October 30, 2020

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

SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2022 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies – Part II

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

On September 14, 2020, we released for comment proposed changes pursuant to section 17006(f) of the 21st Century Cures Act to the Part C risk adjustment model used to pay for aged and disabled beneficiaries with a comment deadline of November 13, 2020. We are extending this deadline and are continuing to solicit comment on those proposed changes until Monday, November 30, 2020. In accordance with section 1853(b)(2) of the Social Security Act (the Act), we are now notifying you of additional planned changes in the Medicare Advantage (MA) capitation rate methodology and risk adjustment methodology applied under Part C of the Medicare statute for CY 2022. Also included with this notice is a discussion of the annual adjustments for CY 2022 to the Medicare Part D benefit parameters for the defined standard benefit. CMS will announce the MA capitation rates and final payment policies for CY 2022 no later than Monday, April 5, 2021, in accordance with section 1853(b) of the Act, as established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) and amended by the Securing Fairness in Regulatory Timing Act of 2015 (Pub. L. 114-106). The Advance Notice of Methodological Changes is published no fewer than 60 days before the publication of the Rate Announcement and provides a minimum 30-day period for public comment.

Attachment I of this document shows the preliminary estimates of the national per capita MA growth percentage and the national Medicare fee-for-service growth percentage, which are key factors in determining the MA capitation rates. Attachment II sets forth changes in the Part C payment methodology for CY 2022. Attachment III presents the annual adjustments to the Medicare Part D benefit parameters for the defined standard benefit, and sets forth the changes in the Part D payment methodology for CY 2022. Attachment IV contains updates for the MA and Part D Star Ratings and solicits input on potential measure topics and measures for future rating years. Attachment V contains economic information for significant provisions in Advance Notice Part II.

To submit comments or questions electronically, go to https://www.regulations.gov, enter the docket number "CMS-2020-0093" in the "Search" field, and follow the instructions for "submitting a comment."

Comments will be made public, so submitters should not include any confidential or personal information. In order to receive consideration prior to the release of the final Announcement of CY 2022 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Rate Announcement), comments on Advance Notice Part I and Part II must be received by 6:00 PM Eastern Time on Monday, November 30, 2020.

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

I, Jennifer Wuggazer Lazio, am a Member of the American Academy of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained in this Advance Notice. My opinion is limited to the following sections of this Advance Notice: The growth percentages and United States per capita cost estimates provided in Attachment I; the qualifying county determination, calculations of Fee for Service cost, kidney acquisition cost carve-out, IME phase out, MA benchmarks, EGWP rates, and ESRD rates discussed in Attachment II; Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2022 described in Attachment III.

/ s /
Jennifer Wuggazer Lazio, F.S.A., M.A.A.A.
Director
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Attachments

2022 ADVANCE NOTICE – PART II
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Introduction: Notice of a Potential Change in the Schedule for Publication of the Rate Announcement for CY 2022

We are issuing Part II of the 2022 Advance Notice on October 30, 2020, earlier than in past practice, in order to accommodate a potential early publication of the CY 2022 Rate Announcement. We released Part I of the Advance Notice on September 14, 2020. We are considering publishing the Rate Announcement a few months earlier than section 1853(b)(1)(B) of the Social Security Act (the Act) requires.

Section 1853(b)(1)(B) of 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 provide the Advance Notice to MA organizations of proposed methodological changes from the methodology and assumptions used in the previous announcement. We provide such organizations 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 considering 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 Advance Notice in September and are publishing Part II now, in October. We believe 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 would give MA organizations and Part D sponsors more time to prepare their bids, which must be submitted by the first Monday in June. We believe 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.

It is important to note that we may yet elect to follow the typical April timeframe for publishing the CY 2022 Rate Announcement. Alternatively, we may elect to publish most or all of the methodologies on the early timeframe in a Part I of the Rate Announcement and publish most or all of the rates and other updates in a Part II of the Rate Announcement on the typical April timeframe. Publishing the rates after finalizing the methodology and assumptions would allow

CMS to tabulate the rates by applying calculations and methodologies that rely on additional, more recent data. This decision will depend on the progress we make with regard to our internal rate development efforts and stakeholder feedback. We have included descriptions in this document of the traditional assumptions, calculations, and methodologies used in MA rate development, which rely on additional, more recent data that would be finalized in either of these events.

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

Each year in the Advance Notice, CMS updates its historical estimates of per capita Medicare costs based on recent data, and provides an estimate for an additional projection year. Specifically, CMS provides estimates of three separate United States Per Capita Costs (USPCCs) for each calendar year:

- Total USPCC: the USPCC for Medicare Part C and Medicare Fee-for-Service (FFS) beneficiaries except those beneficiaries who are in End Stage Renal Disease (ESRD) status for payment purposes, i.e., those beneficiaries who are in dialysis, transplant, or post-graft status.
- FFS USPCC: the USPCC for FFS aged/disabled beneficiaries except those beneficiaries with ESRD
- FFS Dialysis ESRD USPCC: the USPCC for beneficiaries in FFS with ESRD who are in dialysis status (i.e., "Dialysis ESRD")[1]

Based on these estimates, CMS calculates the change, or growth, in each of the USPCCs for the upcoming year. In this Notice, we provide growth percentages from 2021 to 2022. These growth percentages represent the year-over-year changes to the factors used to calculate the MA payment rates, or benchmarks, as discussed below. Throughout this document, we use the terms "benchmark" and "county rate" interchangeably, and the term "service area benchmark" indicates the bidding benchmark for an MA plan based on its specific service area.

The MA county rates are based on the specified amount as described in Attachment II Section A2 below. Section 1853(n)(2)(A) of the Social Security Act ("the Act") defines the specified amount as the base amount multiplied by the applicable percentage for the area (set under section 1853(n)(2)(B) through (D)). Section 1853(n)(4) requires that the benchmark for an area for a year (including increases for quality bonus percentages) be capped at the level of the applicable amount, as defined at section 1853(k)(1) and described in Attachment II Section A1.

The PACE county rates are established using the applicable amount as determined under section 1853(k)(1). This amount is calculated without excluding indirect medical education (IME) amounts under section 1853(k)(4), (as required by section 1894(d)(3)), or organ acquisition costs for kidney transplants, as discussed in Attachment II Section C of this document.

Section A. 2022 Growth Percentage Estimates

[1] Dialysis ESRD USPCCs are trended from a base year using the trend in total ESRD net of an adjustment factor for dialysis-only.

The MA growth percentage reflects the growth in per capita costs for non-ESRD beneficiaries enrolled in either FFS or MA, excluding expenditures attributable to sections 1848(a)(7), 1848(o), 1886(b)(3)(B)(ix), and 1886(n) of the Act,[2] based upon estimates of the Total USPCC. The MA growth percentage is also referred to as the total growth percentage and the National Per Capita MA Growth Percentage. The MA growth percentage is used in calculating the applicable amount for a county, as required under section 1853(k)(1).

The non-ESRD FFS growth percentage reflects the growth in per capita costs based upon estimates of the FFS USPCC. As required by section 1853(n)(2)(E)(ii)(II) of the Act, the FFS USPCC calculated under section 1853(c)(1)(D) is used to calculate the specified amount in years in which CMS elects to rebase the adjusted average FFS per capita cost. CMS intends to rebase as part of the calculation of the rates for 2022.

The ESRD growth percentage reflects the growth in per capita costs based on the ESRD FFS USPCC. ESRD state rates are determined by applying an historical average geographic adjustment to a projected FFS dialysis-only ESRD USPCC.

Table I-1 below provides the current estimate of the change in the three USPCC estimates. The percentage change in each USPCC is shown as the current projected USPCC for 2022 divided by the prior projected USPCC for 2021.

Table I-1. Increase in the USPCC Growth Percentage for CY 2022

	Total USPCC – Non-ESRD	FFS USPCC – Non-ESRD	FFS Dialysis-only ESRD USPCC
Current projected 2022 USPCC	$1,071.23	$1,019.09	$8,254.07
Prior projected 2021 USPCC	$1,021.93	$975.06	$8,110.21
Percent increase	4.82%	4.52%	1.77%

The current estimate of the MA growth percentage[1] (or change in the Total USPCC non-ESRD) for aged and disabled enrollees combined in CY 2022 is 4.82 percent. This estimate reflects an underlying trend change for CY 2022 in per capita cost of 3.473 percent and, as required under

[2] Sections 1848(o) and 1886(n) provide for incentive payments under the Medicare FFS program for eligible physicians and hospitals, respectively, for meaningful use of certified EHR technology (CEHRT). 2016 was the final year that eligible physicians and hospitals outside of Puerto Rico could earn incentive payments under these provisions; eligible hospitals in Puerto Rico can earn incentive payments for meaningful use of CEHRT until 2022. Sections 1848(a)(7) and 1886(b)(3)(B)(ix) require a reduction in Medicare FFS payments for eligible physicians and hospitals that are not meaningful users of certified EHR technology, starting in 2015 for eligible physicians and hospitals outside of Puerto Rico and in 2022 for eligible hospitals in Puerto Rico. 2018 was the final year that eligible physicians who were not meaningful users of CEHRT could be subject to negative payment adjustments under section 1848(a)(7).

section 1853(c)(6)(C) of the Act, adjustments to the estimates for prior years as indicated in the table below.

Table I-2 below provides additional detail on the estimates for the change in the Total USPCC or national per capita MA growth percentage for aged/disabled beneficiaries.

Table I-2. Increase in the MA Growth Percentage for 2022

	Prior Increases	Current Increases			MA Growth Percentage for 2022 With §1853(c)(6)(C) adjustment[2]
	2003 to 2021	2003 to 2021	2021 to 2022	2003 to 2022	
Aged+Disabled	87.910%	90.363%	3.473%	96.975%	4.82%

[1] The MA growth percentage is also known as the National Per Capita MA Growth Percentage and is equal to change in the Total USPCC.

[2] (1 + current increases for 2003 to 2022) divided by (1 + prior increases for 2003-2021) minus 1.

Section B. USPCC Estimates

Table I-3 compares last year's estimate of the total non-ESRD USPCC with current estimates for 2003 to 2024; Table I-4 compares last year's FFS non-ESRD USPCC estimates with current estimates; and Table I-5 compares last year's dialysis-only ESRD USPCC estimates with current estimates. In addition, these tables show the current projections of the USPCCs through 2024. Caution should be employed in the use of this information. It is based upon nationwide averages, and local conditions can differ substantially from conditions nationwide. None of the data presented here pertain to the Medicare prescription drug benefit.

The tabulation of FFS costs supporting the USPCCs includes payments made outside the Medicare FFS claim systems, such as provider settlements via cost reports, Innovation Center model payments, Medicare Shared Savings Program shared savings settlements, and other adjustments. Also included in the USPCCs are the cost impacts of program changes enacted through known legislation, regulation, and national coverage determinations (NCDs) applicable for the contract year (2022). Attachment II Section B contains additional information regarding the calculation of FFS costs.

Our estimates for the USPCCs for 2020 and subsequent years reflect the projected cost impacts related to the COVID-19 pandemic, including estimates for applicable costs related to any COVID-19 vaccine, and changes in utilization of health care services. These USPCCs also reflect estimated cost impacts of changes in MA coverage created by recent legislation. Section 6003 of the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127), which amended section 1852(a)(1)(B) of the Act, prohibits MA organizations from requiring cost-

sharing in excess of Medicare FFS cost-sharing for testing for COVID-19 and specified testing-related services during the public health emergency. This, in effect, eliminates MA cost-sharing for COVID-19 testing because there is no cost-sharing under Medicare FFS for the testing and there is no cost sharing for the specified testing-related services during the same period. Section 6003 also prohibits MA plans from applying prior authorization or any other utilization management requirement with respect to COVID-19 clinical diagnostic laboratory tests and specified COVID-19 testing-related services. In addition, Section 3713 of the CARES Act, which amended section 1852(a)(1)(B) of the Act, prohibits MA organizations from requiring cost-sharing in excess of Medicare FFS cost-sharing (which is zero) for a COVID-19 vaccine and its administration described in section 1861(s)(10)(A) of the Act; this limitation on cost sharing is not limited to the public health emergency and, therefore, will apply in 2022 regardless whether the public health emergency declaration is still in place.

Note: The USPCCs and growth rates in this document reflect the experience, data, and projections available as of this Advance Notice release and will be updated to reflect the experience, data, and projections available as of the Rate Announcement. With an early release of the CY 2022 Rate Announcement, the experience, data, and projections will be based on claims data through the third quarter of 2020, rather than through the fourth quarter of 2020 if the CY 2022 Rate Announcement were published under the later timeline. The difference in data sources may impact year-to-year differences in estimates of projected USPCCs.

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

	Part A		Part B		Part A + Part B		
Calendar Year	Current Estimate	Last Year's Estimate	Current Estimate	Last Year's Estimate	Current Estimate	Last Year's Estimate	Ratio
2003	$296.18	$296.18	$247.66	$247.66	$543.84	$543.84	1.000
2004	314.08	314.08	271.06	271.06	585.14	585.14	1.000
2005	334.83	334.83	292.86	292.86	627.69	627.69	1.000
2006	345.30	345.30	313.70	313.70	659.00	659.00	1.000
2007	355.44	355.44	330.68	330.68	686.12	686.12	1.000
2008	371.90	371.90	351.04	351.04	722.94	722.94	1.000
2009	383.91	383.91	367.35	367.30	751.26	751.21	1.000
2010	383.94	383.94	376.12	376.12	760.06	760.06	1.000
2011	387.73	387.73	385.19	385.19	772.92	772.92	1.000
2012	377.40	377.40	391.82	391.84	769.22	769.24	1.000
2013	380.06	380.06	398.60	398.63	778.66	778.69	1.000
2014	370.41	370.41	418.18	418.19	788.59	788.60	1.000
2015	373.91	373.92	434.75	434.76	808.66	808.68	1.000
2016	378.00	378.01	443.87	443.91	821.87	821.92	1.000
2017	383.41	383.38	458.81	458.83	842.22	842.21	1.000
2018	387.32	387.29	488.13	488.29	875.45	875.58	1.000
2019	406.07	398.66	522.46	521.72	928.53	920.38	1.009
2020	394.85	419.53	522.12	558.89	916.97	978.42	0.937
2021	430.25	433.78	605.02	588.15	1,035.27	1,021.93	1.013
2022	449.42	449.17	621.81	616.15	1,071.23	1,065.32	1.006
2023	465.98	466.70	657.93	651.30	1,123.91	1,118.00	1.005
2024	481.77		694.48		1,176.25		

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

	Part A		Part B		Part A + Part B		
Calendar Year	Current Estimate	Last Year's Estimate	Current Estimate	Last Year's Estimate	Current Estimate	Last Year's Estimate	Ratio
2010	$371.20	$371.20	$373.99	$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	364.25	364.25	408.58	408.58	772.83	772.83	1.000
2015	369.16	369.16	427.33	427.33	796.49	796.49	1.000
2016	372.04	372.04	432.85	432.90	804.89	804.94	1.000
2017	374.26	374.27	447.52	447.62	821.78	821.89	1.000
2018	376.62	376.60	471.71	472.01	848.33	848.61	1.000
2019	391.92	385.10	500.98	501.41	892.90	886.51	1.007
2020	355.09	400.59	464.55	531.75	819.64	932.34	0.879
2021	405.66	415.36	591.24	559.70	996.90	975.06	1.022
2022	427.54	429.79	591.55	586.05	1,019.09	1,015.84	1.003
2023	443.24	446.16	625.58	618.89	1,068.82	1,065.05	1.004
2024	457.57		659.17		1,116.74		

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

	Part A		Part B		Part A + Part B		
Calendar Year	Current Estimate	Last Year's Estimate	Current Estimate	Last Year's Estimate	Current Estimate	Last Year's Estimate	Ratio
2010	$2,952.75	$2,952.75	$3,881.39	$3,881.39	$6,834.14	$6,834.14	1.000
2011	2,862.38	2,862.38	3,908.01	3,908.01	6,770.39	6,770.39	1.000
2012	2,774.49	2,774.49	3,944.59	3,944.59	6,719.08	6,719.08	1.000
2013	2,794.19	2,794.19	4,088.66	4,088.66	6,882.85	6,882.85	1.000
2014	2,784.52	2,784.52	4,115.70	4,115.70	6,900.22	6,900.22	1.000
2015	2,775.84	2,775.84	4,060.87	4,060.87	6,836.71	6,836.71	1.000
2016	2,895.91	2,895.91	4,081.27	4,081.27	6,977.18	6,977.18	1.000
2017	2,883.27	2,883.27	4,102.66	4,102.66	6,985.93	6,985.93	1.000
2018	2,952.21	2,952.21	4,526.09	4,526.09	7,478.30	7,478.30	1.000
2019	3,045.39	3,034.25	4,618.29	4,661.83	7,663.68	7,696.08	0.996
2020	2,749.48	3,163.25	4,520.33	4,747.62	7,269.81	7,910.87	0.919
2021	3,109.70	3,232.31	4,991.44	4,877.90	8,101.14	8,110.21	0.999
2022	3,279.84	3,317.94	4,974.23	4,999.52	8,254.07	8,317.46	0.992
2023	3,390.21	3,431.07	5,144.02	5,168.08	8,534.23	8,599.15	0.992
2024	3,498.16		5,319.87		8,818.03		

These estimates are preliminary and could change when the final rates are announced in the Announcement of CY 2022 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies. Further details on the derivation of the national per capita MA growth percentage and the FFS growth percentage will also be presented in the Rate Announcement.

Attachment II. Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2022

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

Section 1853(n)(2) of the Act requires that, in determining the specified amount, CMS use as the base amount the amount described in section 1853(c)(1)(D) for a rebasing year or, for years that are not a rebasing year, the base amount from the previous year increased by the national per capita MA growth percentage. Section 1853(c)(1)(D)(ii) requires CMS to rebase the county FFS rates, which form the basis of the specified amount described in Section A2 below, periodically but not less than once every three years. When the rates are rebased, CMS updates its estimate of each county's FFS costs using more current FFS claims information. CMS intends to rebase the county FFS rates for 2022 using FFS claims data from 2015 through 2019. (Please note that throughout this document, the terms "benchmark" and "county rate" are used interchangeably, and the term "service area benchmark" indicates the bidding target for an MA plan based on its specific service area.) Section 1853(n)(4) requires that the benchmark for an area for a year (including increases for quality bonus percentages) be capped at the level of the applicable amount, as defined at section 1853(k)(1).

Rates for the Programs of All-Inclusive Care for the Elderly (PACE) plans are not developed using the specified amount, per section 1853(n)(5) of the Act, but are developed using the applicable amount, as defined at section 1853(k)(1), as discussed below.

A1. Applicable Amount

The applicable amount is the rate established under section 1853(k)(1) of the Act. As CMS intends to rebase the rates in 2022, the applicable amount for 2022 is the greater of: (1) the county's 2022 FFS cost or (2) the 2021 applicable amount increased by the CY 2022 National Per Capita Medicare Advantage Growth Percentage. As discussed in Section A5, section 1853(n)(4) of the Act requires that the benchmark (determined taking into account the quality bonus percentage increase) for each county must be capped at the county's applicable amount.

A2. Specified Amount

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

(2022 FFS cost[3] minus (IME phase-out amount and kidney acquisition costs)) × (applicable percentage + applicable percentage quality increase)

Where:

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

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

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

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

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

Section 1853(n)(2)(B) and (C) of the Act requires CMS to determine applicable percentages for a year based on county FFS rate rankings for the most recent year that was a rebasing year. To determine the CY 2022 applicable percentages for counties in the 50 States and the District of Columbia, CMS will rank counties from highest to lowest based upon their 2021 average per capita FFS rate adjusted to exclude the IME phase out and, beginning for 2021, payments for kidney acquisition. The 2021 rates are used because 2021 is the most recent rebasing year prior to 2022. CMS will then place the rates into four quartiles. For the territories, CMS will assign an applicable percentage to each territory county based on where the territory county rate falls in the quartiles established for the 50 States and the District of Columbia.

CMS is publishing the 2022 applicable percentages by county with the Advance Notice at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html. Each county's applicable percentage is assigned based upon its quartile ranking, as follows:

Table II-1. FFS Quartile Assignment

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

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

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

A3. Quality Bonus Payment Percentage

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

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

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

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

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

New MA Plans

New MA plans are treated as qualifying plans that are eligible to receive a QBP percentage increase to the county rates, except that the QBP percentage will be 3.5 percentage points, per section 1853(o)(3)(A)(iii)(I)(cc) of the Act and § 422.258(d)(7)(v)(C).[4] That is, new MA plans will bid against a service area benchmark that reflects a 3.5 percentage point increase to the applicable percentage used to set the benchmark for each county in the plan's service area. Per section 1853(o)(3)(A)(iii)(II) of the Act and § 422.252, for the purpose of determining a QBP percentage, the term "new MA plan" refers to an MA plan offered by a parent organization that has not had another MA contract in the preceding three-year period.

In 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) (referred to hereinafter as the "COVID-19 first interim final rule"), we modified the definition of "new MA plan" in the regulations at § 422.252 for the 2022 QBPs only. As amended, § 422.252 provides that for purposes of 2022 QBPs based on 2021 Star Ratings 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. This change affects new contracts that started in 2019. (A new contract with an effective date of January 1, 2019 would normally be treated as new for purposes of QBPs for 2019, 2020, and 2021 only; such a contract will now be treated as new for 2022 as well, per § 422.252 as amended by the COVID-19 first interim final rule.)

CMS intends to continue the policy finalized in the 2012 Rate Announcement (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2012.pdf) that for a parent organization that has had a contract with CMS in the preceding three-year-period (or four-year period for 2022 QBP ratings), any new MA contract under that parent organization will receive an enrollment-weighted average of the Star Ratings earned by the parent organization's existing MA contracts. This policy was also addressed in a rulemaking for CY 2012 (75 FR 21485-89). Such plans under the new MA contract may qualify for a QBP increase based on the enrollment-weighted average rating of the parent organization.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10) contained provisions to permit reasonable cost reimbursement contracts to transition into MA plans through CY 2019, and allowed MA organizations to deem the enrollment of their cost enrollees into successor affiliated MA plans that meet specific conditions. MACRA amended section 1853(o)(4) of the Act such that, for its first three years as a converted MA plan receiving deemed enrollment, the converted plan shall not be treated as a new MA plan.

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

Low Enrollment Plans

Section 1853(o)(3)(A)(ii)(II) of the Act, as implemented at § 422.258(d)(7)(iv)(B), provides that for 2013 and subsequent years, CMS shall develop a method for determining whether an MA plan with low enrollment is a qualifying plan for purposes of receiving an increase in payment under section 1853(o). We apply this determination at the contract level, and thus determine whether a contract (meaning all plans under that contract) is a qualifying contract. Pursuant to § 422.252, a low enrollment contract is one that could not undertake Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcome Survey (HOS) data collections because of a lack of a sufficient number of enrollees (that is, fewer than 500 enrollees) to reliably measure the performance of the health plan.

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

Contract Consolidations and QBP

Section 1853(o)(4) of the Act was amended by the Bipartisan Budget Act of 2018 to add subsection (D) regarding the determination of star ratings for consolidating MA plans, and the regulations at §§ 422.162(b)(3) and 423.182(b)(3) implement section 1853(o)(4)(D) for contract consolidations approved on or after January 1, 2019. When two or more contracts for health and/or drug services of the same plan type under the same legal entity are combined into a single contract at the start of a contract year, the rating used to determine QBP status ("QBP rating") for the first year following the consolidation will be the enrollment weighted average of what would have been the QBP ratings of the surviving and consumed contracts, using the contract enrollment in November of the year the Star Ratings were released.

A4. Qualifying County Bonus Payment

Beginning with contract year 2012, pursuant to section 1853(o)(2) of the Act and § 422.258(d)(7)(ii), the QBP percentage is doubled for a qualifying plan located in a "qualifying county." A qualifying county is a county that meets the following three criteria:

(1) has an MA capitation rate that, in 2004, was based on the amount specified in section 1853(c)(1)(B) for a Metropolitan Statistical Area with a population of more than 250,000;

(2) as of December 2009, had at least 25 percent of MA-eligible beneficiaries residing in the county enrolled in a MA plan; and

(3) has per capita FFS County spending for the year (2022) that is less than the national monthly per capita cost for FFS for the year (2022).

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

Example: As described in Section A3, a plan with a rating of 4.5 stars will have 5 QBP percentage points added to the applicable percentage of each county in its service area. For each county that meets the three criteria stated above in that plan's service area, that percentage will be doubled so that an additional 5 percentage points will be added to that county's applicable percentage for a total increase of 10 percentage points. If this qualifying county otherwise has an applicable percentage of 95 percent, this is increased to 105 percent to reflect the quality bonus payment percentage for that county. As discussed in section A5 below, all benchmarks are capped at the section 1853(k)(1) applicable amount (determined after application of the QBP percentage) per section 1853(n)(4) of the Act.

CMS will publish a complete list of qualifying counties with the final 2022 Rate Announcement. The listing will contain all counties that meet all three criteria stated above. Two of the three elements for determining a qualifying county (2004 urban floors (Y/N) for each county, and 2009 Medicare Advantage penetration rates) can be found in the 2021 Rate Calculation Data file (columns AA and AC) on the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html. The 2022 FFS rates, which are necessary for the third criterion, are not available at the time this Advance Notice is published. The FFS rates and the national average FFS spending amount will be published in the final 2022 Rate Announcement.

A5. Cap on Benchmarks

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

While we appreciate the concerns stakeholders have raised in connection with the cap on benchmarks, CMS believes that section 1853(n)(4) of the Act prevents elimination of the rate cap or excluding the bonus payment from the cap calculation.

A6. Rebate

Under section 1854(b)(1)(C)(v) of the Act, except for MSA plans, the level of rebate for each plan is based on the plan's Star Rating. Rebates for each plan are calculated as a percentage of the amount by which the risk-adjusted service area benchmark exceeds the risk-adjusted bid.

Under § 422.266(b), plans may use rebates to pay for mandatory supplemental benefits and/or to buy down beneficiary premiums for Part B and/or Part D prescription drug coverage. Pursuant to section 1854(b)(1)(C)(v), which is implemented in § 422.266(a)(2)(ii), the rebate percentages apply based on a plan's Star Rating, as shown in Table II-3.

Table II-3. MA Rebate Percentages

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

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

As mentioned above, MACRA amended section 1853(o)(4) of the Act such that, for the first three years that a former reasonable cost reimbursement contract is a converted MA plan receiving deemed enrollment, the converted plan shall not be treated as a new MA plan. Section 1854(b)(1)(C)(vi) incorporates the definition of new MA plan from section 1853(o) in establishing the rebate percentage for new MA plans, so the MACRA provision applies for purposes of the rebate percentage as well as the QBP.

Section B. Calculation of Fee for Service Cost

B1. Introduction

The FFS per capita cost for each county is the product of (1) the national FFS per capita cost, or United States per-capita cost (USPCC), and (2) a county-level geographic index called the average geographic adjustment (AGA). Each year, CMS strives to improve the development of the AGAs and estimated FFS per capita costs with refinements to how these figures are calculated.

We will continue to incorporate refinements developed and used in prior years to update the claims data used to calculate the AGAs and to continue the repricing of historical data in the

AGA calculation to reflect changes in FFS payment rules. CMS will reprice historical hospital inpatient, hospital outpatient, skilled nursing facility, and home health claims to reflect the most currently available wage indices, and re-tabulate physician claims with the most currently available Geographic Practice Cost Index. We will also reprice historical claims to account for legislative and regulatory changes made to payments to disproportionate share hospitals and reprice durable medical equipment claims to account for the changes in prices associated with the competitive bidding program. Repricing historical claims used for the AGAs, in conjunction with rebasing rates, ensures that the FFS rates for each county reflect the most current FFS fee schedules and payment rules.

Note: With the exception of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) due to the expected timing of related rulemaking, we will base the repricing adjustments on the most current final FFS payment rules available as of the CY 2022 Rate Announcement release. The proposed repricing approach for DMEPOS is described in Section B2. Given the timing of the FFS payment rules and the availability of data, the rates will reflect repricing associated with all of the FFS payment rules that are finalized by December 4, 2020 for an early publication of the CY 2022 Rate Announcement, and by February 5, 2021 for publication of the CY 2022 Rate Announcement on or just before the statutory deadline. If the final CY 2021 or FY 2021 payment rules for a specific type of service are not finalized by December 4, 2020 (for an early publication) or February 5, 2021 (for publication on or just before the statutory deadline), then the 2022 ratebook repricing will be based on the final CY 2020 or FY 2020 payment rules for that type of service.

We will continue a refinement to the methodology used in the ratebook development to include Health Professional Shortage Areas (HPSAs) bonus payments. Specifically, we propose to tabulate the HPSA bonuses by county of residence for years 2015–2019 and add these values to our ratebook FFS expenditures. The HPSA bonuses are disbursed quarterly to providers and are not reflected in the standard claim files.

With this Advance Notice, we are releasing the 2019 FFS cost data by county used in the development of the 2022 ratebook. This data is available on the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data.html. These data will not reflect adjustments for Innovation Center Models and Demonstration Programs and the Medicare Shared Savings Program, and will not reflect adjustments for claim repricing for the most current available Medicare FFS payment rules and parameters.

B2. AGA Methodology

In the first step of the AGA methodology, CMS will add the 2019 cost and enrollment data to, and drop the 2014 cost and enrollment data from, the historical claims experience used to develop new geographic cost indices for each county. As a result, the five-year rolling average will be based on non-hospice Medicare FFS claims data from 2015–2019. CMS will then

perform a series of adjustments to the Medicare FFS data to estimate FFS rates per county, explained below as successive steps.

For Puerto Rico, CMS will continue to include five years (2015–2019) of historical claims and enrollment only for beneficiaries with Part A and Part B enrollment at the time of the dates of service for the FFS claim. While most Medicare beneficiaries are automatically enrolled in Part B and must opt out to decline it, beneficiaries in Puerto Rico must take affirmative action to opt-in to Part B coverage. CMS continues to believe it is appropriate to adjust the FFS rate calculation in Puerto Rico used to determine MA rates so that it is based on beneficiaries who are enrolled in both Part A and Part B in order to produce a more accurate projection of FFS costs per capita in Puerto Rico.

In the second step, CMS will reprice the historical inpatient, hospital outpatient, skilled nursing facility, and home health claims from 2015–2019 to reflect the most current (i.e., FY 2021) wage indices, and re-tabulate physician claims with the most current Geographic Practice Cost Indices.[5] We will continue to adjust the uncompensated care payments (UCP) represented in the 2015–2019 claims to reflect the requirements of the most recent final rule (here, the FY 2021 Inpatient Prospective Payment System (IPPS) final rule). Repricing for Puerto Rico inpatient claims will continue to reflect the Consolidated Appropriations Act, 2016 (Pub. L. 114-113, Division O, section 601), which amended section 1886(d)(9)(E) of the Act.

We propose to reprice DMEPOS claims by adjusting claims from 2015–2019 to reflect the single payment amounts established under the DMEPOS Competitive Bidding Program (CBP), as well as the fee schedule amounts for DMEPOS items and services furnished outside of the CBP, based on the final regulations CMS-1691-F and CMS-1713-F as amended by the interim final rule CMS-5531-IFC. Section 1847(b)(5) of the Act requires that "single payment amounts" replace the Medicare DMEPOS fee schedule amounts for certain DMEPOS items and services furnished in competitive bidding areas (CBAs). A temporary lapse in the CBP began on January 1, 2019. During the lapse in the CBP, for items and services that were previously included in the CBP, including mail order items and supplies, furnished in former CBAs, the single payment amounts established under the CBP are updated by the change in the CPI-U once every 12-month period beginning on the date after the contract periods ended (January 1, 2019). Diabetic supplies were included in the National Mail Order (NMO) program, which also lapsed as of January 1, 2019. Even so, in accordance with section 1834(a)(1)(H) of the Act, as amended by the American Taxpayer Relief Act of 2012 (Pub. L. 112-240), the fee schedule amounts for non-mail-order diabetic supplies, including testing strips, are equal to the single payment amounts

[5] Repricing for Geographic Practice Cost Index will reflect section 2201 of Pub. L. 116-159, the "Continuing Appropriations Act, 2021 and Other Extensions Act" (sic) which amended section 1848(e)(1)(E) of the Act such that, for services furnished on or after December 12, 2020, the floor on the work geographic index will no longer apply to increase the value to 1.00 for any locality for which such work geographic index is less than 1.00.

established under the NMO competition for diabetic supplies. We will continue to use the single payment amounts for mail-order diabetic supplies established under the NMO program, without update, to reprice the historical payments for DMEPOS claims.

Section 1834(a)(1)(F) of the Act requires CMS to adjust the fee schedule amounts for DMEPOS items furnished on or after January 1, 2016 in non-CBAs based on information from the CBP. However, the current fee schedule adjustment methodology for items and services furnished in non-CBAs is due to expire on December 31, 2020. *See* 42 CFR 414.210(g)(9). The interim final rule CMS-5531-IFC temporarily continues the fee schedule adjustment methodology for rural and non-contiguous non-CBAs, and changes the fee schedule adjustment methodology for non-rural contiguous non-CBAs. For DMEPOS items and services furnished in rural and non-contiguous non-CBAs, the fee schedule amounts are based on a 50/50 blend of adjusted and unadjusted fee schedule amounts, beginning on March 6, 2020 through the remainder of the duration of the public health emergency period described in section 1135(g)(1)(B) of the Act (42 U.S.C. 1320b-5(g)(1)(B)). *See* 42 CFR 414.210(g)(9)(iii). For items and services furnished in non-rural contiguous non-CBAs, the fee schedule amounts are based on a 75/25 blend of adjusted and unadjusted fee schedule amounts, beginning on March 6, 2020 through the remainder of the duration of the public health emergency period described in section 1135(g)(1)(B) of the Act (42 U.S.C. 1320b-5(g)(1)(B)). *See* 42 CFR 414.210(g)(9)(iii). The public health emergency period described in section 1135(g)(1)(B) of the Act (42 U.S.C. 1320b-5(g)(1)(B)) was recently extended until January 20, 2021.

Note: See the Note on page 21 regarding the impact to repricing adjustments under an early release of the CY 2022 Rate Announcement and under a later release date of the CY 2022 Rate Announcement.

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

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

As in prior years, (1) CMS will make additional adjustments to the FFS costs described below, and (2) the average of each county's five year geographic indices, based on the adjusted claims

data, will be divided by the county's average five-year risk score from the risk adjustment model used for contract year (2022) payment in order to develop the AGA for that county.

B3. Adjustments for Medicare Shared Savings Program and Innovation Center Models and Demonstration Programs

As indicated in Table B3-1, we will continue to adjust historical FFS experience to incorporate shared savings and losses or episode savings and losses experienced under the Medicare Shared Savings Program and Innovation Center models and demonstration programs. We will update the experience years used for this adjustment as noted on Table B3-1. All adjustments of this type apply to the non-ESRD ratebook except the model(s) noted as ESRD in Table B3-1.

Note: The table below identifies the experience years that will be reflected in the ratebook adjustments, under both an early release of the CY 2022 Rate Announcement and under the later release date of the CY 2022 Rate Announcement. With an early release of the CY 2022 Rate Announcement, we will rely on episode savings and losses data for the Comprehensive Care for Joint Replacement model and the Oncology Care model available by the time of the release. This will include at least data from 2018.

Table B3-1. The Medicare Shared Savings Program and Innovation Center Models and Demonstration Programs with Ratebook Adjustments

Program/Models and Demonstration Programs	**Experience Years**			**Payment Type**
	2021 Ratebook	**2022 Ratebook *under an Early Release of Rate Announcement***	**2022 Ratebook *under Later Release Date of Rate Announcement***	
Medicare Shared Savings Program	2014–2018	2015–2019	2015–2019	Shared savings / losses
Pioneer ACO	2014–2016	2015–2016	2015–2016	Shared savings / losses
Comprehensive Care for Joint Replacement (CJR)	2016–2018	2016–2018	2016–2019*	Episode savings / losses
Next Generation ACO (NGACO)[(1)]	2016–2018	2016–2019	2016–2019	Shared savings / losses
Oncology Care Model (OCM)	7/1/2016–2018	7/1/2016–2018	7/1/2016–2019*	Episode savings / losses
Comprehensive Primary Care (CPC)	2014–2016	2015–2016	2015–2016	Shared savings / losses
Bundled Payment for Care Improvement (BPCI)	2014–2018	2015–2018	2015–2018	Episode savings / losses

Program/Models and Demonstration Programs	Experience Years			Payment Type
	2021 Ratebook	2022 Ratebook *under an Early Release of Rate Announcement*	2022 Ratebook *under Later Release Date of Rate Announcement*	
Bundled Payment for Care Improvement Advanced (BPCI Advanced)	N/A	10/1/2018–2019	10/1/2018–2019	Episode savings / losses
Medicare-Medicaid Financial Alignment Initiative Managed FFS Model	2014–2017	2015–2018	2015–2018	Shared savings
Vermont Medicare ACO Initiative (2)	2018	2018–2019	2018–2019	Shared Savings / losses
Pioneer ACO	2014–2016	2015–2016	2015–2016	Population-based payment
Next Gen ACO (NGACO)	2016–2018	2016–2019	2016–2019	Population-based payment
Vermont Medicare ACO Initiative (2)	2018	2018–2019	2018–2019	Population-based payment
Comprehensive Primary Care Plus (CPC+)	2017–2018	2017–2019	2017–2019	Comprehensive Primary Care Payments
Comprehensive Primary Care Plus (CPC+)	2017–2018	2017–2019	2017–2019	Performance Payment
Comprehensive Primary Care Plus (CPC+)	2017–2018	2017–2019	2017–2019	Care Management Fees
ESRD				
Comprehensive ESRD Care (CEC)	2016–2017	2016–2018	2016–2018	Shared savings / losses

* See the Note preceding Table B3-1.

Notes:

- 2018–2019 shared savings for "Vermont Medicare ACO Initiative" is included with Next Generation ACO
- In the 2021 Rate Announcement, "Vermont Medicare ACO Initiative" was labeled "Vermont All-Payer ACO", and payments were not actually made in 2017 but began in 2018 and were reported under the program "Next Generation ACO."

The key aspects of these adjustments are:

- The adjustments reflect an allocation of the savings and losses based on the distribution of the participating entity's enrollment by county of residence. The adjustments applied to the non-ESRD ratebook exclude experience for beneficiaries in ESRD status as of July 1 of the experience year. (The adjustments for the model(s) noted as ESRD in Table B3-1, which are applied to the ESRD ratebook in a similar manner, would include experience for beneficiaries in ESRD status.)
- The adjustments include the application of the two percent sequestration reduction on these ACO adjustments for claims incurred on or after April 1, 2013.
- Under the models noted as using "population-based payments" in Table B3-1, participants receive a monthly fee that ultimately offsets a percentage reduction in FFS payments to certain providers and suppliers aligned with participants over the same year. For each affected claim, the reduction amount represents the portion of the fee associated with that particular claim and is therefore added back to the reduced FFS amount so that the total reimbursement amount is represented.
- Under the CPC+ models, participants receive quarterly payments that replace a percentage of FFS claim amounts for each affected claim. The "comprehensive primary care payments" are included with claim costs to compile the total reimbursement amount.
- In the ratebooks for contract years 2020 and earlier, the allocation of the Medicare Shared Savings Program and Innovation Center model and demonstration payment adjustments between the Part A and Part B trust funds was based on the Part A and Part B proportion of the FFS USPCC for each calendar year. Consistent with the actual payments by the trust fund, we intend to continue to allocate the entire amount of following payments for all experience years to the Part B trust fund: (i) Oncology Care Model episode savings / losses, (ii) Comprehensive Primary Care shared savings / losses, and (iii) Comprehensive Primary Care Plus primary care payments, performance payments, and care management fees. The remaining Medicare Shared Savings Program and Innovation Center model and demonstration payment adjustments will continue to be allocated in the MA ratebook calculations between the Part A and Part B trust funds based on the Part A and Part B proportion of the FFS USPCC for each calendar year.

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

Although we considered whether to adjust 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,[6] we intend to continue prior policy and will not take fees of this type into account in our adjustments to historical FFS experience when such fees or payments were not funded from Medicare Parts A or B Trust Funds. We have determined that the fees paid under the Multi-Payer Advanced Primary Care Practice Demonstration are already reflected in historical FFS claims, and therefore, no adjustment is warranted. We plan to monitor certain programs operating under the Maryland Total Cost of Care model and the Pennsylvania Rural Health Model, most notably provider payments that began in 2019 under the Maryland Primary Care Program and global budgets that began in 2019 for certain rural hospitals in Pennsylvania, and in the future will consider potentially including adjustments if data become available for attribution at a county level.

B4. Additional Adjustment to FFS per Capita Costs in Puerto Rico

For the past five years, the Secretary has directed the Office of the Actuary to adjust the fee-for-service experience for beneficiaries enrolled in Puerto Rico to reflect the nationwide propensity of beneficiaries with zero claims. For the CY 2017–2021 Rate Announcements, the Office of the Actuary evaluated experience exclusively for beneficiaries who were enrolled in both Parts A and B and were not dually eligible for Veterans Affairs (VA) coverage. The study for setting the CY 2021 rates analyzed experience for calendar years 2014 through 2018 and only considered FFS beneficiaries enrolled mid-year. On average, 15.1 percent of A&B Puerto Rico FFS beneficiaries were found to have no Medicare Part A or Part B claim reimbursements per year. This compares to a nationwide, non-territory, proportion of 6.1 percent of FFS beneficiaries found to have no Medicare Part A claim reimbursements and no Medicare Part B claim reimbursements per year. Based on the Secretary's direction, the Puerto Rico FFS weighting of enrollment and risk scores for the zero-claim cohort was adjusted to reflect the nationwide proportion of zero-claim beneficiaries. The resulting impact was measured as an average increase in the standardized per-capita FFS costs in Puerto Rico of 4.7 percent for 2014 through 2018. Accordingly, a 4.7 percent adjustment was then applied to the pre-standardized Puerto Rico FFS rates supporting the CY 2021 ratebook development.

We are considering whether a similar adjustment should be applied for 2022. The Office of the Actuary will perform an analysis that is similar to the prior analysis but with an updated five years of data: 2015–2019. We welcome comments regarding a similar update to Puerto Rico's experience in the development of the 2022 FFS rates. We will review the results of this study and any comments that we receive, and we will specify in the final Rate Announcement any adjustment that we determine may be necessary based on those results and comments.

We are aware of concerns raised by stakeholders regarding the FFS data used to establish MA benchmarks in Puerto Rico. As discussed in the CY 2017 Advance Notice, the law requires that

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

MA benchmarks be based on a county's average Medicare FFS per-capita cost, and there is no evidence that FFS costs in Puerto Rico are higher than the costs observed in the FFS claims data, and thus no basis for overhauling Puerto Rico's Medicare Advantage benchmarks. As we stated in the CY 2017 and CY 2018 Rate Announcements, we believe that the FFS data in Puerto Rico is sufficient for establishing accurate MA benchmarks. The CY 2020 Advance Notice (page 21) and Rate Announcement (pages 27 and 28) included discussion and analysis of trends in the FFS data, and concluded that our methodology of using five years of FFS experience mitigates annual fluctuations and anomalies in the data that may occur for a variety of reasons and provides for stability in the rates.

B5. Additional Adjustments

The following adjustments are made after the AGA is calculated:

- Direct Graduate Medical Education: removed from FFS county costs (section 1853(c)(1)(D)(i) of the Act).
- Credibility: for counties with fewer than 1,000 members, blend county experience with that of others in the market area.
- Veterans Affairs (VA) and Department of Defense (DoD): apply an adjustment to FFS per capita costs for beneficiaries dually enrolled in VA and/or the DoD health programs (the Uniformed Services Family Health Plan (USFHP) and/or the Veterans Health Administration (VHA)) pursuant to section 1853(c)(1)(D)(iii) of the Act. The VA/DoD adjustment is described in more detail in Section B6 below.
- Organ Acquisition Costs for Kidney Transplants: removed from FFS costs, described in more detail in Section C.
- Indirect Medical Education: removed from FFS county costs (sections 1853(n)(2)(E) and (F) of the Act), described in more detail in Section D.

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

B6. Adjustment to FFS per Capita Costs for VA and DoD Costs

We will continue to adjust the FFS rates by the Veterans Affairs (VA) and the Department of Defense (DoD) ratios concurrently based upon an updated study that uses FFS data from calendar years 2014–2018.

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

beneficiaries) to all Medicare beneficiaries (that is, all veteran and non-veteran beneficiaries) for each county.

Similar analysis was done for DoD. This analysis was performed separately for all DoD and Uniformed Services Family Health Plan (USFHP)-only enrollees to compare the average FFS costs to determine if there were significant differences between the DoD groups and the total Medicare population. To approximate an adjustment to the county FFS payment rates, we analyzed the cost impact of removing the dual-benefit eligible beneficiaries from the Medicare claims and enrollment. For this analysis, dual-benefit eligible beneficiaries were defined as those Medicare beneficiaries who are also eligible to receive care through the DoD. Specifically, we calculated the ratio of standardized per capita costs of all Medicare beneficiaries excluding dual-benefit eligibles (that is, all non-DoD beneficiaries) to all Medicare beneficiaries (that is, all DoD and non-DoD beneficiaries) for each county. We analyzed the ratios in counties with at least 10 members in the respective groups and found that there was no statistical significance of the DoD ratios, but did find that the USFHP-only ratios were significant. Accordingly, adjustments were made to counties with at least 10 USFHP members.

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

Section C. Organ Acquisition Costs for Kidney Transplants

Section 17006(b) of the 21st Century Cures Act amended section 1853(k) and (n) of the Act to exclude CMS' estimate of the standardized costs for payments for organ acquisition for kidney transplants from MA benchmarks starting in 2021. Section 1853(k)(5) of the Act, implemented in § 422.306(d), provides for the exclusion of these costs from the applicable amount and section 1853(n)(2)(A)(i), implemented in § 422.258(d), provides for the exclusion from the base amount (used to calculate the specified amount). Further, section 17006(c) of the 21st Century Cures Act amended sections 1851(i) and 1852(a)(1)(B); the amendments, implemented in § 422.100(c)(1) and § 422.322, require FFS coverage of organ acquisition costs for kidney transplants incurred by MA beneficiaries and exclude coverage of organ acquisitions for kidney transplants from the benefits that MA plans must provide to their enrollees.

The 21st Century Cures Act did not require Medicare FFS coverage of organ acquisition costs for kidney transplants incurred by PACE participants. Therefore, as noted in the final rule (CMS-4190-F) (85 FR 33796, 33824–25) titled "Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program," PACE organizations must continue to cover organ acquisition costs for kidney transplants consistent with the requirement in section 1894(b)(1)(A)(i) of the Act that PACE organizations provide all Medicare-covered items and services. Accordingly, CMS will continue to include the costs for kidney acquisitions in PACE

payment rates–both the PACE county rates and the PACE state ESRD rates–unlike for MA benchmarks.

In order to exclude costs for kidney acquisitions from MA benchmarks by county (or by state for MA ESRD rates), we will first tabulate FFS kidney acquisition costs from the Medicare Cost Reports (Form CMS-2552-10; OMB control number 0938-0050) for calendar years 2015–2019 (the same five years used for the average geographic adjustment, discussed in section B2 above) by provider (steps 1–3 below). We will then compute the kidney acquisition cost per discharge by provider and use FFS inpatient claims data to develop the "pass-through" kidney acquisition costs (steps 4–5). We will then compute the percentage of kidney acquisition costs to total FFS costs for the five-year historical period (steps 6–8). Finally, we will apply these ratios to projected 2022 FFS county and state costs (step 9) to carve out kidney acquisition costs from the MA benchmarks.

The specific steps are outlined below:

1) Extract Medicare's share of kidney acquisition costs and the number of Medicare discharges from the Cost Reports for certified kidney transplant centers.
    a) Organ acquisition costs for transplants are accumulated by organ type on the applicable Cost Report (Form CMS 2552-10) and are paid on a reasonable cost basis, separately from the Medicare Severity Diagnosis Related Group payment. Hospitals are paid the estimated amount for these costs through interim biweekly payments throughout the year, referred to as "pass-through amounts." The "pass-through" amounts are averaged over all Medicare discharges. Therefore, the number of Medicare discharges tabulated from the Cost Reports include both kidney transplant discharges and discharges not related to kidney transplants for certified kidney transplant centers.
2) Allocate these kidney acquisition costs and discharges to calendar years, in proportion to the number of cost report days in each calendar year (2015–2019).
    a) Note that Cost Reports can span/overlap calendar years, and reports can vary in the length of time included. (For example, one Cost Report may include 10/1/2018 through 9/30/2019, while another Cost Report may include 1/1/2019 through 12/31/2019, etc.)
    b) Some transplant centers will have submitted Cost Reports that include the first part of CY 2019, but have not yet submitted cost reports that cover the later portion of CY 2019.
        i) In these cases, we will estimate kidney acquisition costs per discharge for the discharges that will be reported for the later portion of CY 2019. For example, if Cost Reports include experience through 9/30/2019, we will apply an annual rate of increase to estimate corresponding cost per discharge for reports ending 9/30/2020. To determine this average increase in costs per discharge, we will compute the average annual rate of increase in kidney acquisition costs per discharge for calendar years 2016–2018, aggregated across all transplant centers. Finally, we take ¾ of the cost per discharge for reports ending 9/30/2019 plus ¼ of the cost per discharge for the estimated reports ending 9/30/2020 to arrive at a CY 2019 cost per discharge.

3) Aggregate these kidney acquisition costs and discharges by provider and calendar year.
4) Calculate the kidney acquisition cost per discharge by dividing the kidney acquisition costs by the number of discharges.
5) Calculate the "pass-through" kidney acquisition costs by multiplying the kidney acquisition cost per discharge by the number of Medicare discharges in the kidney transplant center's fee-for-service inpatient claims.
    a) Similar to step 1, the number of Medicare discharges tabulated include both kidney transplant discharges and discharges not related to kidney transplants for certified kidney transplant centers.
    b) The inpatient claims provide the beneficiary county of residence, allowing the "pass-through" kidney acquisition costs to be allocated to counties based on where beneficiaries reside.
6) Aggregate the "pass-through" kidney acquisition costs for each county, or for each state for MA ESRD rates, for the five-year historical period (2015–2019).
7) Aggregate the Part A and Part B claims for each county, or for each state for MA ESRD rates, for the five-year historical period (2015–2019).
8) Compute a ratio of the "carve-out" as a percentage of FFS by dividing the results of step 6 by the results of step 7.
9) Multiply this factor by the projected contract year (2022) county FFS costs, or state-level FFS costs for MA ESRD rates, to calculate the "carve-out" amount.

Note: In step 2b above, we describe the process by which we estimate kidney acquisition costs per discharge for the later portion of CY 2019 in the event that Cost Reports for the later portion of CY 2019 have not been submitted yet. Under any scenario, it is necessary to estimate missing months. Under a later release of the CY 2022 Rate Announcement, we anticipate that we will need to estimate fewer missing months in 2019 than under an early release date. Under a later release date, we expect almost 80 percent of kidney transplant centers would have submitted cost reports covering all 12 months in 2019 and over 90 percent would have submitted cost reports covering nine or more months in 2019. Under an early release of the CY 2022 Rate Announcement, we expect that at least one third of kidney transplant centers would have submitted cost reports that cover all 12 months in 2019 and about half would have submitted cost reports that cover nine or more months in 2019.

The impact of excluding kidney acquisition costs from the FFS experience as described above varies by jurisdiction. The kidney acquisition cost carve-out factors will be published with the CY 2022 Rate Announcement and reflect the impact of the carve-out on the ratebook. For information on the impact of the FFS cost of kidney acquisitions on the Medicare Trust Funds, please refer to the CY 2021 final rule (CMS-4190-F) (85 FR 33796, 33887–90). However, as the estimates provided in the final rule represent national-level impacts, the trending assumptions and underlying data are different from those used to determine the county-level average impacts of excluding kidney acquisition costs 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.

For CY 2022, we are proposing to change the order in which we adjust for kidney acquisition expenses. As noted above, the fee-for-service claim costs used as the basis for MA county rates are adjusted for graduate medical expenses, claims experience for Medicare enrollees who are also eligible for health care services from VA or DOD, indirect medical expenses, and kidney acquisition expenses. These first two adjustments (for graduate medical education and beneficiaries who are also eligible for coverage from VA or DOD) are required by section 1853(c)(1)(D) of the Act;[7] section 1853(n)(2)(E) provides that the amount specified in section 1853(c)(1)(D) is the base payment amount. *See also* § 422.258(d)(3) and (d)(4).

The adjustments are applied to a base amount that is used to determine the specified amount (section 1853(n)(2)(A)). The base payment amount is a county fee-for-service cost defined in section 1853(n)(2)(E) of the Act. Section 1853(n)(2)(F) and (G) require the base amount to be adjusted by: a) the indirect medical education (IME) phase-out, and b) the kidney acquisition cost (KAC) carve-out. *See also* § 422.258(d)(3).

However, prior to calculating the base payment amount for any year, whether it be a rebasing year or non-rebasing year, we first exclude graduate medical expenses and adjust to account for the provision of care outside of Medicare for dually eligible VA and DOD health plan enrollees when calculating the underlying FFS costs. This is in accordance with the adjusted average per capita cost (AAPCC) calculation described in section 1853(c)(1)(D). The AAPCC is the underlying amount upon which the base payment amount is determined. Once we apply the IME phase-out and KAC carve-out to the AAPCC amount, the base payment amount reflects all four of the required adjustments.

The 2021 KAC carve-out was applied prior to accounting for the cost of the VA and DOD dual eligibles. For 2022, we are proposing to apply the KAC adjustment at a later step in the process, subsequent to the application of the IME adjustment. We believe that this approach is more consistent with the statute. The impact of this change in methodology is small. If we had applied the KAC adjustment at the later point for the 2021 rates, the base payment amounts would have changed in a range from -$0.94 to $0.51, with an average change of $0.04.

[7] Section 1853(c)(1)(D)(i) of the Act also requires adjustments to exclude costs attributable to payments for meaningful use of certified ERT under sections 1848(o) and 1886(n). Those costs are not included in the claims data used to develop FFS costs and therefore not addressed here.

Section D. 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 IME amounts from MA capitation rates. Sections 1853(n)(2)(E) and (F) apply the same phase-out to FFS costs in the calculation of the specified amount in setting MA rates. Payment to teaching facilities for IME expenses for MA plan enrollees will continue to be made under FFS Medicare. Section 1894(d)(3) of the Act provides that the IME payment phase-out does not apply to PACE capitation rates.

For purposes of making this adjustment, we will first calculate the FFS rates including the IME amount. This initial amount will serve as the basis for calculating the IME reduction that we will carve out of the rates. The absolute effect of the IME phase-out on each county will be determined by the amount of IME included in the initial FFS rate. Under section 1853(k)(4)(B)(ii) of the Act, the maximum reduction for any specific county in 2022 is 7.8 percent of the FFS rate. To help plans identify the impact, CMS will separately identify the amount of IME for each county rate in the 2022 MA ratebook. We will continue to publish the rates with and without the IME reduction for the year.

Section E. ESRD Rates[8]

Pursuant to section 1853(a)(1)(H) of the Act, CMS establishes "separate rates of payment" with respect to ESRD beneficiaries enrolled in MA plans. As we stated in the 2012 Rate Announcement (page 32), it is in keeping with our understanding of the legislative intent to more

[8] As stated in the CY 2022 Final Rule, we 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 the population served and is consistent with the prevailing community pattern of health care delivery in the areas where the network is being offered. Importantly, the regulations at § 422.112(a) provide a critical beneficiary protection in that even if a provider or facility specialty type is not subject to specific quantitative network adequacy standards, that access to providers at in-network cost sharing must be provided by the MA organization. This critical beneficiary protection, in conjunction with the standard that MA plan networks provide access and availability of services consistent with prevailing community pattern of health care delivery, ensures that MA enrollees have similar reasonable access to providers and facilities as beneficiaries in FFS Medicare. Therefore, we expect that MA plans will continue to provide adequate access to outpatient dialysis providers. Section 1852(b) of the Act prohibits MA plans from denying, limiting, or conditioning the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status–related factor and prohibits use of a plan design that discourages enrollment by certain beneficiaries, such as those with diagnoses of ESRD.

If beneficiaries believe that an MA organization is not providing adequate access to services, complaints may be submitted by calling 1-800-MEDICARE. CMS monitors and investigates complaints related to plan coverage and CMS caseworkers assist in the resolution of any issues with the MA organizations. CMS 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, as warranted.

closely align MA payment rates with FFS costs that the ESRD state rates are also based on FFS costs.

We will use the 2015–2019 FFS reimbursement and enrollment data for beneficiaries in dialysis status for each state to develop the 2022 ESRD MA benchmarks. For each year, we compute the FFS dialysis per capita costs (for Part A and Part B items and services for beneficiaries in dialysis status) by state. The geographic indices for each year are calculated by dividing the state per capita cost by the total per capita cost of the nation. The five-year weighted average of the geographic indices is standardized by dividing by the five-year average risk scores (calculated using the risk adjustment model for CY 2022 payment). This standardized five-year weighted average is the average geographic adjustment (AGA), which represents the ratio of historical FFS dialysis per capita costs by state to national FFS dialysis per capita costs. We calculated the 2019 FFS ESRD dialysis United States per capita cost (ESRD dialysis USPCC) based on the 2019 data above, and, using trend factors, develop the prospective 2022 FFS ESRD dialysis USPCC. The 2022 ESRD state rates are determined by multiplying the 2022 FFS ESRD dialysis USPCC by the state AGA.

We will continue to incorporate refinements developed and used in prior years regarding the repricing of historical data in the AGA calculation for the ESRD rates. Similar to the non-ESRD rate methodology, we intend to reprice the ESRD historical inpatient, hospital outpatient, skilled nursing facility, and ESRD PPS claims from 2015–2019 to reflect the most current (i.e., FY 2021) wage indices, and re-tabulate physician claims with the most current (i.e., CY 2021) Geographic Practice Cost Indices. We will continue to adjust the uncompensated care payments (UCP) represented in the 2015–2019 claims to reflect the requirements of the most recent final rule. The adjustments will also include shared savings and shared losses performance-based payments made under the Comprehensive ESRD Care (CEC) model, as described in Section B3 of this document. The adjustments will not include ESRD experience from models other than the CEC model.

Note: See the Notes in Section B of this document (on pages 21 and 24) regarding the repricing adjustments for FFS payment rules and models under an early release of the CY 2022 Rate Announcement and under a later release date of the CY 2022 Rate Announcement. The adjustments related to the early schedule and the later schedule that apply to non-ESRD rates also apply to ESRD rates.

Pursuant to section 1853(k)(5) and (n)(2)(A)(i), MA benchmarks for 2021 and subsequent years exclude organ acquisition costs for kidney transplants (described in detail in Section C above). As noted in the final rule (CMS-4190-F) (85 FR 33796, 33825) titled “Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program,” and in the 2021 Rate Announcement, the exclusion of KACs is also applied to the MA ESRD state rates for 2021 and subsequent years. In addition, the 2022 MA ESRD state rate is adjusted by removing the

direct graduate medical education (GME) expenses and the gradual phase-out of IME expenses, consistent with adjustments made for the non-ESRD MA rates that are discussed in Section B of this document.

We will publish a file with the CY 2022 Rate Announcement that includes the key components of the rate development, similar to the rate calculation data supporting the MA non-ESRD county rates.

As stated in Section C, CMS will continue to include organ acquisition costs for kidney transplants in the PACE state ESRD rates. As stated in Section D, the IME payment phase-out does not apply to PACE capitation amounts. Therefore, for 2022 the ESRD state rates for PACE organizations will continue to include KACs and IME amounts.

Section F. Location of Network Areas for Private Fee-for-Service (PFFS) Plans in Plan Year 2023

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

Network area is defined in section 1852(d)(5)(B) of the Act, for a given plan year, as an area that the Secretary identifies (in the announcement of the proposed payment rates for the previous plan year under section 1853(b)(1)(B)) as having at least two network-based plans (as defined in section 1852(d)(5)(C)) with enrollment as of the first day of the year in which the Announcement is made. We intend to publish the list of network areas for plan year 2023 with the CY 2022 Rate Announcement. We will make this list available on the CMS website at https://www.cms.gov/Medicare/Health-Plans/PrivateFeeforServicePlans/NetworkRequirements. We will use January 1, 2021 enrollment data to identify the location of network areas for plan year 2023.

Section G. MA Employer Group Waiver Plans

We intend to continue to waive the Bid Pricing Tool bidding requirements for all MA employer/union-only group waiver plans (EGWPs) for 2022. As a condition of the waiver of the bidding requirements and the waivers otherwise provided to EGWPs, CMS will establish payment amounts using the same methodology for 2022 as was used for 2021. As has been the case since 2017, for 2022, Part C entities offering EGWPs will not be required to submit Part C bid pricing information in the Part C Bid Pricing Tool. CMS has authority under section 1857(i)

of the Act to waive or modify requirements that hinder the design of, the offering of, or the enrollment in employment-based Medicare plans offered by employers and unions to their members. Waiving the requirement to submit 2022 Part C bid pricing information will facilitate the offering of Part C plans for employers and unions seeking to establish high quality coverage for their Medicare-eligible retirees by avoiding the cost and administrative burden of submitting the complex bids required from non-EGWPs. We refer the reader to the detailed discussion of our rationale and responses to commenters' questions in the CY 2017 Rate Announcement, Attachment III, Section F (pages 27–44) for additional information, and to the responses to questions received by the Office of the Actuary that are available at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/ActuarialBidQuestions.

In connection with the continuation of this waiver, for 2022, CMS will continue to use the payment methodology implemented for MA EGWPs, as finalized in the CY 2021 Rate Announcement, with one change. For 2022, we propose to change the methodology for setting MA EGWP rates, specifically the enrollment data used to weight the bid-to-benchmark ratios, depending on the timing of the release of the CY 2022 Rate Announcement.

The payment methodology relies on bid-to-benchmark ratios, as described below, that reflect average bid amounts, weighted by plan enrollment. The calculations for the bid-to-benchmark (B2B) ratios would therefore be as follows:

> First: [(Weighted Average of the Intra-Service Area Rate Adjustment (ISAR) Adjusted County Bid Amounts for 2021 Individual Market Plan Bids by January 2021 Actual Enrollment)/(Weighted Average of the County Standardized Benchmarks for 2021 Individual Market Plans by January 2021 Actual Enrollment)] = 2021 Individual Market B2B Ratios by Quartile[9]
>
> Second: The 2021 individual market B2B ratios will be calculated separately for HMO plan types and PPO plan types by quartile.[10] The PPO B2Bs by quartile will be weighted by the total proportion of EGWP PPO plan type enrollment, and the HMO B2Bs by

[9] As in prior years, territories will not be included in the weighted average B2B ratio, but they will be assigned the weighted average of the quartile within which their counties fall. To determine the CY 2022 applicable percentages, CMS ranks counties from highest to lowest based upon their 2021 average per capita FFS costs and places the rates into four quartiles. When calculating the 2021 B2B ratios, CMS will group counties by the 2021 unblended quartiles and will then apply these B2B ratios to the 2022 unblended quartiles.

[10] Consistent with 2021, HMO and HMOPOS plans have been combined into an "HMO plan type" and LPPO and RPPO plans have been combined into a "PPO plan type." "HMO" Health Maintenance Organization, "HMOPOS" Health Maintenance Organization Point of Service, "PPO" Preferred Provider Organization, "LPPO" Local Preferred Provider Organization, "RPPO" Regional Preferred Provider Organization. "PFFS" Private Fee-for-Service individual market plans are excluded from these calculations.

quartile will be weighted by the total proportion of EGWP HMO plan type enrollment to result in the final B2B ratios for 2022 by quartile.

Note: The earlier release of the CY 2022 Rate Announcement will require that we use January 2021 enrollment data as of the January payment month for the purpose of weighting plan bids when calculating B2B ratios. In previous years, we used February enrollment data as of the February payment month. If we publish the Rate Announcement in the later timeframe, we will continue to use the February 2021 enrollment data as of the February payment month in the calculation methodology outlined below. The use of the February 2021—as opposed to the January 2021—enrollment data allows us to use enrollment that will have fewer retroactive adjustments in the following months. This is because January enrollment reflects larger changes in plan enrollment than other months as a result of open enrollment, and there are more retroactive adjustments to January enrollment than for other payment months. Therefore, using the February enrollment will affect the weighting used to calculate B2B ratios. We believe that the benefit of an early announcement of MA rates for CY 2022 could outweigh the benefit of using the later data.

As has been in effect since 2017, for 2022:

- The B2B ratios will be applied to each of the published 5%, 3.5%, and 0% bonus county ratebook rates for the payment year to establish Part C base payment amounts for EGWPs based on their Star Rating, for each county.
- In order to calculate a county rebate payment, each county-level EGWP Part C base payment amount will be compared to the corresponding published 5%, 3.5%, and 0% bonus county benchmarks for the payment year (2022), which include adjustments for qualifying counties, to determine the amount of savings. The savings amount will be multiplied by the corresponding rebate percentage to determine the Part C EGWP county-level rebate amount.
- The EGWP Part C base payment amount will be added to the Part C EGWP rebate amount to establish the county-level local EGWP total payment amount.
- The total payment amount will be risk adjusted in payment using beneficiary-specific risk scores. Therefore, the formula applied for local EGWP payment on a per-beneficiary basis would be: (Base County Payment Rate + County Rebate) × Beneficiary-Level Risk Score.

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

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

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

- Base County Payment Rate = Bid to Benchmark Ratio × 2022 MA Monthly Capitation Rate
- Regional Rebate = (1 − Bid to Benchmark Ratio) × 2022 Regional Rate × Rebate Percentage
- The 2022 Regional rate is based on a blend of the statutory and bid component. As with non-EGWPs, if there is no bid component of the 2022 Regional rate (i.e., no individual bids in a region), then the EGWP rate will be based solely on the statutory component.

As has been the case since 2017, for 2022, there will be no Part C Regional PPO EGWP bids to include in the calculation of the MA regional benchmarks. The statutory components of the regional standardized A/B benchmarks will continue to be published each year as part of the Announcement of Medicare Advantage Payment Rates. CMS will also continue to publish the final MA regional standardized A/B benchmarks in late summer, which will reflect the average bid component of the regional benchmark based on non-EGWP bid submissions.

For 2022, we will also continue the existing policy permitting MA EGWPs to buy down Part B premiums for their enrollees using a portion of the Part C payment. A detailed discussion of this policy appears in the CY 2020 Advance Notice, Part II, Section F (pages 26–27).

We will continue to collect a Part B premium buy-down amount in the EGWP's Plan Benefit Package (PBP) submission to CMS. Any MA EGWP that chooses to use a portion of its payment to buy down the Part B premium must apply such Part B premium buy-down amount consistently to every beneficiary enrolled in the EGWP, in accordance with uniformity of benefit rules. Those MA EGWPs that choose to use a portion of their payment to buy down the Part B premium for their enrollees will have that amount reduced from their capitated payment. For example, if an MA EGWP determines that under its benefit offering there will be a $5 reduction to each of its enrollee's Part B premium, $5 per member per month will entered into the requisite field in the PBP, and then $5 will be subtracted from the monthly capitated amount. For local MA EGWPs this will be reflected in the proposed payment formula described above as follows:

Total Payment = (Base County Payment Rate + County Rebate) × Beneficiary Level Risk Score - *Part B Buy Down Amount*.

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

As in 2020 and 2021, MA EGWPs will be subject to the same maximum CY 2022 Part B buy-down amount as non-EGWP plans. That is, EGWPs may only buy down the Part B premium up to the maximum amount displayed in the CY 2022 MA Bid Pricing Tool Worksheet 6. Additionally, as with non-EGWP plans, the Part B premium buy-down amount cannot vary

among beneficiaries enrolled in an EGWP. The Part B buy-down amount applies to every beneficiary under the plan ID. Therefore, if an EGWP would like to reduce the Part B premium for one employer group under the plan ID by $5 and reduce the Part B premium for another employer group by $10, then two separate EGWP plan IDs would need to be established/utilized. As an example, the PBP for plan 801 would contain a $5 buy-down amount and the PBP for plan 802 would contain a $10 buy-down amount.

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

- CMS will continue to waive the requirement that MA EGWPs must specify how they are allocating MA rebate dollars for 2022. 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.
- MA EGWPs will not receive capitation payments for members that elect Hospice.
- MA EGWPs will continue to be paid using the ESRD ratebook for their ESRD beneficiaries in Transplant and Dialysis status and the individual market MA ratebook for those beneficiaries in Functioning Graft status, in keeping with the current payment policy for non-EGWP MA organizations.
- Consistent with how CMS pays capitation for Part B-only enrollees in the non-EGWP context, Part B-only MA EGWPs will continue to receive only the Part B portion of the EGWP payment amount, which is determined by multiplying it by the Part B percentage of the MA rate.
- MA EGWP MSA plans will continue not to submit Bid Pricing Tools for 2022, but the 2022 local EGWP payment rates will continue to not be applied to EGWP MSA plans. The monthly prospective payments for EGWP MSAs will be based on the following formula: 2022 MA Monthly Capitation County Rate x beneficiary risk score – 1/12 of the Annual MSA Deposit Amount. The 2022 Annual MSA Deposit Amount must be submitted in the appropriate Plan Benefit Package field. Consistent with individual market MSA plans, MA EGWP MSA plans will not be able to use a portion of the Part C payment to buy down the Part B premium.
- Notwithstanding the payment policies described above, entities offering MA EGWPs must continue to meet all of the CMS requirements that are not otherwise specifically waived or modified, including, but not limited to, submitting information related to plan service areas, plan benefit packages, and formularies in accordance with the rules for 2022. MA organizations must continue to make a good faith effort in projecting CY 2022 member months for each plan and place the amount in the appropriate section of the 2022 Plan Benefit Package (PBP) submissions to CMS.

Section H. Medical Loss Ratio Credibility Adjustment

In the CY 2021 final rule (CMS-4190-F) (85 FR 33796), CMS amended the regulations at §§ 422.2440 and 423.2440 to codify the MLR credibility adjustment factors that were published in

the May 23, 2013 Medicare MLR final rule (CMS-4173-F) (78 FR 31284). The credibility adjustment factors codified in the regulations at §§ 422.2440 and 423.2440 will apply to MLRs calculated for CY 2021 and subsequent contract years. In the CY 2021 final rule, CMS also amended § 422.2440 to add a deductible factor to the MLR calculation for MA MSA contracts that receive a credibility adjustment. The deductible factor functions as a multiplier on the credibility adjustment factor and applies to MLRs calculated for CY 2021 and subsequent years.

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

On September 14, 2020, CMS published for public comment the proposal related to the Part C risk adjustment model in Part I of the CY 2022 Advance Notice.[11] For CY 2022, CMS is proposing to fully phase in the CMS-Hierarchical Condition Categories (HCC) model that was first implemented for CY 2020 (i.e., the 2020 CMS-HCC model), thereby calculating 100% of the risk score using the 2020 CMS-HCC model. In addition, CMS proposes to calculate risk scores for payment to MA organizations and certain demonstrations, including MMPs, using only risk adjustment-eligible diagnoses identified from encounter data and FFS claims for CY 2022.

For CY 2022 payment to PACE organizations, we propose to continue to use the 2017 CMS-HCC model to calculate risk scores, which we began using for CY 2020 payment and will continue to use for CY 2021 as described in the CY 2020 Advance Notice Part II and the CY 2021 Advance Notice Part I.[12]

As noted above, all comments on the Advance Notice must be submitted to https://www.regulations.gov. To submit comments or questions electronically, go to https://www.regulations.gov, enter the docket number "CMS-2020-0093" in the "Search" field, and follow the instructions for "submitting a comment." As noted above, the comment period for Part I proposals has been extended and comments will be accepted until 6:00 PM Eastern Time on Monday, November 30, 2020. We will address comments in the 2022 Rate Announcement.

Section J. ESRD Risk Adjustment Models for CY 2022

CMS uses separate models to calculate the risk scores applied in payment for the Part A and Part B benefits provided to beneficiaries in ESRD status when enrolled in MA plans, PACE organizations, and certain demonstrations, including MMPs. For CY 2020, CMS began implementation of updated versions of the ESRD dialysis and ESRD functioning graft models (i.e., 2020 ESRD models). For CY 2021 risk adjustment for ESRD, we will blend 25% of the risk score using the 2019 ESRD models (using diagnoses from RAPS and FFS) summed with 75% of the risk score calculated with the 2020 ESRD models (using diagnoses from encounter

[11] 2022 Advance Notice Part I: https://www.cms.gov/files/document/2022-advance-notice-part-i.pdf.

[12] The CY 2020 and 2021 Advance Notices are available on the CMS website at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.

data, RAPS inpatient records, and FFS). Consistent with the proposal in Part I of the CY 2022 Advance Notice for the Part C risk adjustment model, for CY 2022, CMS is proposing to fully phase in the 2020 ESRD models. In addition to calculating 100% of the risk score using the 2020 ESRD models, CMS proposes 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 began using 2019 ESRD models, which are described in Part II of the CY 2019 Advance Notice,[13] to calculate risk scores for ESRD beneficiaries in CY 2019, and continues to use the 2019 ESRD models for CY 2020 and CY 2021. For CY 2022, CMS proposes to continue to use the 2019 ESRD dialysis and ESRD functioning graft models as well as the 2019 transplant factors to calculate ESRD risk scores.[14] Refer to Section N for information on encounter data as a source of diagnoses for CY 2022 ESRD risk score calculation.

Section K. Frailty Adjustment for PACE Organizations and FIDE SNPs

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

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

The underlying data used to calculate the frailty factors for each model used for payment in CY 2021 are based on the ADLs from the 2008-2009 FFS Consumer Assessment of Health Providers & Systems (CAHPS). For CY 2022, CMS estimated the frailty factors using ADLs from more recent survey results. The proposed 2022 frailty factors for the 2020 CMS-HCC model are recalibrated using the 2014–2015 FFS CAHPS data, using an updated sample of respondents. For the frailty model calibration, CMS obtains ADL counts from surveys of the general FFS

[13] Part II of the 2019 Advance Notice is available on the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents-Items/2019Advance.

[14] The CY 2019 ESRD relative factors are in Attachment VI of the 2019 Rate Announcement: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents-Items/2019Announcement.

Medicare population. By using the FFS CAHPS ADL results to calibrate the frailty factors, CMS uses methodologically-similar surveys for both calibrating the frailty model to estimate the frailty factors and for calculating annual frailty scores. Similar to the CAHPS survey, the annual frailty scores are calculated using results from the Health Outcomes Survey (HOS) and Health Outcomes Survey – Modified (HOS-M), which are also anonymous mail-in surveys with telephone follow-up.[15]

In CY 2021, we will continue to have separate frailty factors for beneficiaries in dual (Medicaid) and in non-dual (non-Medicaid) status for FIDE SNPs. For CY 2022, CMS recalibrated the frailty factors for FIDE SNPs to be separated out by non-dual, partial-dual, and full-dual-eligible status to better align the frailty factors with the segments of the 2020 CMS-HCC model, which was calibrated with separate segments based on the three dual-eligible statuses. Partial-dual and full-dual status for the frailty model calibration was identified to be consistent with the 2020 CMS-HCC model calibration. The recalibrated factors are in Table II-4.

For FIDE SNPs in CY 2021, the frailty scores will be calculated using a 75%/25% blend of the frailty scores calculated with the frailty factors associated with the 2020 CMS-HCC model and the frailty scores calculated with the frailty factors associated with the 2017 CMS-HCC model, respectively. As discussed in Part I of the CY 2022 Advance Notice, for CY 2022 CMS proposes to calculate risk scores for non-ESRD MA enrollees (including those in FIDE-SNPs) using the 2020 CMS-HCC model. Therefore, CMS proposes to calculate the frailty scores for FIDE SNPs using 100% of the recalibrated frailty factors associated with the 2020 CMS-HCC model (Table II-4). Each FIDE SNP's frailty score will be compared with the PACE level of frailty in the same manner as will be done for CY 2021 and has been done in prior years to determine whether that FIDE SNP has a similar average level of frailty as PACE.

MA organizations that are planning to sponsor a FIDE SNP and that wish to receive frailty payments in 2022, must contract with a CMS-approved survey vendor to field the 2021 Health Outcomes Survey (HOS) or the 2021 Modified Health Outcomes Survey (HOS-M), at the PBP level. CMS uses the activities of daily living (ADLs) obtained from the HOS or HOS-M in one year, for the PBP of the FIDE SNP, to calculate frailty scores for the following year for FIDE SNPs.

Consistent with the proposal in Section I to continue calculating risk scores for beneficiaries enrolled in PACE organizations using the 2017 CMS-HCC model, we will use the frailty factors associated with the 2017 CMS-HCC model (Table II-5) to calculate frailty scores for PACE organizations in CY 2022.

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[15] See the 2008 Advance Notice for more information on using the CAHPS survey for the frailty model calibration: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2008.pdf.

Table II-4. Frailty Factors Associated with the 2020 CMS-HCC Model – FIDE SNPs

ADL	Non Medicaid	Partial Medicaid	Full Medicaid
0	-0.066	-0.140	-0.082
1-2	0.102	0.000	0.217
3-4	0.227	0.142	0.282
5-6	0.227	0.142	0.282

Table II-5. Frailty Factors Associated with the 2017 CMS-HCC Model – PACE Organizations

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

Section L. Medicare Advantage Coding Pattern Adjustment

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

For CY 2022, CMS proposes to apply the statutory minimum MA coding pattern adjustment of 5.90 percent.

Section M. Normalization Factors

The Part C risk adjustment model is calibrated with diagnostic and cost information for beneficiaries enrolled in Medicare FFS who are entitled to Part A, enrolled in Part B, and not in ESRD or hospice status. The model estimates incremental costs for a variety of beneficiary characteristics (e.g., age and gender) and health conditions in a historical period (or "calibration year"). Each model variable's incremental cost estimate, referred to as a dollar coefficient, is divided by the predicted average per capita expenditure for beneficiaries in the Medicare FFS program in a given year (the denominator) to create relative factors. Risk scores are the sum of relative factors assigned to each beneficiary based on their demographic characteristics and health status. For FFS beneficiaries, the average risk score is 1.0 in the denominator year.

When a risk adjustment model predicts expenditures in years other than the denominator year (prior or future years), the average risk score for FFS beneficiaries may no longer be 1.0 due to an underlying trend that reflects changes, such as those in coding and population characteristics, between the denominator year and other years. CMS applies a normalization factor to risk scores in the payment year to account for this trend in the average FFS risk score between the

denominator year risk score (1.0) and the payment year. The normalization factor is a projection of this trend, and applying the factor effectively keeps the average risk score at 1.0 in the payment year for beneficiaries in FFS.[16]

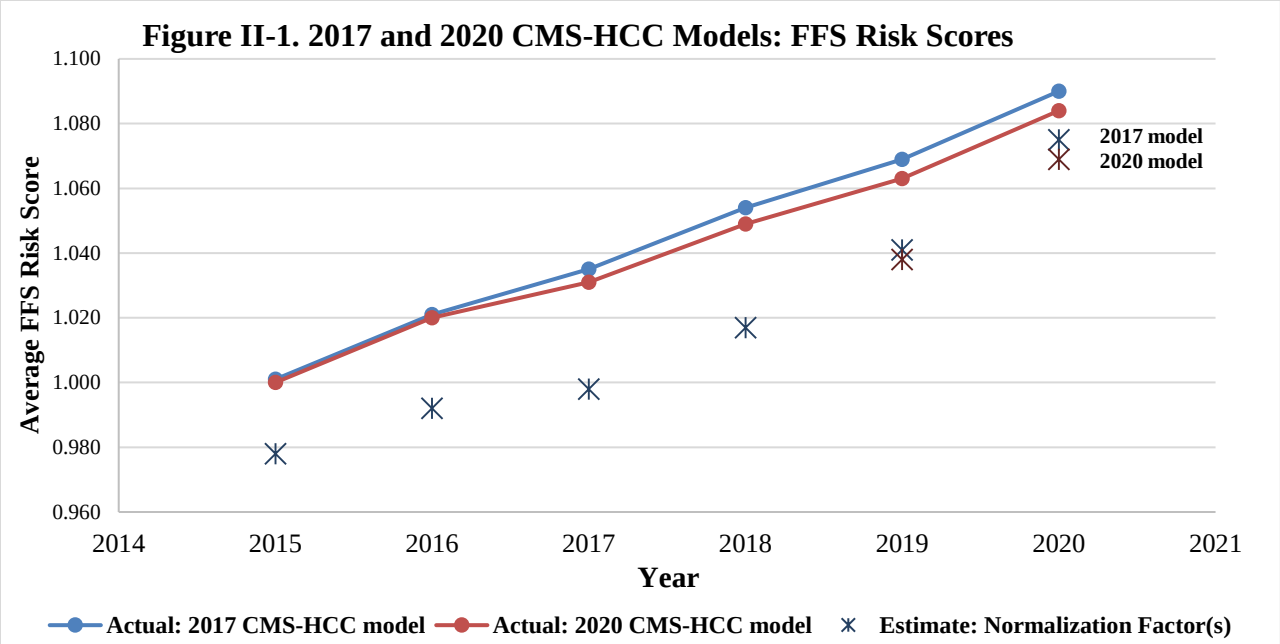
In determining the Part C normalization factor under each model, we use the observed trend to predict the average risk score of FFS beneficiaries in the payment year, calculated using the model that will be used in the payment year. In determining the RxHCC normalization factor, we use the observed trend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

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

Second, updating the normalization factor annually stabilizes payments between model calibrations. Periodically, CMS updates the risk adjustment model with more current data and resets the year that the average risk score is 1.0 (i.e., the denominator year). Because there is a trend between the denominator year and the payment year, applying a normalization factor to risk scores provides year-over-year stability and avoids the volatility that would otherwise occur when the model is updated with a more recent denominator.

The risk scores that underlie the normalization factor calculation have continued to increase at a faster rate than in earlier years. Figure II-1 shows the average FFS risk score trends under the 2017 and 2020 CMS-HCC models from 2015–2020, as well as the normalization factors over time.

[16] *See* section 1853(a)(1)(C)(ii)(I) of the Act.



Our analysis continues to suggest a number of reasons for this increase, including changes in demographics, the reported health status in the FFS population, and the implementation of ICD-10. We continue to believe the effect on the change in average risk score from implementing ICD-10 is stabilizing as providers have more experience using the ICD-10 code set and establish their coding practices. However, we believe that other factors, such as more complete reporting of diagnosis codes as a result of the changing incentive to report more completely in alternative payment models (which are increasing in penetration), and a changing case mix in FFS may continue to put upward pressure on FFS risk scores. Therefore, for CY 2022 we are proposing to maintain the same methodology for calculating the normalization factor that we have predominantly used since 2007. We propose to project the slope, calculated from the observed trend over five years of historical risk scores, from the denominator year to the payment year. We apply the equation (1+X)^n, where X is the slope calculated from the trend of historical FFS risk scores, and the exponent n is the number of years between the denominator year and the payment year to calculate the normalization factor. Given the observed historical data, this proposed methodology results in an increase in the normalization factor for CY 2022 relative to that calculated for CY 2021.

In Part I of the CY 2022 Advance Notice, published September 14, 2020, CMS proposed to calculate risk scores based 100 percent on the 2020 CMS-HCC model. Consistent with that proposal, for CY 2022, CMS proposes to calculate the Part C normalization factor for non-ESRD aged/disabled enrollees in MA plans and certain demonstrations using the 2020 CMS-HCC model. Consistent with the proposal above to use the 2017 CMS-HCC model for calculating risk scores for non-ESRD aged/disabled participants of PACE organizations, CMS proposes to calculate the normalization factor for PACE using the 2017 CMS-HCC model for CY 2022.

The proposed Part C normalization factor for the 2020 CMS-HCC model is 1.118 and the proposed PACE normalization factor for the 2017 CMS-HCC model is 1.128. The proposed ESRD dialysis normalization factor is 1.077. The proposed ESRD functioning graft normalization factor is 1.126. The proposed Part D normalization factor for the recalibrated RxHCC 17/18 model is 1.056. The preliminary normalization factors for each of these models and the annual trends are in subsections M1 through M3.

M1. Normalization for the CMS-HCC Models

The proposed 2022 normalization factor estimated for the 2020 CMS-HCC risk adjustment model is 1.118, and for the 2017 CMS-HCC risk adjustment model is 1.128. Both the 2020 and 2017 CMS-HCC models have a 2015 denominator, meaning there are seven years of trend between the denominator year and the payment year for both models.

The normalization factors for the CMS-HCC risk adjustment models are applied to the community non-dual aged, community non-dual disabled, community full benefit dual aged, community full benefit dual disabled, community partial benefit dual aged, community partial benefit dual disabled, institutional, new enrollee, and C-SNP new enrollee risk scores. The risk scores used to calculate the proposed 2022 normalization factor for the 2020 CMS-HCC model and the 2017 CMS-HCC model are included in Table II-6 Part C Normalization Factor Risk Scores.

Table II-6. Part C Normalization Factor Risk Scores

Year	2020 CMS-HCC Model	2017 CMS-HCC Model
2016	1.020	1.021
2017	1.031	1.035
2018	1.049	1.054
2019	1.064	1.070
2020	1.084	1.090

M2. Normalization for the ESRD Dialysis Model

The proposed 2022 normalization factor estimated for the ESRD dialysis risk adjustment model is 1.077. The ESRD dialysis model has a 2015 denominator, and there are seven years of trend between the denominator year and the payment year.

The normalization factor for the ESRD dialysis model is applied to the risk scores for enrollees in the dialysis, dialysis new enrollee, and transplant segments. The risk scores in the trend used to calculate the proposed normalization factor for the ESRD dialysis model are included in Table II-7 ESRD Dialysis Normalization Factor Risk Scores.

Table II-7. ESRD Dialysis Normalization Factor Risk Scores

Year	ESRD Dialysis Model
2016	1.015
2017	1.030
2018	1.042
2019	1.052
2020	1.057

M3. Normalization for the ESRD Functioning Graft Model

The proposed 2022 normalization factor for the ESRD functioning graft risk adjustment model is 1.126. The ESRD functioning graft model has a 2015 denominator, and there are seven years of trend between the denominator year and the payment year. The trend for the ESRD functioning graft model is calculated using FFS beneficiaries who are entitled to Part A, enrolled in Part B, and who do not have ESRD, or who are not in hospice status.

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

Table II-8. ESRD Functioning Graft Normalization Factor Risk Scores

Year	ESRD Functioning Graft Model
2016	1.024
2017	1.039
2018	1.059
2019	1.074
2020	1.092

M4. Normalization for the RxHCC Model

CMS is proposing to update the RxHCC model for CY 2022. See Attachment III, Section A for more details. The proposed 2022 normalization factor for the recalibrated RxHCC 17/18 model (the 2022 RxHCC model) is 1.056. As previously stated, to estimate the normalization factor we project the growth in Part D risk scores from the denominator year (when the Part D risk scores are set to 1.0) to the payment year. The projected growth is based on the observed trend over five years of historical Part D risk scores. We apply the equation (1+X)^n to calculate the

normalization factor, where X is the slope calculated from the observed trend of historical Part D risk scores, and the exponent, n, is the number of years between the denominator year and the payment year. Therefore, to estimate the Part D normalization factor for the 2022 RxHCC model, we first calculate the slope using five years of historical Part D risk scores that were calculated using the 2022 RxHCC model. The exponent applied for CY 2022 is three years since the proposed 2022 model has a 2019 denominator and three years of trend between the denominator year and the payment year.

The normalization factor for the RxHCC model is applied to all Part D risk scores for beneficiaries enrolled in an MA-PD or PDP plan. The RxHCC model calibration and risk score trends are both estimated using diagnoses from MA and FFS. The 2022 model was calibrated using MA diagnoses from encounter data and FFS diagnoses from FFS claims. Therefore, the risk scores in the trend used to estimate the proposed 2022 normalization factor for the 2022 RxHCC model are encounter data- and FFS claims-based and are calculated using diagnoses for beneficiaries enrolled in both MA-PDs and PDPs. Table II-9, RxHCC Normalization Factor Risk Scores, includes the risk scores in the trend used to estimate the 2022 RxHCC model normalization factor. Also included are encounter data- and FFS claims-based risk scores under the 2020 RxHCC model.

Table II-9. RxHCC Normalization Factor Risk Scores

Year	**2022 RxHCC Model** (ED & HCPCS-Filtered FFS Claims)	**2020 RxHCC Model** (ED & Specialty-Filtered FFS Claims)
2015	0.922	0.976
2016	0.958	1.008
2017	0.972	1.017
2018	0.986	1.030
2019	1.000	1.041

CMS considered two alternatives for estimating the 2022 Part D normalization factor because, although average Part D risk scores increase from 2015 to 2016 when calculated with MA diagnoses from either encounter data or RAPS data, the increase is more pronounced for the encounter data-based scores. CY 2015 was the first year encounter data was incorporated into risk score calculations and it was not used in a blend but as an additional data source. We believe that, in addition to a general increase in the reporting of diagnoses between 2015 and 2016, the increase in the encounter data-based risk score over this same time period may also reflect increases in reporting as the encounter data-based score gained more prominence in payment. With this in mind, we considered projecting the slope, calculated from the observed trend, over *four* years of historical encounter data-based risk scores, specifically 2016-2019, thereby removing the 2015 data point from the trend. In this scenario, we then would have applied that

slope over four years in the estimation of the proposed 2022 RxHCC normalization factor from the denominator year to the payment year. Additionally, CMS considered calculating the RxHCC normalization factor based on the current five-year slope methodology, but substituting a 2015 RAPS-based risk score for the first year in the trend (2022 RxHCC Model: 0.947 & 2020 RxHCC Model: 1.000) to remove the effect of reporting differences that may have occurred early on in encounter data reporting. These two alternative methods resulted in similar trends to each other, and to the RxHCC trend using MA diagnoses from RAPS. CMS is seeking comment on both the proposed method and the alternative options we considered.

Section N. Sources of Diagnoses for Risk Score Calculation for CY 2022

Encounter Data as a Source of Diagnoses. On September 14, 2020, CMS published for public comment Part I of the CY 2022 Advance Notice. Part I contains proposals regarding the Part C risk adjustment model and the use of encounter data and FFS claims as a diagnosis source for CY 2022 risk adjustment payments for aged and disabled beneficiaries based on the 2020 CMS-HCC model. As indicated in that notice and above, all comments must be submitted to www.regulations.gov. Enter the docket number "CMS-2020-0093" in the "Search" field, and follow the instructions for "submitting a comment." As noted above, the comment deadline for Part I has been extended and comments on Part I proposals will be accepted until 6 PM Eastern Time on Monday, November 30, 2020. We will address comments in the CY 2022 Rate Announcement that will be released no later than April 5, 2021.

For CY 2022, to calculate ESRD dialysis and ESRD functioning graft risk scores, CMS will use the 2020 ESRD dialysis and functioning graft models (i.e., 2020 ESRD models) to calculate risk scores. For CY 2022, we propose to calculate ESRD dialysis and ESRD functioning graft risk scores using 100% of the risk scores calculated using diagnoses from encounter data and FFS claims, in alignment with the proposal for calculating risk scores for aged and disabled beneficiaries based on the 2020 CMS-HCC model.

Diagnoses from RAPS Inpatient Data as a Source of Diagnoses for Encounter Data-Based Scores. As discussed in Part I of the CY 2022 Advance Notice, for CY 2022, CMS is proposing to discontinue the policy used for CY 2019, CY 2020, and CY 2021 in which diagnoses from encounter data were supplemented with diagnoses from RAPS inpatient records. As stated in the CY 2019, CY 2020, and CY 2021 Advance Notices, the inclusion of diagnoses from RAPS inpatient records in the encounter data-based risk scores was a temporary approach to minimize the potential impact on risk scores of incomplete data for MA plans facing operational challenges submitting encounter data records. For CY 2022, we propose to stop supplementing encounter data-based scores with diagnoses from RAPS inpatient records for all risk scores: Part C non-ESRD, ESRD dialysis and functioning graft, and Part D.

Risk Score Calculation for PACE Organizations. For PACE organizations for CY 2022, we propose to continue to use the 2017 CMS-HCC model to calculate risk scores for non-ESRD

aged/disabled participants and the 2019 ESRD models to calculate risk scores for participants with ESRD. We propose to continue the same method of calculating risk scores under the CMS-HCC 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.

Identification (Filtering) of FFS Claims for Risk Adjustment Eligible Diagnoses. When CMS calculates the risk score of a full-risk beneficiary (i.e., a beneficiary who has 12 months of Part B in the year prior to the payment year), we use diagnoses from dates of service in the prior year, regardless of whether the beneficiary was enrolled in an MA plan or the Medicare FFS program. If a beneficiary was enrolled in FFS for part or all of the prior year, the risk score may include diagnoses from FFS claims. Historically, CMS identified risk adjustment eligible diagnoses on FFS claims using the specialty-based logic consistent with the filtering methodology MA organizations use to identify risk adjustment eligible diagnoses for RAPS submissions.[17] For CY 2022, CMS intends to identify diagnoses for risk score calculation from FFS claims using the HCPCS-based filtering logic that is used for identifying diagnoses from encounter data.[18] Please refer to the economic impact in Attachment V for information on the risk score impact of updating the way we identify diagnoses from FFS claims for risk score calculation. The models for Part C non-ESRD, ESRD, and Part D that are being proposed to calculate risk scores for CY 2022 are all based on the HCPCS-based filtering logic. Therefore, updating the identification of diagnoses from FFS claims using the same HCPCS-based logic aligns with how CMS identifies risk adjustment eligible diagnoses from encounter data submitted by MA organizations and with the way risk adjustment diagnoses were identified for model calibration. This update is consistent with the proposal to transition to encounter data-based risk scores using the 2020 CMS-HCC model covered in Part I of the CY 2022 Advance Notice.

Attachment III. Benefit Parameters for the Defined Standard Benefit and Changes in the Payment Methodology for Medicare Part D for CY 2022

Section A. RxHCC Risk Adjustment Model

For CY 2022, we are proposing to implement an updated version of the RxHCC risk adjustment model used to adjust direct subsidy payments for Part D benefits offered by stand-alone

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[17] The specialty-based filtering methodology is outlined in Chapter 7 – Risk Adjustment of the Medicare Managed Care Manual, which is available here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf.

[18] Final Encounter Data Diagnosis Filtering Logic HPMS memo, December 22, 2015, available at: https://www.csscoperations.com/internet/cssc3.nsf/files/Final%20Industry%20Memo%20Medicare%20Filtering%20Logic%2012%2022%2015.pdf/$FIle/Final%20Industry%20Memo%20Medicare%20Filtering%20Logic%2012%2022%2015.pdf.

Prescription Drug Plans (PDPs) and Medicare Advantage-Prescription Drug Plans (MA-PDs). The 2022 model will encompass the following changes:

- Incorporation of diagnoses identified using the same approach that is used to filter diagnoses from encounter data to calculate risk scores;
- Update to the data years used to calibrate the model; and
- Update to the catastrophic phase benefit parameter.

There are no changes to the RxHCCs in the model, or to the segments in the model.

A1. Recalibration

The RxHCC model used in CY 2020 and CY 2021 is calibrated on 2014 diagnoses using the specialty-based filtering logic that MA organizations and other organizations that submit risk adjustment data use to identify diagnoses for Risk Adjustment Processing System (RAPS) submissions, and 2015 expenditure data from the PDE Records. For CY 2022, we calibrated an RxHCC model using the same approach we use to filter diagnoses from encounter data records, including the risk adjustment allowable CPT/HCPCS codes.[19,20]

For CY 2022, CMS is proposing a model calibrated on 2017/2018 data in response to requests from stakeholders for an RxHCC model with more updated data. This model uses diagnosis data from 2017 FFS claims and MA-PD encounter data submissions, along with expenditure data from 2018 PDE records. CMS utilized fiscal year 2017 and 2018 ICD-10-to-RxHCC mappings for the model calibration. We used the same RxHCCs that are in the CY 2020 model. Beneficiaries in the 2017/2018 model sample had to be: (1) FFS or Medicare Advantage (MA-PD or MA-only) for all 12 months of the base year (2017); and (2) enrolled in a PDP or an MA-PD for at least one month in the prediction year (2018).

In addition, while updating the model for more recent data years, CMS also considered changes to the catastrophic threshold and how to account for those changes in the model. Therefore, the 2017/2018 model calibration includes a simulation of the threshold for the catastrophic coverage phase. A provision of the Affordable Care Act (ACA) temporarily reduced the rate at which annual increases were applied to the out-of-pocket threshold for the catastrophic coverage phase. As of 2020, the temporary reduction ended, so CMS resumed using the annual percentage increase (API) to calculate the annual increase in the Part D benefit parameters as if the

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[19] Final Encounter Data Diagnosis Filtering Logic HPMS Memo: https://www.csscoperations.com/internet/cssc3.nsf/files/Final%20Industry%20Memo%20Medicare%20Filtering%20Logic%2012%2022%2015.pdf/$FIle/Final%20Industry%20Memo%20Medicare%20Filtering%20Logic%2012%2022%2015.pdf.

[20] List of allowable CPT/HCPCS codes available at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/CPT-HCPCS.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending.

temporary reduction never applied, as required by statute. This simulation assumed that all prior increases were made using the API, instead of the ACA-imposed catastrophic threshold. Therefore, for the 2017/2018 model, CMS simulated the out-of-pocket threshold for 2018 as it would have been in the absence of the ACA requirement and used the simulated threshold in place of the actual threshold that applied in 2018 for the recalibration. This simulation approach ensures that the relative factors reflect the plan liability for the year being simulated.

The proposed model uses updated data years (2017 diagnoses and 2018 PDEs), and 2022 coverage gap parameters, which are the same as the 2021 and 2020 parameters (plan liability remains at 75% for generics and 5% for brands). The model incorporates a single diagnostic classification system (ICD-10) and uses the same clinical structure as the 2020 RxHCC model, which was used for CY 2020 and CY 2021. We imposed hierarchies on the condition categories, ensuring that more advanced and costly forms of a condition are reflected with a coefficient at least as high as related conditions with lower severity. The resulting dollar coefficients represent the marginal (additional) cost of the condition or demographic factor (for example, age/sex group, low-income subsidy status, and disability status).

In order to calculate risk scores for payment, the dollar coefficients must be denominated to create relative factors. To create the relative factors, we used a 2019 denominator. We divided the dollar coefficient for each demographic factor and RxHCC in the model by the average predicted per capita expenditure in 2019. The resulting relative factors for the model finalized for CY 2022 will be used to calculate risk scores for individual beneficiaries in the payment year. We developed the denominator for the recalibrated RxHCC risk adjustment model using data from Medicare beneficiaries enrolled in both MA-PDs and PDPs, which results in an average risk score of 1.0 for the enrolled Part D population in the denominator year. The denominator used to create relative factors for all segments of the 2017/2018 RxHCC model is $1,117.51. The segments in the RxHCC model are unchanged and continue to include separate segments based on low-income and aged (age 65 and older) or non-aged (age < 65) status.

When the RxHCC model is recalibrated, it can result in changes in condition category coefficients. Changes in the relative (denominated) factors can occur when the marginal cost attributable to an RxHCC changes differently than the average beneficiary cost. Recalibration of the RxHCC model can result in changes in risk scores for individual beneficiaries and for plan average risk scores, depending on each individual beneficiary's combination of diagnoses.

Updating a model denominator also serves a normalization function by setting the 1.0 risk score in a specific year. If the normalization factors have not accurately predicted the average risk scores between model updates, then updating the denominator will reset the average risk score to 1.0. Therefore, we believe updating the model is an important step to reflect more recent drug cost patterns, both overall and the relative costs of each condition in the model. The more years there are between model updates, the larger the potential increase in the denominator used to

adjust the coefficients can be, resulting in potentially more significant changes when the average risk score is reset to 1.0.

In Attachment VI of this Notice, we provide draft relative factors for the 2017/2018 calibration for each segment of the model.

For PACE organizations, CMS began using the 2020 RxHCC model, which is described in the CY 2020 Advance Notice,[21] to calculate Part D risk scores for beneficiaries for CY 2020, and will continue to use the 2020 RxHCC model for CY 2021. For CY 2022, CMS proposes to continue to use the 2020 RxHCC model to calculate Part D risk scores for PACE enrollees. Refer to Section B. for information on encounter data as a source of diagnoses for CY 2022 risk score calculation.

Section B. Source of Diagnoses for Part D Risk Score Calculation for CY 2022

Encounter Data as a Source of Diagnoses. For CY 2021, CMS will calculate risk scores using the 2020 RxHCC model by adding 75% of the risk score calculated with risk adjustment eligible diagnoses from encounter data (supplemented with RAPS inpatient records) and FFS claims with 25% of the risk score calculated using risk adjustment eligible diagnoses from RAPS data and FFS claims. For CY 2022, we propose to calculate the Part D risk score using risk adjustment eligible diagnoses entirely from encounter data and FFS claims.

For PACE organizations for CY 2022, we will continue using the 2020 RxHCC model to calculate Part D risk scores using the same method we have been using since CY 2015, which is to pool risk adjustment-eligible diagnoses from the following sources to calculate a single risk score (with no weighting): (1) encounter data, (2) RAPS data, and (3) FFS claims.

Diagnoses from RAPS Inpatient Data as a Source of Diagnoses for Encounter Data-Based Scores. As previously noted in Attachment II Section N, for CY 2022, we propose to stop the supplementation of encounter data-based scores with diagnoses from RAPS inpatient records for all risk scores, including: Part C non-ESRD, ESRD dialysis and functioning graft, and Part D.

For PACE organizations for CY 2021, we will use the 2020 RxHCC model to calculate Part D risk scores using the same method we have been using since CY 2015, which is to pool risk adjustment-eligible diagnoses from the following sources to calculate a single risk score (with no weighting): (1) encounter data, (2) RAPS data, and (3) FFS claims.[22] For CY 2022, we propose to continue calculating risk scores for PACE organizations using diagnoses from encounter data, RAPS data, and FFS claims, without weighting.

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[21] Refer to Attachment III Section A for information on the 2020 RxHCC model: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2020Part2.pdf.

[22] Policy finalized in the CY 2021 Rate Announcement: https://www.cms.gov/files/document/2021-announcement.pdf.

Identification (Filtering) of FFS Claims for Risk Adjustment Eligible Diagnoses. As noted in Attachment II Section N, for CY 2022, CMS intends to identify diagnoses for risk score calculation from FFS claims using HCPCS-based filtering logic, which would align the filtering of FFS claims with how CMS identifies risk adjustment eligible diagnoses from encounter data.

Section C. Annual Adjustments to Medicare Part D Benefit Parameters in 2022

C1. Updating the Medicare Part D Benefit Parameters

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) directs CMS to update the statutory parameters for the defined standard Part D drug benefit each year. These annual adjustments ensure that the actuarial value of the drug benefit remains consistent with changes in Part D drug expenses. These statutory parameters include the defined standard benefit deductible, initial coverage limit, out-of-pocket threshold, and maximum cost sharing for costs above the out-of-pocket threshold. In addition, CMS is required by statute to update the parameters for the low-income subsidy (LIS) benefit. Section C of Attachment III provides the methodologies used to update these statutory parameters for CY 2022.

Note: CMS has customarily released the estimated percentage increases in these statutory parameters along with the associated methodologies in the Advance Notice. Since we are releasing this CY 2022 Advance Notice early, and we do not yet have the data necessary to provide reliable estimates of the Part D parameters at this time, we are including only the methodologies that will be used to update these statutory parameters and not the updated estimates for the various parameters. The actual required statutory updates to the parameters for CY 2022 will be provided in the CY 2022 Rate Announcement, but at the same or earlier time than in years past. We have included placeholder columns and values for the CY 2022 updates in the tables throughout the Attachment.

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

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

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 defined standard Part D prescription drug benefit parameters are updated using the API: deductible; initial coverage limit; out-of-pocket threshold; and maximum cost sharing for costs above the annual out-of-pocket (OOP) threshold. The following LIS cost-sharing parameters are also updated using the API: maximum copayments below the out-of-pocket threshold for certain low-income full subsidy eligible enrollees; the deductible for partial LIS-eligible enrollees; and maximum copayments above the out-of-pocket threshold for partial LIS-eligible enrollees.

The CY 2021 annual percentage trend in the API can be found in Table III-1 below. The percent increase in the benefit parameters indexed to the API for CY 2022 will be provided in the CY 2022 Rate Announcement. This increase will reflect the CY 2021 annual percentage trend in the API as well as a multiplicative update for prior year revisions. See Section C2 for additional information on the calculation of the API.

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

Section 1860D-14(a)(4) of the Act requires CMS to use the annual percentage increase in the CPI for the 12-month period ending in September 2021 to update the maximum copayments up to the out-of-pocket threshold for full benefit dual eligible enrollees with incomes not exceeding 100 percent of the FPL for CY 2022. CMS uses an estimate of the September 2021 CPI based on projections from the President's FY2022 Budget for this purpose.

The CY 2021 annual percentage trend in the CPI can be found in Table III-1 below. The percent increase in the maximum copayments indexed to the CPI for CY 2022 will be released in the CY 2022 Rate Announcement. The CY 2022 increase will reflect the CY 2021 annual percentage trend in the CPI as well as a multiplicative update for prior year revisions.

See Section C2 for additional information on the calculation of the annual percentage increase in the CPI.

Table III-1. Updated API and CPI for 2022

	Annual percentage trend for 2021	Prior year revisions	API for 2022
API	2.85%	TBD (1)	TBD
September CPI (all items, U.S. city average)	1.88%	TBD	TBD

(1) TBD = "to be determined"; values will be released in the CY 2022 Rate Announcement.

For ease of reference, we provide Table III-2 below which summarizes the Part D benefit parameters along with the cost threshold and cost limit of the Retiree Drug Subsidy program (discussed in more detail in Section H) that are required by statute to be updated with either the API or CPI each year. Table III-2 also includes estimates of the total gross covered prescription drug costs at the OOP threshold for both applicable and non-applicable beneficiaries (discussed further in subsection "Determining Total Gross Covered Drugs Costs at Out-of-Pocket Threshold" of Section C3). Table III-2 reflects only the CY 2021 values for the Part D benefit parameters that are required by statute to be updated each year. The CY 2022 values updated using either the CY 2022 API or CPI will be provided in the CY 2022 Rate Announcement. For completeness, we also provide in Table III-2 the Part D benefit parameters that remain constant from year-to-year.

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

	2021	2022
Standard Benefit		
Deductible	$445	TBD (1)
Initial Coverage Limit	$4,130	TBD
Out-of-Pocket Threshold	$6,550	TBD
Total Covered Part D Spending at Out-of-Pocket Threshold for Non-Applicable Beneficiaries (2)	$9,313.75	TBD
Estimated Total Covered Part D Spending for Applicable Beneficiaries (3)	$10,048.39	TBD
Minimum Cost-Sharing in Catastrophic Coverage Portion of the Benefit		
Generic/Preferred Multi-Source Drug	$3.70	TBD
Other	$9.20	TBD
Full Subsidy-Full Benefit Dual Eligible (FBDE) Individuals (4)		
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] (5)	$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 (6)	$1.30	TBD

	2021	2022
Other (6)	$4.00	TBD
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	TBD
Other	$9.20	TBD
Above Out-of-Pocket Threshold	$0.00	$0.00
Full Subsidy-Non-FBDE Individuals (4)		
Applied or eligible for QMB/SLMB/QI or SSI, income at or below 135% FPL and resources ≤ $9,360 (individuals, 2020) or ≤ $14,800 (couples, 2020) [category code 1] (7)		
Deductible	$0.00	$0.00
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.70	TBD
Other	$9.20	TBD
Maximum Copayments above Out-of-Pocket Threshold	$0.00	$0.00
Partial Subsidy (4)		
Applied and income below 150% FPL and resources below $14,160 (individual, 2020) or $29,160 (couples, 2020) [category code 4] (6)		
Deductible (6)	$92.00	TBD
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.70	TBD
Other	$9.20	TBD
Retiree Drug Subsidy Amounts		
Cost Threshold	$445	TBD
Cost Limit	$9,200	TBD

(1) TBD = "to be determined"; values will be provided in the CY 2022 Rate Announcement.

(2) 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.

(3) 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.

(4) 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

(5) 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.

(6) 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.

(7) These resource limit figures will be updated for CY 2022. Additionally, these amounts include $1,500 per person for burial expenses.

C2. Calculation methodologies for the Annual Percentage Increase (API) and Consumer Price Index (CPI)

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

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 CY 2022 benefit parameters that will be released in the 2022 Rate Announcement, Part D program data will be used to calculate the annual percentage trend as follows:

$$\frac{August\ 2020 – July\ 2021}{August\ 2019 – July\ 2020}$$

In the formula, the average per capita cost for August 2019 – July 2020 is calculated from actual Part D PDE data, and the average per capita cost for August 2020 – July 2021 is calculated based on actual Part D PDE data for prescription drug claims with service dates from August 2020 – December 2020 and projected through July 2021.

The CY 2022 benefit parameters will reflect the CY 2021 annual percentage trend, as well as an update for revision to prior year estimates for the API. The annual percentage increases based on updated NHE prescription drug per capita costs and PDE data will be provided in the CY 2022 Rate Announcement (see Table III-3 below).

Table III-3. Revised Prior Years' Annual Percentage Increases

Year	Prior Estimates of Annual Percentage Increases	Revised Annual Percentage Increases
2007	7.30%	TBD (1)
2008	5.92%	TBD
2009	4.69%	TBD
2010	3.14%	TBD
2011	2.36%	TBD
2012	2.15%	TBD
2013	2.53%	TBD
2014	-3.14%	TBD
2015	10.12%	TBD
2016	9.90%	TBD
2017	3.99%	TBD
2018	1.89%	TBD
2019	4.08%	TBD
2020	4.94%	TBD
2021	2.85%	

(1) TBD = "to be determined"; values will be provided in the CY 2022 Rate Announcement.

Accordingly, the CY 2022 benefit parameters will reflect a multiplicative update for prior year revisions. The CY 2021 annual percentage trend in the API can be found in Table III-4. The CY 2022 API will be released in the CY 2022 Rate Announcement.

Table III-4. Annual Percentage Increase

Annual percentage trend for July 2021	2.85%
Prior year revisions	TBD (1)
Annual percentage increase for 2022	TBD

(1) TBD = "to be determined"; values will be provided in the CY 2022 Rate Announcement.
Note: Percentages are multiplicative, not additive. Values are carried to additional decimal places and may not agree to the rounded values presented above.

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

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 FY2022 Budget.

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

$$\frac{\text{Projected September 2021 CPI}}{\text{Actual September 2020 CPI}}$$

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

The CY 2022 benefit parameters will reflect the CY 2021 annual percentage trend in the September CPI, as well as a revision to the prior estimate for the 2020 CPI increase over the 12-month period ending in September 2020. The previously estimated September 2020 CPI increase will be updated based on the actual reported CPI for September 2020. Accordingly, the CY 2022 update will reflect a percentage multiplicative correction for the revision to last year's estimate. The CY 2022 percentage increase in the CPI will be reported in the CY 2022 Rate Announcement. The CY 2021 annual percentage trend in the CPI can be found in Table III-5 below.

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

Annual percentage trend for September 2021	1.88%
Prior year revisions	TBD (1)
Annual percentage increase for 2022	TBD

(1) TBD = "to be determined"; values will be provided in the CY 2022 Rate Announcement.
Note: Percentages are multiplicative, not additive. Values are carried to additional decimal places and may not agree to the rounded values presented above.

C3. Annual Adjustments for Part D Benefit Parameters in 2022

Defined Standard Part D Prescription Drug Benefit Parameters

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

As described in section 1860D-2(b) of the Act and § 423.104(d), the defined standard Part D prescription drug benefit is composed of the four sequential coverage phases: deductible, initial coverage phase, coverage gap, and catastrophic coverage. Progression through the first two coverage phases is based on total gross covered prescription drug costs, as defined in § 423.308, which refers to spending on covered Part D drugs by beneficiaries or on their behalf by any third party as well as the Part D sponsor. Therefore, once total gross covered prescription drug costs for a beneficiary reach the deductible amount under the defined standard benefit, the beneficiary

transitions into the initial coverage phase. Similarly, when total gross covered prescription drug costs for a beneficiary reach the initial coverage limit, the beneficiary transitions into the coverage gap.

In contrast, progression through the coverage gap is determined by accumulated True Out-of-Pocket (TrOOP) spending. TrOOP is spending on covered Part D drugs by the beneficiary or on his/her behalf by certain third parties (*see* sections 1860D-2(b)(4)(C)(iii) and (E) of the Act and the definition of incurred costs in § 423.100). Once accumulated TrOOP for a beneficiary reaches the OOP threshold, the beneficiary enters the catastrophic coverage phase.

Cost-sharing for beneficiaries varies by coverage phase, by LIS status, and whether the drug is applicable or non-applicable.[23] See Table III-6 below for non-LIS beneficiary cost-sharing, the next section for discussion of cost-sharing requirements for LIS beneficiaries, and Section E for additional information on cost-sharing in the coverage gap for applicable and non-applicable drugs.

We note that the term applicable beneficiary, as defined in 1860D-14A(g)(1) and § 423.100, refers to a non-LIS beneficiary enrolled in a stand-alone prescription drug plan or Medicare Advantage prescription drug plan and who is not enrolled in a retiree prescription drug plan. Therefore, an LIS beneficiary is a non-applicable beneficiary. We use the phrase, "non-LIS beneficiary," throughout the rest of Attachment III interchangeably with "applicable beneficiary."

For CY 2022, the defined standard benefit deductible amount, initial coverage limit, out-of-pocket threshold, and minimum cost-sharing after the out-of-pocket threshold (i.e., in the catastrophic phase) are updated by multiplying the CY 2021 amounts by the CY 2022 API and rounding as specified by the statute:

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.

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[23] An applicable drug is defined in section 1860D-14A(g)(2) of the Act and § 423.100 as a covered Part D drug that is either approved under a new drug application (NDA) under section 505(c) of the Federal Food, Drug, and Cosmetic Act or licensed under section 351 of the Public Health Service Act (PHSA), including biosimilar or interchangeable biological products licensed under section 351(k) of the PHSA. Non-applicable drugs are covered Part D drugs that do not meet the definition of an applicable drug, such as generic drugs.

Table III-6 below summarizes the defined standard benefit parameters and provides the CY 2021 parameter values. The updated parameter values for CY 2022 obtained by applying the 2022 API and rounding to a specified amount will be released in the CY 2022 Rate Announcement.

Table III-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: TBD (1)	
Initial Coverage Phase	Cost-sharing: 25%		Cost-sharing: 25%	
	Initial Coverage Limit: $4,130		Initial Coverage Limit: TBD	
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: TBD	
Catastrophic Coverage	Cost-sharing: Greater of 5% or $3.70 (Generic/Preferred Multi-Source Drug) / $9.20 (Other)		Cost-sharing: Greater of 5% or TBD (Generic/Preferred Multi-Source Drug) / TBD (Other)	

(1) TBD = "to be determined"; values will be provided in the CY 2022 Rate Announcement.

(2) 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.

Annual Adjustments for Low-income Subsidy (LIS) Beneficiary Cost-sharing Parameters

The low-income subsidy benefit provides Part D cost-sharing assistance to certain low-income Medicare Part D beneficiaries across the same coverage phases described above. Medicare Part D beneficiaries who are eligible for full Medicaid benefits (full benefit dual eligible (FBDE) individuals, as defined in § 423.772), recipients of Supplemental Security Income (SSI) benefits (*see* § 423.773(c)(1)(ii)), or eligible for the Medicare Savings Program as a Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), or Qualifying Individual under a State's Medicaid plan (*see* § 423.773(c)(1)(iii)) are deemed automatically eligible for the full subsidy and do not have to separately apply for the LIS. Other Medicare Part D beneficiaries must apply for the LIS and may receive the partial or full subsidy if they meet certain income and asset requirements, as described in § 423.773(b) and (d).

The cost-sharing benefits for LIS beneficiaries are described in § 423.782(a) and (b). Full subsidy FBDE individuals who are institutionalized or receiving certain home and community-based services, as defined in § 423.772, have a $0 deductible and $0 copayments for all covered Part D drugs, regardless of the defined standard benefit phase. Other full subsidy (both FBDE and non-FBDE) individuals also have a $0 deductible but pay nominal copayments for all covered Part D drugs below the OOP threshold as described in § 423.782(a). Copayments for these other full subsidy individuals are reduced to $0 for all covered Part D drugs above the out-of-pocket threshold. In accordance with § 423.782(b), partial subsidy individuals receive the following cost-sharing benefits: reduced deductible, 15% coinsurance below the out-of-pocket threshold, and nominal copays above the out-of-pocket threshold. The following LIS cost-sharing parameters are updated each year by multiplying the prior year's value by the API and rounding as specified by the statute:

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[24] 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.

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.[25]

Please see Table III-7 below for complete information on the different LIS benefit categories and cost-sharing parameters for CY 2021. The LIS cost-sharing parameters updated for CY 2022 by either using the 2022 API or CPI will be released in the CY 2022 Rate Announcement.

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[24] 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 $447.40.

[25] Per section 1860D-14(a)(4)(A) of the Act, the copayments are increased from the unrounded 2021 values of $3.70 for multi-source generic or preferred drugs, and $9.21 for all other drugs.

Table III-7. Updated Part D Low-income Cost-Sharing Parameters for 2022

	2021	2022
Full Subsidy-Full Benefit Dual Eligible (FBDE) Individuals (1)		
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] (2)	$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 (3)	$1.30	TBD (4)
Other (3)	$4.00	TBD
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	TBD
Other	$9.20	TBD
Above Out-of-Pocket Threshold	$0.00	$0.00
Full Subsidy-Non-FBDE Individuals (1)		
Applied or eligible for QMB/SLMB/QI or SSI, income at or below 135% FPL and resources ≤ $9,360 (individuals, 2020) or ≤ $14,800 (couples, 2020) [category code 1] (5)		
Deductible	$0.00	$0.00
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.70	TBD
Other	$9.20	TBD
Maximum Copayments above Out-of-Pocket Threshold	$0.00	$0.00
Partial Subsidy (1)		
Applied and income below 150% FPL and resources below $14,160 (individual, 2020) or $29,160 (couples, 2020) [category code 4] (5)		
Deductible (3)	$92.00	TBD
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.70	TBD
Other	$9.20	TBD

(1) 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

(2) 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.

(3) 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.

(4) TBD = "to be determined"; values will be provided in the CY 2022 Rate Announcement.

(5) These resource limit figures will be updated for contract year 2022. Additionally, these amounts include $1,500 per person for burial expenses.

Determining Total Gross Covered Drugs Costs at Out-of-Pocket Threshold

As noted above, while the deductible and ICL thresholds are determined based on total gross covered prescription drug costs, as defined at 42 CFR § 423.308, the OOP threshold is determined based on TrOOP. Each year, for informational purposes, CMS calculates an estimate of the total gross covered prescription drug costs (also referred to as total covered Part D spending elsewhere) at the OOP threshold. This amount reflects the estimated total drug spending, regardless of payer, that is projected to occur when a beneficiary reaches the OOP threshold under the defined standard benefit.

Total gross covered prescription drug costs at the OOP threshold differs for LIS and non-LIS beneficiaries due to differences in beneficiary cost-sharing for drugs in the coverage gap phase for the two types of beneficiaries (*see* sections 1860D-2(b)(2)(C) and (D) of the Act and § 423.104(d)(4)). For LIS beneficiaries, the calculation of total gross covered prescription drug costs reflects 100 percent cost-sharing in the coverage gap for all covered Part D drugs. For non-LIS beneficiaries, the calculation of total gross covered prescription drug costs reflects 25 percent cost-sharing, after the application of the 70 percent discount from the Medicare Coverage Gap Discount Program on ingredient costs, for applicable drugs, and reflects 25 percent cost-sharing for non-applicable drugs. This difference in cost-sharing between LIS beneficiaries and non-LIS beneficiaries in the coverage gap generally leads to TrOOP accumulating more quickly for LIS beneficiaries compared to non-LIS beneficiaries. Therefore, non-LIS beneficiaries can be generally expected to have higher total gross covered drug costs at the out-of-pocket threshold than LIS beneficiaries.

In addition, we note that the total gross covered prescription drug cost estimate at the OOP threshold will vary across both LIS and non-LIS beneficiaries because of other types of additional drug coverage that beneficiaries may have through third party arrangements. The following third party arrangements contribute to both TrOOP and the total gross covered prescription drug cost estimate (*see* sections 1860D-2(b)(4)(C)(iii) and (E) of the Act and the definition of incurred costs in § 423.100): 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. 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. Therefore, if the beneficiary has additional prescription drug coverage through third party arrangements that do not count toward TrOOP, the total gross covered prescription drug cost estimate at the OOP threshold would generally be higher.

CMS is providing the two 2021 values of total gross covered prescription drug costs at the OOP threshold for applicable and non-applicable beneficiaries that take into account additional drug coverage in Table III-8 below. The updated 2022 total gross covered prescription drug cost estimates at the OOP threshold for applicable and non-applicable beneficiaries will be released in the CY 2022 Rate Announcement.

Table III-8. 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	TBD (2)
Estimated Total Gross Covered Drug Costs for Applicable Beneficiaries (3)	$10,048.39	TBD

(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) TBD = "to be determined"; values will be provided in the CY 2022 Rate Announcement.

(3) 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.

Calculation Methodology for Estimated Total Gross Covered Drug Costs at Out-of-Pocket Threshold for Applicable Beneficiaries

For CY 2022, the estimated total gross covered prescription drug costs at the out-of-pocket threshold for applicable beneficiaries will be 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—consisting of 25 percent beneficiary coinsurance and 70 percent Medicare Coverage Gap Discount Program discount.
- 25 percent cost-sharing for the dispensing and vaccine administration fees for applicable drugs purchased in the coverage gap phase of the benefit.

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

The CY 2021 calculation of the estimated total gross covered prescription drug costs at out-of-pocket (OOP) threshold for applicable beneficiaries follows. The CY 2021 calculation is provided as an illustrative example because the defined standard Part D benefit parameters for CY 2022 will not be updated until the Rate Announcement. The CY 2022 calculation will be in the Rate Announcement with the updated defined standard Part D benefit parameters for CY 2022.

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

- *ICL* is the Initial Coverage Limit equal to $4,130.
- *100 percent beneficiary cost-sharing in the gap* is the estimated total drug spending in the gap assuming 100 percent coinsurance and is equivalent to:

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

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

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

  or

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

  - *Brand GDCB % for non-LIS* is the percentage of gross covered drug costs below the OOP threshold for applicable beneficiaries (i.e., non-LIS) attributable to applicable drugs, as reported on the 2019 PDEs.
  - *Gap cost-sharing for applicable drugs* is the coinsurance incurred by applicable beneficiaries (i.e., non-LIS) for applicable drugs in the coverage gap, where:

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

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

    or

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

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

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

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

The law required a phased reduction in applicable beneficiary cost-sharing for drugs in the coverage gap phase of the Medicare Part D benefit which, prior to CY 2011, was set at 100 percent. This gradual reduction in cost-sharing began in 2011 and continued through CY 2019 for applicable drugs and through CY 2020 for non-applicable drugs, ultimately resulting in 25 percent cost-sharing for applicable drugs, after the application of the 70 percent manufacturer discount required by statute, and 25 percent cost-sharing for other, non-applicable Part D covered drugs. As a result, from CY 2020 onward, after applying the 70 percent manufacturer discount, the beneficiary coinsurance for non-LIS beneficiaries under basic prescription drug coverage is 25 percent for applicable covered Part D drugs purchased during the coverage gap phase of the Part D benefit.

The reductions in cost-sharing, in conjunction with the Medicare Coverage Gap Discount Program, effectively served to close the Medicare Part D coverage gap for applicable (i.e., non-LIS) beneficiaries by extending the 25 percent coinsurance for non-LIS beneficiaries from the initial coverage phase into the coverage gap phase for both applicable and non-applicable drugs. For a detailed description of how cost-sharing was gradually reduced year-by-year during the CY 2011 to CY 2020 time period, see Tables III-2 and III-3 of the Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies – Part II.[26]

[26] https://www.cms.gov/files/document/2021-advance-notice-part-ii.pdf

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

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

In CY 2022, applicable beneficiaries will pay 25 percent and plans will pay 75 percent of dispensing fees and vaccine administration fees for applicable drugs in the coverage gap.

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

CMS makes prospective reinsurance payments to all Part D Calendar Year EGWP sponsors based on the average per member-per month (PMPM) actual (final) reinsurance amounts paid to Part D Calendar Year EGWP sponsors for the most recently reconciled payment year, which for CY 2022 is CY 2019. The average PMPM actual reinsurance amount paid to Part D Calendar Year EGWPs for CY 2019 was $65.68.

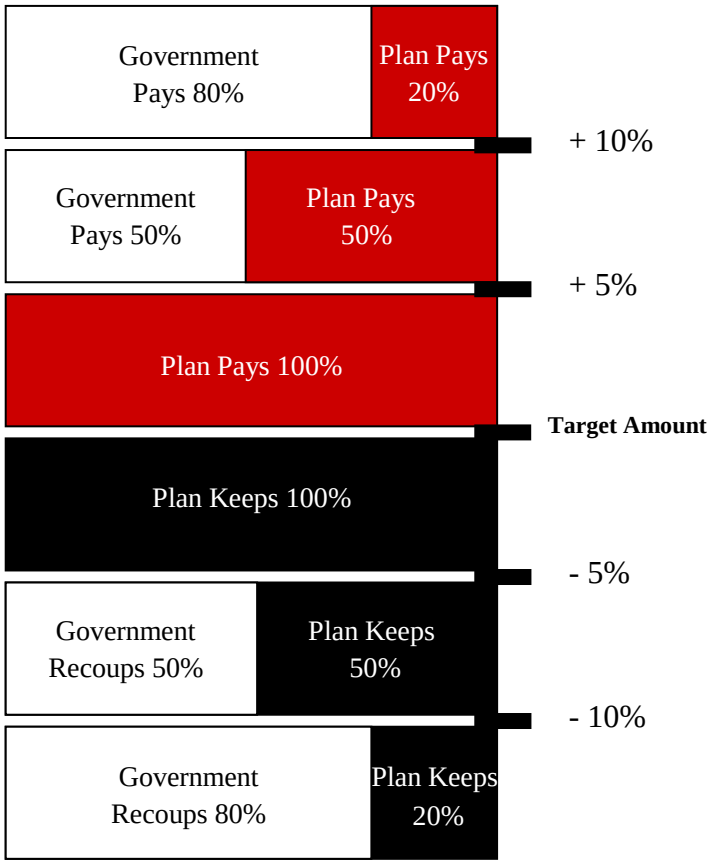
Section G. Part D Risk Sharing

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

CMS has evaluated the risk sharing amounts for CYs 2008–2018 to assess whether they have decreased or stabilized. A steady decline or stabilization in the Part D risk sharing amounts would suggest that Part D sponsors have significantly improved their ability to predict Part D expenditures. However, CMS has found that risk sharing amounts continue to vary significantly in aggregate from year to year and among Part D sponsors in any given year. Therefore, we do not believe it is appropriate to adjust the parameters at this time, and we will apply no changes to the current threshold risk percentages for CY 2022. We will continue to evaluate the risk sharing amounts each year to determine if wider corridors should be applied for Part D risk sharing.

Thus, the risk percentages and payment adjustments for Part D risk sharing are unchanged from CY 2022. The risk percentages for the first and second thresholds remain at +/- 5 percent and +/- 10 percent of the target amount, respectively, for CY 2022. The payment adjustments for the first and second corridors are 50 percent and 80 percent, respectively. Figure III-1 below illustrates the risk corridors for 2022.

Figure III-1. Part D Risk Corridors for 2022



G1. Risk sharing when a plan's adjusted allowable risk corridor costs (AARCC) exceed the target amount

For the portion of a plan's adjusted allowable risk corridor costs (AARCC[27]) that is between the target amount and the first threshold upper limit (105 percent of the target amount), the Part D sponsor pays 100 percent of this amount. For the portion of the plan's AARCC that is between the first threshold upper limit and the second threshold upper limit (110 percent of the target amount), the government pays 50 percent and the plan pays 50 percent. For the portion of the

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

plan's AARCC that exceeds the second threshold upper limit, the government pays 80 percent and the plan pays 20 percent.

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

100% of ($105 − $100) + 50% of ($110 − $105) + 20% of ($120 − $110).

G2. Risk sharing when a plan's adjusted allowable risk corridor costs (AARCC) are below the target amount

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

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

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

Section H. Retiree Drug Subsidy Amounts

Per § 423.886(b)(3), the cost threshold and cost limit for qualified retiree prescription drug plans are 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 CY 2020, and as $445 and $9,200 for plans that end in CY 2021, as noted in Table III-9. The cost threshold and the cost limit for CY 2022 will be released in the CY 2022 Rate Announcement.

Table III-9. Updated Retiree Drug Subsidy Amounts in 2022

	2021	2022
Retiree Drug Subsidy Amounts		
Cost Threshold	$445	TBD (1)
Cost Limit	$9,200	TBD

(1) TBD = "to be determined"; values will be provided in the CY 2022 Rate Announcement.

Attachment IV. 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 will be 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) for COVID-19 (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 are providing information and updates in accordance with §§ 422.164, 422.166, 423.184, and 423.186. In addition, we are soliciting input on future measures and concepts as we continue to enhance the Star Ratings over time.

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 any 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. 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 IV-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 IV-1: 2022 Star Ratings Improvement Measures

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 – Functional Status Assessment	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
C	Medication Reconciliation Post-Discharge	Process Measure	1	Yes	Yes

Part C or D	Measure	Measure Type	Weight	Improvement Measure	Included in the 2022 CAI Values
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

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 will be 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 will be posted with the 2022 CAI values at https://go.cms.gov/partcanddstarratings by late November 2020.

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 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 non-CAHPS 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).

The Secretary of Health and Human Services determined that a PHE exists and has existed since January 27, 2020, nationwide. Table IV-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 IV-2: List of Section 1135 Waivers Issued in Relation to the FEMA Major Disaster Declarations

Section 1135 Waiver Date Issued	Waiver or Modification of Requirements Under Section 1135 of the Social Security Act	FEMA 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

Table IV-3 lists the states and territories with Individual Assistance designations from the nationwide FEMA major disaster declarations as a result of COVID-19 outbreaks as of October 19, 2020. Table IV-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.

Table IV-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

FEMA Declaration	State
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 IV-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	Lake, Monterey, Napa, San Mateo, Santa Cruz, Solano, Sonoma, Yola
DR-4559	Louisiana	Acadia, Allen, Beauregard, Calcasieu, Cameron, Grant, Jackson, Jefferson, Davis, Lincoln, Natchitoches, Ouachita, Rapides, Sabine, 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 the Medicare Plan Finder (MPF) Price Accuracy measure was re-specified and will be transitioned off the display page and into the 2022 Star Ratings as a new measure. CMS will continue weighting it as a process measure with a weight of 1. *See* 84 FR

15762–63.

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.

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.

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 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 per the 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, CMS plans to implement the updated measure specifications for the 2021 measurement year (2023 Star Ratings).

Table IV-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 IV-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%

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).

Kidney Health Evaluation for Patients With Diabetes (Part C). The 21st Century Cures Act (CURES; P.L. 114-255) allows beneficiaries with End-Stage Renal Disease (ESRD) the option to start enrolling in MA plans in 2021. 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.

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 replaces 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.

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.

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 national drug codes (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 plans to implement the updated measure specifications for the 2021 measurement period for the 2023 display measures.

Table IV-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 IV-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%

Potential New Measure Concepts for Future Years

Provider Directory Accuracy (Part C). We are soliciting 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 welcome feedback on the utility of such a measure, given other requirements for application programming interfaces (APIs), and what it could look like.

COVID-19 Vaccination (Part C). We are soliciting comments on a potential new measure concept related to the COVID-19 vaccination for the 2023 Part C & D performance measure display page published in Fall 2022 on CMS.gov and for potential inclusion in the Star Ratings program, pending rulemaking. As work continues to develop a vaccine for COVID-19, we plan to concurrently develop and test question(s) to add to the CAHPS survey administered in early 2022, similar to the flu vaccine. Such question(s) may ascertain whether a beneficiary received the COVID-19 vaccine during a specified timeframe (e.g., in 2021) to therefore measure the percent of beneficiaries who received the COVID-19 vaccine. Health plans play an important role to help educate and encourage their members to get the COVID-19 vaccine. We welcome feedback on the utility of such a measure and any considerations in its development including any potential exclusions.

Attachment V. Economic Information for Part II of the CY 2022 Advance Notice

Below, we provide the economic information for significant provisions in Advance Notice Part II. Provisions not specifically addressed below are intended to represent a continuation of the policies established for CY 2021 and, as a result, do not have an impact associated with them. We note that the information provided below is likely to change as the rates and underlying assumptions are updated; we will provide revised impact estimates in the Rate Announcement that reflect the payment methodologies being finalized and the latest data available.

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

A1. Medicare Advantage and PACE non-ESRD Ratebook

The FFS growth percentage for the 2022 MA non-ESRD rates is estimated to be 4.52 percent, and the MA growth percentage for the 2022 non-ESRD rates is estimated to be 4.82 percent. As a result, the effective growth rate for 2022 MA non-ESRD rates is estimated to be 4.55 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 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 $12.9 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 4.82 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 $80 million. This figure accounts for the portion of the program costs covered by Part B premiums.

If we continue the adjustment to the calculation of county benchmarks in Puerto Rico for the number of beneficiaries with zero claims, then 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 will be published with the CY 2022 Rate Announcement. For information on the impact of the FFS cost of kidney acquisitions 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 the 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.

A2. 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.

A3. Medicare Advantage and PACE ESRD Ratebooks

The FFS growth percentage for the 2022 ESRD state rates is estimated to be 1.77 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 $310 million. This figure accounts for the portion of the program costs covered by Part B premiums.

A4. CMS-HCC Risk Adjustment

Identification (Filtering) of FFS Claims for Risk Adjustment Eligible Diagnoses. The estimated impact, on average, of identifying diagnoses for risk score calculation from FFS claims using HCPCS-based filtering logic is -0.08%, which represents $200 million dollars in net savings.

A5. ESRD Risk Adjustment

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 proposing 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% for ESRD (dialysis and functioning graft combined), which represents a $60 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%. 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%. Since the relative impact was 0.00% beginning in CY 2021 and CMS is proposing to calculate 100% of risk scores based on 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%. The contribution of RAPS inpatient diagnosis supplementation to encounter data-based ESRD risk scores has been getting smaller over time and we anticipate that by CY 2022, the contribution will be 0.00%. Thus, there is no 2022 cost impact of ending RAPS inpatient supplementation. 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%, which represents $30 million dollars in net savings.

A6. Frailty Adjustment for FIDE SNPs

For CY 2022, CMS is proposing to calculate frailty scores for FIDE SNPs using updated frailty factors and the 2020 CMS-HCC model. For CY 2021, CMS will calculate 75% of the frailty score using the frailty factors associated with the 2020 CMS-HCC risk adjustment model and

25% of the frailty score using the frailty factors associated with the 2017 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% 2020 CMS-HCC model and 25% 2017 CMS-HCC model) and the proposed CY 2022 frailty factors (100% 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%, 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 proposing 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 serve to maintain a 1.0 average FFS 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, CMS is proposing to apply the same methodology to calculate the normalization factors that was applied in CY 2021. To determine the CY 2022 normalization factors, we applied the CY 2021 methodology to the most current underlying data available, resulting in updated normalization factors. Since normalization is applied to risk scores to maintain the same average risk scores in each program year-over-year, and there are no changes in the methodology being applied for CY 2022 from the prior year, the impact of normalization is zero.

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

B1. Part D Risk Adjustment Model

For CY 2022, we are proposing to implement an updated version of the RxHCC risk adjustment model and updates to the sources of diagnoses that will be used to calculate Part D risk scores. For CY 2021, CMS will continue to use the CY 2020 model to calculate risk scores. For CY 2022, CMS is providing for comment a model calibrated using 2017/2018 data, as described in Attachment III Section A. 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, and the application of the normalization factor functions to maintain the 1.0 in the payment year. 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.

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 VI. RxHCC Risk Adjustment Factors

Table VI-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 VI-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 VI-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 VI-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 VI-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.