FEMA-designated Individual Assistance areas during the 2020 performance and measurement period from either: (1) the clustering algorithms; or (2) the determination of the performance summary and variance thresholds for the Reward Factor. This means that CMS will use the performance scores for all contracts for the 2020 performance and measurement period to establish cut points for non-CAHPS measures and determine thresholds for the Reward Factor for the 2022 Star Ratings, subject to the other rules in the Star Ratings methodology, including the specific rules adopted in the March 31, 2020 COVID-19 IFC.

Under the 25 percent rules at §§ 422.166(i)(2)–(6) and 423.186(i)(2)–(5), contracts with at least 25 percent of their service area in a FEMA-designated Individual Assistance area in 2020 will receive the higher of their measure-level rating from the current and prior Star Ratings years for purposes of calculating the 2022 Star Ratings (thus, for 2022 Star Ratings, affected contracts will receive the higher of their measure-level ratings from 2021 or 2022 for the applicable measures following the rules described at 84 FR 15770–77).

We appreciate most commenters' support for the extreme and uncontrollable circumstances policy. Some commenters advocated for an expanded policy, such as applying the measure-level adjustments for COVID-19 to the 2021 measurement year as well as 2020; including the call center measures in the adjustments; continuing to count contracts newly receiving ratings in the 2022 Star Ratings as too new rather than receiving ratings, since they do not have prior year data for the higher of comparison; and for the policy to include state and local disasters, FEMA emergency declarations, and Fire Management Assistance declarations. We note that any changes to the extreme and uncontrollable circumstances policy would have to be implemented through rulemaking.

The Secretary of Health and Human Services determined that a PHE exists and has existed since January 27, 2020, nationwide. Table VI-2 lists the emergency periods and emergency areas in place during 2020, as defined in section 1135 of the Act, and the exercise of the Secretary's authority under section 1135 of the Act.

Table VI-2: List of Section 1135 Waivers Issued in Relation to the FEMA Major Disaster Declarations[b]

Section 1135 Waiver Date Issued	Waiver or Modification of Requirements Under Section 1135 of the Social Security Act	FEMA Incident Type	Affected State	Incident Start Date
03/13/2020	Nationwide as a result of COVID-19 outbreak	2019 Novel Coronavirus (COVID-19) pandemic	Nationwide	01/27/2020
08/26/2020	California Wildfires	Wildfires	California	08/14/2020
08/26/2020	Hurricane Laura	Hurricane	Louisiana	08/22/2020
09/16/2020	Oregon Wildfires	Wildfires	Oregon	09/07/2020

[b]For the California wildfires there are two FEMA declarations, so we have listed the earlier incident start date.

Table VI-3 lists the states and territories with Individual Assistance designations from the nationwide FEMA major disaster declarations as a result of COVID-19 outbreaks. Table VI-4 lists the states and territories with Individual Assistance designations from the nationwide FEMA major disaster declarations as a result of disasters other than the COVID-19 pandemic. We have added counties or county-equivalents that qualified after publication of the Advance Notice.

Table VI-3: Individual Assistance in FEMA Major Disaster Declared States/Territories from COVID-19

FEMA Declaration	State
DR-4503	Alabama
DR-4533	Alaska
DR-4524	Arizona
DR-4518	Arkansas
DR-4482	California
DR-4498	Colorado
DR-4500	Connecticut
DR-4526	Delaware
DR-4502	District of Columbia
DR-4486	Florida
DR-4501	Georgia
DR-4495	Guam
DR-4510	Hawaii
DR-4534	Idaho
DR-4489	Illinois
DR-4529	Indiana
DR-4483	Iowa
DR-4504	Kansas
DR-4497	Kentucky
DR-4484	Louisiana
DR-4522	Maine
DR-4491	Maryland
DR-4496	Massachusetts
DR-4494	Michigan
DR-4531	Minnesota
DR-4528	Mississippi
DR-4490	Missouri
DR-4508	Montana
DR-4521	Nebraska
DR-4523	Nevada
DR-4516	New Hampshire
DR-4488	New Jersey
DR-4515	New Mexico
DR-4480	New York
DR-4487	North Carolina
DR-4509	North Dakota
DR-4507	Ohio
DR-4530	Oklahoma
DR-4499	Oregon
DR-4506	Pennsylvania
DR-4493	Puerto Rico

DR-4505	Rhode Island
DR-4492	South Carolina
DR-4527	South Dakota
DR-4514	Tennessee
DR-4485	Texas
DR-4525	Utah
DR-4532	Vermont
DR-4513	U.S. Virgin Islands
DR-4512	Virginia
DR-4481	Washington
DR-4517	West Virginia
DR-4520	Wisconsin
DR-4535	Wyoming

Table VI-4: Individual Assistance in FEMA Major Disaster Declared States/Territories Other than from the COVID-19 Pandemic

FEMA Declaration	State	FEMA Individual Assistance Counties or County-Equivalents
DR-4558	California	Butte, Lake, Lassen, Mendocino, Monterey, Napa, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Trinity, Tulare, Yolo
DR-4569	California	Fresno, Los Angeles, Madera, Mendocino, Napa, San Bernardino, San Diego, Shasta, Siskiyou, Sonoma
DR-4559	Louisiana	Acadia, Allen, Beauregard, Caddo, Calcasieu, Cameron, Grant, Jackson, Jefferson Davis, La Salle, Lincoln, Morehouse, Natchitoches, Ouachita, Rapides, Sabine, St. Landry, Union, Vermilion, Vernon, Winn
DR-4562	Oregon	Clackamas, Douglas, Jackson, Klamath, Lane, Lincoln, Linn, Marion

Changes to Existing Star Ratings Measures in 2022 and Future Years

CMS will continue to solicit feedback on new measure concepts as well as 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), 423.184(c)(2)–(4), 422.164(d)(2), 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).

We remind sponsors that, as finalized in the CY 2020 Final Rule, the re-specified Medicare Plan Finder (MPF) Price Accuracy measure will move into the 2022 Star Ratings as a new measure, after being on the display page for the last two years. CMS will continue weighting it as a process measure with a weight of 1. *See* 84 FR 15762–63. We received comments about measure specifications and the impact of COVID-19. As discussed above, most MA and Part D contracts

qualify for the disaster adjustments for calculating 2022 Star Ratings. Under the disaster policy for new measures at §§ 422.166(i)(5) and 423.186(i)(3), we will calculate each contract's summary and overall Star Ratings with and without the new MPF measure. The higher ratings will be used for the contract's 2022 Star Ratings.

Changes to Existing 2022 Star Ratings Measures based on Non-Substantive Specification Changes

Controlling Blood Pressure (Part C). As announced by NCQA in July 2020 through the HEDIS Volume 2 Technical Specifications release for Measurement Years 2020 and 2021, NCQA is modifying the requirements for out-of-office readings to allow readings taken by a member with any digital device for the 2020 measurement year. This is a non-substantive change as described at § 422.164(d)(1)(v) as it effectively adds additional data sources. All commenters supported NCQA's modification to the Controlling Blood Pressure measure to allow patient self-reported blood pressure readings, as well as telephone and e-visit encounters, to be recognized in the data capture for this measure.One commenter asked what types of digital devices can be used to satisfy this measure.As stated in the technical specifications, the measure allows blood pressures taken by any digital device; readings are not used for the measure when a plan member takes it using a non-digital device such as with a manual blood pressure cuff and a stethoscope.

HEDIS Measures and Telehealth (Part C). As announced by NCQA in July 2020 through the HEDIS Volume 2 Technical Specifications release for Measurement Years 2020 and 2021, NCQA has added additional codes for the 2020 measurement year for several HEDIS measures. These are non-substantive changes as described at § 422.164(d)(1)(v) as they effectively add additional data sources. All commenters appreciated the additional codes added to account for telehealth.

The measures included in this change are:

- **Rheumatoid Arthritis Management** – NCQA removed from the denominator the restriction that only one of the two visits with a rheumatoid arthritis diagnosis could be an outpatient telehealth, telephone visit, e-visit or virtual check-in (when identifying the event/diagnosis) and added telephone visit, e-visit and virtual check-in encounter codes to the advanced illness exclusion.
- **Breast Cancer Screening** – NCQA added telephone visit, e-visit and virtual check-in encounter codes to identify the advanced illness diagnosis exclusion.
- **Care for Older Adults** – NCQA clarified that for the numerator services rendered during a telephone visit, e-visit or virtual check-in meet criteria for Functional Status Assessment and Pain Assessment numerator indicators.
- **Controlling High Blood Pressure** – NCQA removed the restriction that only one of the two visits with a hypertension diagnosis could be an outpatient telehealth, telephone visit, e-visit or virtual check-in when identifying the event/diagnosis and added telephone visit,

e-visit and virtual check-in encounter codes to identify the advanced illness diagnosis exclusion.

- **Comprehensive Diabetes Care** – NCQA removed from the denominator the restriction that only one of the two visits with a diabetes diagnosis could be an outpatient telehealth, telephone visit, e-visit or virtual check-in (when identifying the event/diagnosis) and added telephone visit, e-visit and virtual check-in encounter codes that could be used to identify the advanced illness diagnosis exclusion.
- **Colorectal Cancer Screening** – NCQA added telephone visit, e-visit and virtual check-in encounter codes to identify the advanced illness diagnosis exclusion.
- **Osteoporosis Management in Women Who Had a Fracture** – NCQA added telephone visit, e-visit and virtual check-in encounter codes to identify the advanced illness diagnosis exclusion.
- **Plan All-Cause Readmissions** – NCQA added telephone visits to the Risk Adjustment Comorbidity Category Determination in the Guidelines for Risk Adjusted Utilization Measures.
- **Statin Therapy for Patients with Cardiovascular Disease** – NCQA removed the restriction from the denominator that only one of the two visits with an ischemic vascular disease (IVD) diagnosis could be an outpatient telehealth, telephone visit, e-visit or virtual check-in (when identifying the event/diagnosis) and added telephone visit, e-visit and virtual check-in encounter codes to identify the advanced illness diagnosis exclusion.

Changes to Existing Star Ratings Measures for Future Years

Statin Use in Persons with Diabetes (SUPD) (Part D). The Pharmacy Quality Alliance (PQA) clarified that the index prescription start date (IPSD) for the SUPD measure should occur at least 90 days prior to the end of the measurement year; this will be formally released in an upcoming PQA measure manual revision. This means that beneficiaries are included in the SUPD measure calculation if the earliest date of service for a diabetes medication is at least 90 days prior to the end of the measurement year. As a reminder, the SUPD measure currently excludes beneficiaries enrolled in hospice or that have end-stage renal disease (ESRD) at any time during the measurement period. The PQA added the following exclusions: beneficiaries with rhabdomyolysis or myopathy; pregnancy, lactation, or fertility; liver disease; pre-diabetes; and polycystic ovary syndrome (PCOS). We tested the impact of these changes using the 2019 data (limited to contracts with more than 30 denominator member-years).

Our analysis found that the mean SUPD rate change across all contracts was small (1.16 percentage points). These changes would be considered non-substantive updates under § 423.184 since they modify the index start date and add additional exclusions to the measure, which narrows the denominator. Based on the results of the analysis, in the Advance Notice, CMS announced it will implement the updated measure specifications for the 2021 measurement year (2023 Star Ratings).

Table VI-5: Distribution of the Rates Using the Current (YOS 2019) Measure Specifications for SUPD by Medicare Part D Contract Type, 2019 Data

Contract Type	Distribution by Percentiles							
	Number of contracts	Mean	Standard Deviation	Min	25%	50%	75%	Max
All Contracts	685	82.01%	5.21%	28.22%	79.34%	81.86%	84.73%	100.00%
MAPDs	627	82.20%	5.49%	28.22%	79.72%	82.17%	85.08%	100.00%
MAPDs (non-MMP)	584	82.18%	5.44%	28.22%	79.65%	82.14%	85.16%	100.00%
PDPs	58	79.74%	3.40%	68.03%	78.02%	79.05%	81.78%	88.82%

Table VI-6: Distribution of the Rates Using the PQA Updated Measure Specifications for SUPD by Medicare Part D Contract Type, 2019 Data

Contract Type	Distribution by Percentiles							
	Number of contracts	Mean	Standard Deviation	Min	25%	50%	75%	Max
All Contracts	675	83.17%	4.71%	61.37%	80.47%	83.03%	85.74%	97.00%
MAPDs	617	83.43%	4.81%	61.37%	80.79%	83.30%	86.13%	100.00%
MAPDs (non-MMP)	574	83.34%	4.88%	61.37%	80.67%	83.20%	86.13%	97.00%
PDPs	58	80.76%	3.15%	71.75%	79.25%	80.25%	82.47%	89.87%

Although commenters overwhelmingly supported the updated measure specifications for the SUPD measure, some commenters requested clarifications. A few commenters requested clarification on whether the IPSD applied to the first or second diabetes medication fill. Per the PQA, the IPSD is defined as the earliest date of service for a diabetes medication during the measurement year. Thus, for the SUPD measure, and as intended by the PQA, the IPSD is the first prescription claim for a diabetes medication during the measurement period.

Other commenters requested clarification on how the new exclusions would be identified. Consistent with other PQA measures, the PQA Value Sets will include the ICD-10 and national drug code (NDC) lists for the new exclusion conditions added to the SUPD measure, which will be used by CMS. Furthermore, CMS will use similar data sources to identify the new exclusions added to the SUPD measure such as the Common Working File, encounter data (for MA-PDs), and PDE data. CMS received comments on whether supplemental data could be submitted for the new exclusions. We cannot accept supplemental data (see HPMS memorandum dated May

11, 2012, *Prohibition on Submitting PDEs for non-Part D prescriptions*). Some commenters requested alignment between the SUPD and the Medication Adherence for Cholesterol (Statin) measure by adding the new exclusions to the Medication Adherence for Cholesterol (Statin) measure and adding the sociodemographic risk adjustment to the SUPD measure. CMS appreciates the comments received and will share specification related comments with the PQA.

A few commenters did not agree that the updated specifications for the SUPD measure were non-substantive, for example due to operational implications to implement all of the changes, and requested that the SUPD measure be transitioned to a display page to gain experience with the updates. As noted above, CMS will announce non-substantive specification changes as described at §§ 422.164(d)(1) and 423.184(d)(1), and if the change narrows the denominator, such as additional exclusions, the changes are considered non-substantive. Moreover, these changes generally benefit the Star Ratings of sponsoring organizations.

Additionally, some commenters requested that the SUPD measure receive a weight of 1 rather than a weight of 3 for the 2022 Star Ratings. We remind sponsors that changing the weight of SUPD is a substantive change and must be proposed and finalized through rulemaking. As finalized in the CY 2019 Final Rule, the SUPD measure is classified as an intermediate outcome measure with a weight of 3 for the 2021 and 2022 Star Ratings. Subsequently, per the CY 2021 Final Rule (85 FR 33843–44), it will be re-classified as a process measure with a weight of 1 starting with the 2023 Star Ratings (2021 measurement year).

Display Measures

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 2021 display measures will continue to be shown on CMS.gov in 2022 unless noted below.

CMS continues to reassess if the display measures publicly reported on CMS.gov continue to provide value to Part C and D stakeholders. We will retire the following measures from the display page for 2022 to help reduce sponsors' burden and to focus quality improvement resources.

1. Timely Receipt of Case Files for Appeals (Part D).
2. Timely Effectuation of Appeals (Part D).
3. Drug-Drug Interactions (Part D).
4. Antipsychotic Use in Persons with Dementia – for Community-Only Residents (APD-COMM) (Part D). This measure will also be removed from patient safety reporting. The overall Antipsychotic Use in Persons with Dementia (APD) and

Antipsychotic Use in Persons with Dementia - for Long-term Nursing Home Residents (APD-LTNH) measures will remain on the display page.

5. Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) (Part D). This measure will also be removed from patient safety reporting. The Use of Opioids at High Dosage in Persons Without Cancer (OHD) and Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) measures will remain on the display page.
6. Drug Plan Provides Current Information on Costs and Coverage for Medicare's Website. (Part D).

Commenters supported retiring these six Part D display measures. Based on the feedback, all six measures will be retired from the display page for 2022. As a reminder, even though the APD-COMM measure will be retired from both the patient safety reporting and the display page, the Medicare Part D beneficiaries included in the APD-COMM are still monitored through the Antipsychotic Use in Persons with Dementia, Overall (APD) measure which remains on the display page. CMS carefully evaluates all of the Part C and Part D measures and continues to actively assess the measures for alignment within and across CMS rating systems when possible.

Kidney Health Evaluation for Patients With Diabetes (Part C). The 21st Century Cures Act (P.L. 114-255) allows beneficiaries with End-Stage Renal Disease (ESRD) the option to start enrolling in MA plans in 2021. This NCQA measure assesses 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) during the measurement year. This new measure aligns with recommendations from the American Diabetes Association and provides critical information for screening and monitoring of kidney health for patients with diabetes. We intend to report this measure on the display page for the 2022 Star Ratings and will consider adding it to Star Ratings through future rulemaking, since this measure provides important information regarding screening and monitoring for kidney health. Most commenters supported the addition of this measure to the display page, with one commenter asking for further alignment of the populations covered by this measure and the Comprehensive Diabetes Care (CDC) measure. We have shared this feedback with NCQA for their consideration as they make future updates to this measure.

Controlling Blood Pressure (Part C). This measure was temporarily moved to the display page for the 2020 and 2021 Star Ratings because NCQA made substantive changes to the measure specification. The March 31, 2020 COVID-19 IFC adopted a series of changes to the 2021 Star Ratings to accommodate the disruption to data collection posed by the COVID-19 pandemic. Specifically, this rule replaced measures calculated based on HEDIS data collections with earlier values from the 2020 Star Ratings. Consequently, the HEDIS data were not collected for the 2021 Star Ratings and updated data will not appear on the display page for 2021. Pursuant to § 422.164(d)(2), measures with substantive updates will be placed on the display page for at least two years prior to using the updated measure to calculate and assign Star Ratings: thus, this

measure will be on the display page for the second year for the 2022 Star Ratings. This measure, with the substantive specification change, will return to and be used in calculating the 2023 Star Ratings.Commenters appreciated including this measure on the display page for the 2022 Star Ratings.

Plan All-Cause Readmissions (Part C). This measure was temporarily moved to the display page for the 2021 and 2022 Star Ratings because NCQA made substantive changes to the measure specification. The March 31, 2020 COVID-19 IFC adopted a series of changes to the 2021 Star Ratings to accommodate the disruption to data collection posed by the COVID-19 pandemic, including replacing measures calculated based on HEDIS data collections with earlier values from the 2020 Star Ratings. Therefore, this measure will not appear on the display page for 2021. Pursuant to § 422.164(d)(2), measures with substantive updates will be placed on the display page for at least two years prior to using the updated measure to calculate and assign Star Ratings: thus, this measure will be on the display page for the 2022 and 2023 Star Ratings. This measure, with the substantive specification change, will return to and be used in calculating the 2024 Star Ratings with the substantive specification change. Commenters appreciated including this measure on the display page for the 2023 Star Ratings.

Polypharmacy: **Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS)/ Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH) (Part D).** As stated in the 2020 Advance Notice and 2020 Rate Announcement, these measures will be added to the 2021 display page (using 2019 performance data). Starting with the 2021 measurement year, per the updated PQA specifications, beneficiaries with a seizure disorder diagnosis during the measurement year will be excluded from the Poly-CNS measure. The PQA also added serotonin-norepinephrine reuptake inhibitors (SNRIs) and antiepileptics to the measure medication list for Poly-CNS. Additionally, PQA excluded injectable and inhalation routes of administration from both polypharmacy measures in order to improve accuracy in estimating days' supply. We tested the updated specifications using the 2019 data. The analysis was limited to contracts with more than 30 denominator member-years.

The change in the Poly-ACH overall rate was negligible. The exclusion of NDCs for injectable and inhalation routes of administration led to a small decrease in the eligible population for this measure. However, the analysis found that there was a change in the mean rate across all contracts for Poly-CNS. The overall Poly-CNS rate increased by 8.78 percentage points due to the increase in both the numerator and denominator, mainly related to the addition of SNRIs and antiepileptic NDCs to the Poly-CNS measure. Based on the results of these analyses, CMS announced plans to implement the updated measure specifications for the 2021 measurement period for the 2023 display measures.

Table VI-7. Distribution of the Rates Using the Current (YOS 2019) Measure Specifications by Medicare Part D Contract Type, 2019 Data

Measure	Contract Type	Distribution by Percentiles							
		Number of contracts	Mean	Standard Deviation	Min	25%	50%	75%	Max
Poly-ACH	All Contracts	655	8.56%	3.76%	0.00%	6.06%	7.59%	10.02%	23.27%
	MAPDs	597	8.68%	3.88%	0.00%	6.04%	7.60%	10.71%	23.27%
	MAPDs (non-MMP)	555	8.50%	3.86%	0.00%	5.93%	7.46%	9.99%	23.27%
	PDPs	58	7.53%	2.13%	1.84%	6.15%	7.47%	8.59%	15.38%
Poly-CNS	All Contracts	722	7.21%	3.92%	0.00%	4.67%	6.25%	8.61%	30.72%
	MAPDs	664	7.32%	4.06%	0.00%	4.65%	6.25%	8.83%	30.72%
	MAPDs (non-MMP)	620	7.25%	4.12%	0.00%	4.57%	6.15%	8.75%	30.72%
	PDPs	58	5.93%	1.56%	2.33%	4.95%	5.85%	6.83%	10.82%

Table VI-8: Distribution of the Rates Using the PQA Updated Measure Specifications by Medicare Part D Contract Type, 2019 Data

Measure	Contract Type	Distribution by Percentiles							
		Number of contracts	Mean	Standard Deviation	Min	25%	50%	75%	Max
Poly-ACH	All Contracts	655	8.56%	3.76%	0.00%	6.06%	7.59%	10.02%	23.27%
	MAPDs	597	8.68%	3.88%	0.00%	6.04%	7.60%	10.71%	23.27%
	MAPDs (non-MMP)	555	8.50%	3.86%	0.00%	5.94%	7.46%	9.99%	23.27%
	PDPs	58	7.53%	2.13%	1.84%	6.15%	7.47%	8.59%	15.38%
Poly-CNS	All Contracts	728	15.99%	8.38%	0.72%	10.27%	12.94%	19.42%	51.37%
	MAPDs	670	16.25%	8.65%	0.00%	10.24%	12.98%	20.36%	51.37%
	MAPDs (non-MMP)	626	16.19%	8.80%	0.72%	10.15%	12.75%	20.40%	51.37%
	PDPs	58	12.59%	2.80%	8.24%	10.75%	12.24%	13.89%	20.86%

CMS will include the measure specification updates to the Poly-CNS and Poly-ACH measures in the 2021 measurement year for the 2023 display page. The majority of commenters supported the updated measure specifications to exclude the injectable and inhalable routes of

administration from both the Poly-CNS and Poly-ACH measures. Additionally, many commenters supported the exclusion of seizure disorder diagnosis from the Poly-CNS measure.

However, a few commenters were concerned with adding the SNRIs and anti-epileptics to the medication list for the Poly-CNS measure. As a reminder, PQA is the measure steward of the Poly-CNS measure. The updates to include the anti-epileptics and SNRIs to the Poly-CNS measure are based on the changes to the American Geriatrics Society Beers Criteria from 2015 to 2019 and were supported by the PQA Measure Update Panel to align with current clinical guidelines. Furthermore, commenters had requested that additional diagnoses be considered for exclusions to the Poly-CNS measure and when applicable to the Poly-ACH measure, such as primary psychotic disorders, bipolar depression, obsessive-compulsive disorder, severe anxiety disorders, and neuropathic pain. One commenter also requested that CMS to consider increasing the overlap of concurrent therapy from 30 days to 90 days or more. CMS appreciates the feedback received and will share specification related comments with the PQA.

Potential New Measure Concepts for Future Years

Provider Directory Accuracy (Part C). We solicited comments on a potential new Star Ratings measure on provider directory accuracy. For example, the measure could consider what percent of plan information is inaccurate. We welcomed feedback on the utility of such a measure, given other requirements for application programming interfaces (APIs), and what it could look like. All commenters acknowledged the importance of having accurate provider directories. Most commenters were not in favor of the development of a measure related to provider directory accuracy. Many commenters noted that directory accuracy may be more suited for monitoring as part of plan compliance and oversight activities, rather than as a quality measure. Some commenters noted that CMS is currently encouraging MA plans to work with providers and the National Plan & Provider Enumeration System (NPPES), which could eventually be used as a single source of provider data accuracy, and noted that a Star Ratings measure may discourage this partnership and the current work. Some commenters also noted that developing a measure right now would be complicated by more challenges in ensuring the accuracy of this information during the COVID-19 pandemic. A few commenters noted that this measure would favor certain plan types such as those that own their provider groups. Additional comments focused on how this information would be verified since there is not a standard, accurate source for this information. CMS will take these comments into consideration as we continue to explore the utility and feasibility of developing a measure related to the accuracy of provider directories.

COVID-19 Vaccination (Part C). We solicited comments on a potential new measure concept related to the COVID-19 vaccination for the Part C & D performance measure display page on CMS.gov and for potential inclusion in the Star Ratings program, pending rulemaking. Health plans play an important role to help educate and encourage their members to get the COVID-19 vaccine. Most commenters thought it was premature to develop a COVID-19 vaccination

measure and consider including it in the Star Ratings program. A number of challenges were raised in the comments, including the following: distribution channels differing across the country; lack of sufficient testing of the efficacy and safety of the vaccination among beneficiaries with multiple chronic conditions and dually eligible enrollees; whether the vaccine will be annual or lifetime; the availability of vaccinations in adequate volumes; precise guidelines determining to whom the vaccines should be administered; the amount of control MA plans would have over vaccination rates; cultural differences in vaccine acceptance; and rural/urban differences. If CMS moves forward with a measure, some commenters suggested that CMS may want to consider registries or administrative data as an alternative to CAHPS data. Others suggested that CAHPS data may be useful to ascertain where beneficiaries are being vaccinated and any concerns or resistance about receiving the vaccination. A couple of commenters suggested this measure may be useful for the display page.CMS will take these comments into consideration as we continue to explore the feasibility of developing a measure of COVID-19 vaccination for potential inclusion on the display page for CYCY 2024.

Attachment VII. Economic Information for the CY 2022 Rate Announcement

Below, we provide the economic information for significant provisions in the Rate Announcement. Provisions not specifically addressed below are intended to represent a continuation of the policies established for CY 2021 and, as a result, do not have an impact associated with them. Comments related to the economic information presented in Parts I and II of the Advance Notice have been summarized and addressed in the applicable sections above with the remainder of the comments.

Section A. Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2022

A1. CMS-HCC Risk Adjustment Model for 2022

The economic information below provides the year-to-year impact (2021 to 2022) of the policies being finalized to fully implement the 2020 CMS-HCC risk adjustment model and the transition to calculating risk scores based on diagnoses from encounter data and FFS, for non-PACE organizations.

Risk Adjustment Model Impact. The impact of the last phase in the transition of the risk adjustment model for CY 2022 reflects the impact on MA risk scores of fully phasing in the 2020 CMS-HCC model relative to the policy finalized for CY 2021 of blending 75 percent of the 2020 CMS-HCC model and 25 percent of the 2017 CMS-HCC model. The CY 2022 impact on MA risk scores of the full transition to the 2020 CMS-HCC model, relative to CY 2021, is projected to be 0.25 percent, which represents a $670 million net cost to the Medicare Trust Funds in 2022. This estimate 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.

Risk Scores - Sources of Diagnoses. The CY 2022 impact on MA risk scores of the transition to a greater percent of the risk score being calculated with encounter data and FFS claims is 0.00 percent. In the CY 2021 Advance Notice, CMS projected the differential between the RAPS-based risk score and the encounter data-based risk score, calculated using the risk adjustment models proposed, to be 0.00 percent. Since the relative impact was 0.00 percent beginning in CY 2021, and CMS is finalizing the policy to calculate 100 percent of risk scores based on encounter data, the impact of the transition to a risk score based entirely on diagnoses from encounter data and FFS claims in CY 2022 is 0.00 percent. The contribution of RAPS inpatient diagnosis supplementation to encounter data-based risk scores has been getting smaller over time and we anticipate that, were we to continue this policy into 2022, the contribution will be 0.00 percent. Thus, there is no CY 2022 cost impact of ending RAPS inpatient supplementation. The update to the FFS claims filtering logic impacts beneficiaries who have risk scores based on diagnoses from FFS during the data collection period, and are enrolled in MA during the payment year (i.e., switchers). The estimated impact, on average, of identifying diagnoses for risk score calculation

from FFS claims using HCPCS-based filtering logic is -0.08 percent, which represents $210 million dollars in net savings.

A2. Medicare Advantage and PACE non-ESRD Ratebook

The FFS growth percentage for the 2022 MA non-ESRD rates is estimated to be 5.47 percent, and the MA growth percentage for the 2022 non-ESRD rates is estimated to be 6.30 percent. As a result, the effective growth rate for 2022 MA non-ESRD rates is estimated to be 5.59 percent. The MA non-ESRD ratebook impact summarized here is calculated by comparing 2022 Part C expenditures reflecting these growth rate assumptions to the expected 2022 Part C expenditures assuming for the purposes of this analysis that the MA non-ESRD ratebook remains unchanged from that finalized for 2021. The net impact on the Medicare Trust Funds for CY 2022 is expected to be $16.6 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.

The MA growth percentage, used to calculate the 2022 PACE non-ESRD rates as well as in development of the applicable amount used in setting MA non-ESRD rates, is estimated to be 6.30 percent. The PACE non-ESRD ratebook impact is calculated by comparing the 2022 PACE expenditures reflecting this growth rate assumption to the expected 2022 PACE expenditures assuming that the PACE non-ESRD ratebook remains unchanged from the CY 2021 PACE non-ESRD ratebook. The net impact on the Medicare Trust Funds for CY 2022 for the PACE ratebook change is expected to be $90 million. This figure accounts for the portion of the program costs covered by Part B premiums.

To continue the adjustment to the calculation of county benchmarks in Puerto Rico for the number of beneficiaries with zero claims, the net impact on the Medicare Trust Funds for CY 2022 of implementing the zero-claims adjustment in Puerto Rico is expected to be $280 million.

The impact of excluding standardized costs for kidney acquisitions from MA benchmarks varies by jurisdiction. The KAC carve-out factors are included as part of the rate calculation data for 2022 published with the CY 2022 Rate Announcement, which can be accessed by navigating to the following page: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data. For information on the impact of the FFS cost of kidney acquisitions for beneficiaries enrolled in MA plans on the Medicare Trust Funds, please refer to the CY 2021 final rule (CMS-4190-F) (85 FR 33796, 33887–90). The estimates provided in that final rule represent national-level impacts and are based on different trending assumptions and underlying data than those used to determine county-level average impacts of excluding KACs from FFS experience. Further, because these national-level impacts in the final rule represent the impact on the Trust Funds and not the ratebook, additional adjustments were made in the CY 2021 final rule estimate to reflect the

government's share of the Part B premium and gross savings due to the difference between MA bids and MA benchmarks.

A3. 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. We estimated the impact of the IME phase-out change between 2021 and 2022. Since the maximum IME reduction is 7.2 percent in 2021 and 7.8 percent in 2022, we calculate the impact as the difference for those counties with IME percentages of at least 7.2 percent, with the maximum impact of 0.6 percent (i.e., the difference between 7.8 and 7.2 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 three counties in payment year 2022 have IME amounts greater than 7.2 percent of the FFS rate. All other counties have IME amounts less than 7.2 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 2022. For the ESRD ratebook, IME amounts are calculated at the state level, and all IME amounts aggregated at the state level are less than 7.2 percent of the FFS rate, so there is no impact from the IME phase-out change on the ESRD ratebook for 2022.

The results are a net savings of $10 million to the Medicare Trust Funds for CY 2022. 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 2022 is the same as that provided by statute for CY 2021; we are providing this impact assessment for informational purposes.

Section 1894(d)(3) of the Act provides that the IME payment phase-out does not apply to PACE capitation rates, so there is no impact associated with PACE.

A4. Medicare Advantage and PACE ESRD Ratebooks

The FFS growth percentage for the 2022 ESRD state rates is estimated to be 5.00 percent. The impact on the MA and PACE ESRD ratebooks is calculated by comparing projected 2022 Part C expenditures with this growth rate assumption to the expected 2022 Part C expenditures with the assumption that the MA and PACE ESRD ratebooks remain unchanged from that finalized for 2021. The net impact on the Medicare Trust Funds for CY 2022 is expected to be $870 million. This figure accounts for the portion of the program costs covered by Part B premiums.

A5. ESRD Risk Adjustment

The economic information below provides the year-to-year impact (2021 to 2022) of the policies being finalized to fully implement the 2020 ESRD risk adjustment models and the transition to calculating risk scores based on diagnoses from encounter data and FFS, for non-PACE organizations.

ESRD Risk Adjustment Model. The impact of transitioning the ESRD risk adjustment models for CY 2022 reflects the change in the blend of risk scores using the 2019 ESRD models and the 2020 ESRD models. CMS is finalizing the policy to calculate risk scores with the 2020 ESRD risk adjustment models for CY 2022 payments. The impact of the ESRD risk adjustment model transition is the effect of fully phasing in the 2020 ESRD models. The CY 2022 impact on ESRD risk scores of the transition to the 2020 ESRD models, relative to the CY 2021 blend, is 0.35 percent for ESRD (dialysis and functioning graft combined), which represents a $70 million net impact on the Medicare Trust Funds in 2022. This impact takes into account the portion of the program costs covered by Part B premiums.

ESRD Risk Scores - Sources of Diagnoses. The CY 2022 impact on ESRD risk scores of the transition to a greater percent of the risk score being calculated with encounter data and FFS claims is 0.00 percent. In the CY 2021 Advance Notice, CMS projected the differential between the RAPS-based risk score and the encounter data-based risk score, calculated using the ESRD risk adjustment models proposed, to be 0.00 percent. Since the relative impact was 0.00 percent beginning in CY 2021 and CMS is finalizing the policy to calculate 100 percent of risk scores based on diagnoses from encounter data and FFS claims, the impact of the transition to ESRD risk scores based entirely on diagnoses from encounter data and FFS claims in CY 2022 is 0.00 percent. The contribution of RAPS inpatient diagnosis supplementation to encounter data-based ESRD risk scores has been getting smaller over time and we anticipate that, were we to continue this policy into 2022, the contribution will be 0.00 percent. Thus, there is no 2022 cost impact of ending RAPS inpatient supplementation for CY 2022 payment. The update to the FFS claims filtering logic impacts beneficiaries who have ESRD risk scores based on diagnoses from FFS during the data collection period, and are enrolled in MA during the payment year (i.e., switchers). The estimated impact, on average, of identifying diagnoses for risk score calculation from FFS claims using HCPCS-based filtering logic is -0.18 percent, which represents $30 million dollars in net savings.

A6. Frailty Adjustment for FIDE SNPs

For CY 2022, CMS is finalizing the policy to calculate frailty scores for FIDE SNPs using updated frailty factors and the 2020 CMS-HCC model. For CY 2021, CMS will calculate 75 percent of the frailty score using the frailty factors associated with the 2020 CMS-HCC risk adjustment model and 25 percent of the frailty score using the frailty factors associated with the 2017 CMS-HCC risk adjustment model. To calculate impacts, CMS utilized the survey results

from the 2019 HOS / HOS-M to estimate the frailty scores based on the frailty factors used for CY 2021 (75 percent 2020 CMS-HCC model and 25 percent 2017 CMS-HCC model) and the finalized CY 2022 frailty factors (100 percent 2020 CMS-HCC model). The CY 2022 impact of transitioning to frailty scores calculated using the updated frailty factors associated with 2020 CMS-HCC model, relative to CY 2021, is a change in frailty scores of 19 percent, which represents a net impact of $30 million dollars to the Medicare Trust Funds in 2022. 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.

A7. MA Coding Pattern Adjustment

For CY 2022, we are finalizing the statutory minimum coding intensity adjustment (5.90%). There is no change in policy from CY 2021, and we applied the same factor for CY 2021, therefore the year-over-year impact is zero.

A8. Normalization

The normalization factors for the CMS-HCC and ESRD risk adjustment models serve to maintain a 1.0 average risk score. We do this by predicting the payment year risk score so as to make an adjustment to offset the trend in risk scores.

For CY 2022 for the CMS-HCC and ESRD risk adjustment models, CMS is finalizing the policy to apply the same methodology to calculate the normalization factors that was applied in CY 2021 (calculating the linear slope using five years of data). To determine these CY 2022 normalization factors, we applied the CY 2021 methodology to the most current underlying data available, resulting in updated normalization factors. These normalization factors are applied to the CMS-HCC and ESRD model risk scores so that the year-over-year average risk score stays 1.0 in the FFS program.

For CY 2022 for the RxHCC risk adjustment model, CMS is finalizing the policy to use the same linear slope methodology to calculate the normalization factor that was used in CY 2021; however, we will use four years of data rather than five years of data because we think this is the best approach to maintain the 1.0 across the Part D program for CY 2022. To determine the CY 2022 normalization factor, we applied the CY 2021 linear slope methodology to the most current four years of underlying data available, resulting in an updated normalization factor. This normalization factor is applied to the RxHCC model risk scores so that the year-over-year average risk score stays 1.0 in the Part D program.

Section B. Changes in the Payment Methodology for Medicare Part D for CY 2022

B1. RxHCC Risk Adjustment Model

The economic information below provides the year-to-year impact (2021 to 2022) of the policies being finalized to implement an updated version of the RxHCC risk adjustment model and the

transition to calculating risk scores based on diagnoses from encounter data and FFS, for non-PACE organizations.

RxHCC Risk Adjustment Model Impact. In order to calculate risk scores for payment, the dollar coefficients must be denominated to create relative factors. The denominator is the average predicted per capita expenditure predicted by the payment model for a given year. To calculate the denominator, we use the recalibrated model and diagnosis data for Medicare beneficiaries enrolled in both MA-PDs and PDPs, which results in an average risk score for the enrolled Part D population in the denominator year of 1.0. Recalibration of the RxHCC model can result in changes in risk scores for individual beneficiaries and for plan level risk scores; however, the average risk score in the denominator year remains a 1.0. Since the average risk score is 1.0 under the existing model and the recalibrated model, the economic impact of the recalibrated model is zero.

Part D Risk Scores - Sources of Diagnoses. Changes in the sources of diagnoses for Part D risk scores, in tandem with changes to the RxHCC risk adjustment model, do not change the projected CY 2022 average risk score from 1.0.

B2. Annual Percentage Increase for Part D Parameters

The methodology for updating other Part D parameters for CY 2022 remains unchanged from that used for CY 2021. 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.

Attachment VIII. RxHCC Risk Adjustment Factors

Table VIII-1. RxHCC Model (2017/2018) Relative Factors for Continuing Enrollees

Variable	Disease Group	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
Female						
0-34 Years		-	0.215	-	0.447	2.020
35-44 Years		-	0.372	-	0.612	2.017
45-54 Years		-	0.429	-	0.680	1.760
55-59 Years		-	0.392	-	0.615	1.575
60-64 Years		-	0.355	-	0.524	1.397
65-69 Years		0.157	-	0.331	-	1.411
70-74 Years		0.174	-	0.301	-	1.268
75-79 Years		0.172	-	0.267	-	1.144
80-84 Years		0.153	-	0.232	-	1.031
85-89 Years		0.140	-	0.191	-	0.925
90-94 Years		0.105	-	0.122	-	0.790
95 Years or Over		0.030	-	0.035	-	0.590
Male						
0-34 Years		-	0.192	-	0.484	1.932
35-44 Years		-	0.293	-	0.570	1.881
45-54 Years		-	0.332	-	0.584	1.693
55-59 Years		-	0.366	-	0.560	1.490
60-64 Years		-	0.365	-	0.506	1.327
65-69 Years		0.196	-	0.327	-	1.289
70-74 Years		0.201	-	0.299	-	1.177
75-79 Years		0.206	-	0.293	-	1.108
80-84 Years		0.155	-	0.270	-	1.029
85-89 Years		0.092	-	0.238	-	0.929
90-94 Years		0.035	-	0.189	-	0.803
95 Years or Over		-	-	0.117	-	0.657
Originally Disabled Interactions with Sex						
Originally Disabled Female		0.071	-	0.203	-	0.096
Originally Disabled Male		-	-	0.137	-	0.096
Disease Coefficients	**Description Label**					
RXHCC1	HIV/AIDS	4.503	5.616	4.482	4.736	2.596
RXHCC5	Opportunistic Infections	0.247	0.389	0.262	0.311	0.077
RXHCC15	Chronic Myeloid Leukemia	6.930	6.811	8.459	10.616	5.109
RXHCC16	Multiple Myeloma and Other Neoplastic Disorders	5.678	6.811	4.942	5.799	1.734
RXHCC17	Secondary Cancers of Bone, Lung, Brain, and Other Specified Sites; Liver Cancer	2.011	1.426	2.740	2.322	1.033
RXHCC18	Lung, Kidney, and Other Cancers	0.312	0.307	0.487	0.443	0.124
RXHCC19	Breast and Other Cancers and Tumors	0.110	0.058	0.131	0.213	0.083

Variable	Disease Group	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC30	Diabetes with Complications	0.479	0.524	0.642	0.859	0.559
RXHCC31	Diabetes without Complication	0.233	0.205	0.309	0.353	0.298
RXHCC40	Specified Hereditary Metabolic/Immune Disorders	2.583	9.907	4.346	10.232	0.231
RXHCC41	Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders	0.090	0.234	-	0.261	0.061
RXHCC42	Thyroid Disorders	0.095	0.167	0.114	0.175	0.094
RXHCC43	Morbid Obesity	0.073	-	0.118	0.117	0.204
RXHCC45	Disorders of Lipoid Metabolism	-	-	0.050	0.088	0.049
RXHCC54	Chronic Viral Hepatitis C	0.518	0.662	0.685	0.638	0.677
RXHCC55	Chronic Viral Hepatitis, Except Hepatitis C	0.440	0.562	0.685	0.593	0.240
RXHCC65	Chronic Pancreatitis	0.310	0.378	0.301	0.351	0.239
RXHCC66	Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis	0.165	0.378	0.220	0.351	0.120
RXHCC67	Inflammatory Bowel Disease	0.556	0.440	0.672	1.343	0.305
RXHCC68	Esophageal Reflux and Other Disorders of Esophagus	0.056	0.054	0.137	0.161	0.105
RXHCC80	Aseptic Necrosis of Bone	0.208	0.304	0.159	0.224	0.079
RXHCC82	Psoriatic Arthropathy and Systemic Sclerosis	0.708	0.643	2.107	3.304	1.118
RXHCC83	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	0.305	0.297	0.704	1.149	0.284
RXHCC84	Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	0.164	0.251	0.246	0.374	0.151
RXHCC87	Osteoporosis, Vertebral and Pathological Fractures	0.062	0.209	0.165	0.298	-
RXHCC95	Sickle Cell Anemia	0.132	0.280	0.121	0.866	-
RXHCC96	Myelodysplastic Syndromes and Myelofibrosis	1.403	1.567	1.204	1.277	0.453
RXHCC97	Immune Disorders	0.782	0.582	0.825	0.742	0.597
RXHCC98	Aplastic Anemia and Other Significant Blood Disorders	0.132	0.170	0.121	0.293	-
RXHCC111	Alzheimer`s Disease	0.265	0.153	0.101	-	-
RXHCC112	Dementia, Except Alzheimer`s Disease	0.096	0.056	0.015	-	-
RXHCC130	Schizophrenia	0.247	0.275	0.467	0.797	0.182
RXHCC131	Bipolar Disorders	0.215	0.196	0.291	0.434	0.182
RXHCC132	Major Depression	0.116	0.145	0.140	0.232	0.139
RXHCC133	Specified Anxiety, Personality, and Behavior Disorders	0.116	0.145	0.140	0.232	0.097
RXHCC134	Depression	0.116	0.121	0.140	0.197	0.097
RXHCC135	Anxiety Disorders	0.045	0.103	0.099	0.140	0.097
RXHCC145	Autism	0.247	0.275	0.426	0.318	0.097

Variable	Disease Group	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC146	Profound or Severe Intellectual Disability/Developmental Disorder	0.247	0.275	0.426	0.318	-
RXHCC147	Moderate Intellectual Disability/Developmental Disorder	0.247	-	0.238	0.124	-
RXHCC148	Mild or Unspecified Intellectual Disability/Developmental Disorder	0.247	-	0.108	0.009	-
RXHCC156	Myasthenia Gravis, Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	0.527	1.020	0.571	0.876	0.203
RXHCC157	Spinal Cord Disorders	0.138	0.089	0.127	0.040	-
RXHCC159	Inflammatory and Toxic Neuropathy	0.145	0.410	0.102	0.368	0.103
RXHCC160	Multiple Sclerosis	2.287	3.221	2.459	4.241	1.173
RXHCC161	Parkinson`s and Huntington`s Diseases	0.595	0.776	0.383	0.553	0.307
RXHCC163	Intractable Epilepsy	0.372	0.529	0.506	1.498	0.222
RXHCC164	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy	0.118	0.082	0.073	0.186	0.037
RXHCC165	Convulsions	0.049	-	0.015	0.056	-
RXHCC166	Migraine Headaches	0.124	0.175	0.148	0.162	0.130
RXHCC168	Trigeminal and Postherpetic Neuralgia	0.151	0.221	0.210	0.236	0.225
RXHCC185	Primary Pulmonary Hypertension	0.858	2.603	1.008	3.066	0.342
RXHCC186	Congestive Heart Failure	0.186	0.195	0.244	0.202	0.188
RXHCC187	Hypertension	0.101	0.057	0.171	0.102	0.085
RXHCC188	Coronary Artery Disease	0.083	-	0.138	-	-
RXHCC193	Atrial Arrhythmias	0.529	0.214	0.335	0.145	0.221
RXHCC206	Cerebrovascular Disease, Except Hemorrhage or Aneurysm	0.028	-	0.028	-	-
RXHCC207	Spastic Hemiplegia	0.225	0.163	0.136	0.144	-
RXHCC215	Venous Thromboembolism	0.334	0.331	0.269	0.311	0.213
RXHCC216	Peripheral Vascular Disease	-	-	-	-	-
RXHCC225	Cystic Fibrosis	2.052	9.273	1.449	10.915	1.145
RXHCC226	Chronic Obstructive Pulmonary Disease and Asthma	0.387	0.196	0.467	0.338	0.253
RXHCC227	Pulmonary Fibrosis and Other Chronic Lung Disorders	0.387	0.196	0.254	0.338	0.101
RXHCC241	Diabetic Retinopathy	0.377	0.322	0.380	0.369	0.202
RXHCC243	Open-Angle Glaucoma	0.294	0.224	0.393	0.334	0.294
RXHCC260	Kidney Transplant Status	0.065	0.123	0.143	0.072	0.034
RXHCC261	Dialysis Status	0.086	0.032	0.223	0.293	0.137
RXHCC262	Chronic Kidney Disease Stage 5	0.086	0.032	0.112	0.014	0.078
RXHCC263	Chronic Kidney Disease Stage 4	0.086	0.032	0.112	0.014	0.078
RXHCC311	Chronic Ulcer of Skin, Except Pressure	0.163	0.173	0.121	0.144	0.064

Variable	Disease Group	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
RXHCC314	Pemphigus	0.296	0.106	0.318	0.338	0.058
RXHCC316	Psoriasis, Except with Arthropathy	0.149	0.144	0.643	1.174	0.392
RXHCC355	Narcolepsy and Cataplexy	0.743	1.457	0.729	1.484	0.373
RXHCC395	Lung Transplant Status	1.213	0.123	0.815	0.072	0.034
RXHCC396	Major Organ Transplant Status, Except Lung, Kidney, and Pancreas	1.213	0.123	0.713	0.072	0.034
RXHCC397	Pancreas Transplant Status	0.065	0.123	0.143	0.072	0.034
Non-Aged Disease Interactions						
NonAged_RXHCC1	NonAged * HIV/AIDS	-	-	-	-	1.262
NonAged_RXHCC130	NonAged * Schizophrenia	-	-	-	-	0.276
NonAged_RXHCC131	NonAged * Bipolar Disorders	-	-	-	-	0.260
NonAged_RXHCC132	NonAged * Major Depression	-	-	-	-	0.148
NonAged_RXHCC133	NonAged * Specified Anxiety, Personality, and Behavior Disorders	-	-	-	-	0.047
NonAged_RXHCC134	NonAged * Depression	-	-	-	-	0.047
NonAged_RXHCC135	NonAged * Anxiety Disorders	-	-	-	-	0.047
NonAged_RXHCC145	NonAged * Autism	-	-	-	-	0.047
NonAged_RXHCC160	NonAged * Multiple Sclerosis	-	-	-	-	1.475
NonAged_RXHCC163	NonAged * Intractable Epilepsy	-	-	-	-	0.320

NOTE: The Part D Denominator used to calculate relative factors is $1,117.51. This Part D Denominator is based on the combined PDP and MA-PD populations.

SOURCE: RTI Analysis of 100% 2017-2018 Medicare Enrollment Data, 2018 Prescription Drug Event (PDE) Data, 2017 Professional Claims (Carrier), 2017 Inpatient Claims, 2017 Outpatient Claims, and 2017 Medicare Advantage Encounter Data.

Table VIII-2. RxHCC Model (2017/2018) Relative Factors for New Enrollees, Non-Low Income

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Originally Disabled, Not Concurrently ESRD	Originally Disabled, Concurrently ESRD
Female				
0-34 Years	0.787	1.014	-	-
35-44 Years	1.262	1.377	-	-
45-54 Years	1.286	1.377	-	-
55-59 Years	1.203	1.663	-	-
60-64 Years	1.203	2.193	-	-
65 Years	0.479	1.903	1.102	1.903
66 Years	0.499	1.903	1.102	1.903
67 Years	0.520	1.903	1.102	1.903
68 Years	0.561	1.903	1.102	1.903
69 Years	0.577	1.903	1.102	1.903
70-74 Years	0.625	1.903	1.201	1.903
75-79 Years	0.683	1.903	0.913	1.903
80-84 Years	0.756	1.903	0.756	1.903
85-89 Years	0.756	1.903	0.756	1.903
90-94 Years	0.437	1.903	0.437	1.903
95 Years or Over	0.437	1.903	0.437	1.903
Male				
0-34 Years	0.578	0.925	-	-
35-44 Years	0.947	0.978	-	-
45-54 Years	1.156	1.410	-	-
55-59 Years	1.156	1.706	-	-
60-64 Years	1.200	1.785	-	-
65 Years	0.563	1.919	1.064	1.919
66 Years	0.590	1.919	1.064	1.919
67 Years	0.598	1.919	1.064	1.919
68 Years	0.625	1.919	1.064	1.919
69 Years	0.658	1.919	1.064	1.919
70-74 Years	0.722	1.919	0.952	1.919
75-79 Years	0.844	1.919	0.844	1.919
80-84 Years	0.844	1.919	0.844	1.919
85-89 Years	0.844	1.919	0.844	1.919
90-94 Years	0.669	1.919	0.669	1.919
95 Years or Over	0.669	1.919	0.669	1.919

NOTES:

1. The Part D Denominator used to calculate relative factors is $1,117.51. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).
3. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or post-graft.

SOURCE: RTI Analysis of 100% 2017-2018 Medicare Enrollment Data, 2018 Prescription Drug Event (PDE) Data, 2017 Professional Claims (Carrier), 2017 Inpatient Claims, 2017 Outpatient Claims, and 2017 Medicare Advantage Encounter Data.

Table VIII-3. RxHCC Model (2017/2018) Relative Factors for New Enrollees, Low Income

Variable	Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Originally Disabled, Not Concurrently ESRD	Originally Disabled, Concurrently ESRD
Female				
0-34 Years	1.166	2.068	-	-
35-44 Years	1.738	2.161	-	-
45-54 Years	1.867	2.234	-	-
55-59 Years	1.677	2.362	-	-
60-64 Years	1.558	2.273	-	-
65 Years	1.019	2.279	1.423	2.279
66 Years	0.682	2.279	0.962	2.279
67 Years	0.682	2.279	0.962	2.279
68 Years	0.682	2.279	0.962	2.279
69 Years	0.682	2.279	0.962	2.279
70-74 Years	0.682	2.279	0.962	2.279
75-79 Years	0.694	2.279	0.694	2.279
80-84 Years	0.694	2.279	0.694	2.279
85-89 Years	0.694	2.279	0.694	2.279
90-94 Years	0.481	2.279	0.481	2.279
95 Years or Over	0.481	2.279	0.481	2.279
Male				
0-34 Years	1.015	2.395	-	-
35-44 Years	1.378	2.226	-	-
45-54 Years	1.555	2.176	-	-
55-59 Years	1.419	2.176	-	-
60-64 Years	1.355	2.007	-	-
65 Years	0.985	2.084	1.172	2.084
66 Years	0.640	2.084	0.818	2.084
67 Years	0.626	2.084	0.818	2.084
68 Years	0.614	2.084	0.717	2.084
69 Years	0.591	2.084	0.677	2.084
70-74 Years	0.591	2.084	0.645	2.084
75-79 Years	0.569	2.084	0.612	2.084
80-84 Years	0.563	2.084	0.563	2.084
85-89 Years	0.563	2.084	0.563	2.084
90-94 Years	0.471	2.084	0.471	2.084
95 Years or Over	0.471	2.084	0.471	2.084

NOTES:

1. The Part D Denominator used to calculate relative factors is $1,117.51. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).
3. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or post-graft.

SOURCE: RTI Analysis of 100% 2017-2018 Medicare Enrollment Data, 2018 Prescription Drug Event (PDE) Data, 2017 Professional Claims (Carrier), 2017 Inpatient Claims, 2017 Outpatient Claims, and 2017 Medicare Advantage Encounter Data.

Table VIII-4. RxHCC Model (2017/2018) Relative Factors for New Enrollees, Institutional

Variable	Not Concurrently ESRD	Concurrently ESRD
Female		
0-34 Years	2.718	3.001
35-44 Years	2.997	3.001
45-54 Years	2.997	3.001
55-59 Years	2.439	3.001
60-64 Years	2.439	3.001
65 Years	2.435	3.001
66 Years	2.191	3.001
67 Years	2.191	3.001
68 Years	2.191	3.001
69 Years	2.191	3.001
70-74 Years	1.811	3.001
75-79 Years	1.534	3.001
80-84 Years	1.390	3.001
85-89 Years	1.254	3.001
90-94 Years	0.973	3.001
95 Years or Over	0.973	3.001
Male		
0-34 Years	2.767	2.865
35-44 Years	2.591	2.865
45-54 Years	2.453	2.865
55-59 Years	2.390	2.865
60-64 Years	2.230	2.865
65 Years	2.281	2.865
66 Years	1.855	2.865
67 Years	1.855	2.865
68 Years	1.855	2.865
69 Years	1.855	2.865
70-74 Years	1.855	2.865
75-79 Years	1.659	2.865
80-84 Years	1.538	2.865
85-89 Years	1.266	2.865
90-94 Years	1.266	2.865
95 Years or Over	1.266	2.865

NOTES:

1. The Part D Denominator used to calculate relative factors is $1,117.51. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or post-graft.

SOURCE: RTI Analysis of 100% 2017-2018 Medicare Enrollment Data, 2018 Prescription Drug Event (PDE) Data, 2017 Professional Claims (Carrier), 2017 Inpatient Claims, 2017 Outpatient Claims, and 2017 Medicare Advantage Encounter Data.

Table VIII-5. List of Disease Hierarchies for RxHCC Model (2017/2018)

Rx Hierarchical Condition Category (RxHCC)	If the Disease Group is listed in this column…	…Then drop the RxHCC(s) listed in this column
	Rx Hierarchical Condition Category (RxHCC) LABEL	
15	Chronic Myeloid Leukemia	16, 17, 18, 19, 96, 98
16	Multiple Myeloma and Other Neoplastic Disorders	17, 18, 19, 96, 98
17	Secondary Cancers of Bone, Lung, Brain, and Other Specified Sites; Liver Cancer	18, 19
18	Lung, Kidney, and Other Cancers	19
30	Diabetes with Complications	31
54	Chronic Viral Hepatitis C	55
65	Chronic Pancreatitis	66
82	Psoriatic Arthropathy and Systemic Sclerosis	83, 84, 316
83	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	84
95	Sickle Cell Anemia	98
96	Myelodysplastic Syndromes and Myelofibrosis	98
111	Alzheimer's Disease	112
130	Schizophrenia	131, 132, 133, 134, 135, 145, 146, 147, 148
131	Bipolar Disorders	132, 133, 134, 135
132	Major Depression	133, 134, 135
133	Specified Anxiety, Personality, and Behavior Disorders	134, 135
134	Depression	135
145	Autism	133, 134, 135, 146, 147, 148
146	Profound or Severe Intellectual Disability/Developmental Disorder	147, 148
147	Moderate Intellectual Disability/Developmental Disorder	148
163	Intractable Epilepsy	164, 165
164	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy	165
185	Primary Pulmonary Hypertension	186, 187
186	Congestive Heart Failure	187
225	Cystic Fibrosis	226, 227
226	Chronic Obstructive Pulmonary Disease and Asthma	227
260	Kidney Transplant Status	261, 262, 263, 397
261	Dialysis Status	262, 263
262	Chronic Kidney Disease Stage 5	263
395	Lung Transplant Status	396, 397
396	Major Organ Transplant Status, Except Lung, Kidney, and Pancreas	397

How Payments are Made with a Disease Hierarchy

EXAMPLE: If a beneficiary triggers Disease Groups (DG) 163 (Intractable Epilepsy) and 164 (Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy), then DG 164 will be dropped. In other words, payment will always be associated with the DG in column 1 if a DG in column 3 also occurs during the same collection period. Therefore, the organization's payment will be based on DG 163 rather than DG 164.

SOURCE: RTI International.