

September 14, 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 I, CMS-HCC Risk Adjustment Model

Medicare Advantage (MA) has been successful in providing Medicare beneficiaries with health care options that best fit their individual health needs. The MA program demonstrates bringing the value of private sector innovation and creativity to a government program, and CMS is committed to continuing to strengthen MA by promoting greater innovation, transparency, flexibility, and program simplification.

A key element in the success of MA is ensuring that payments to plans reflect the relative risk of the people who enroll. A critical tool that CMS uses to accomplish that goal is the risk adjustment models that adjust payments based on the characteristics and health conditions of each plan's enrollees.

As amended by the 21st Century Cures Act, section 1853(a)(1)(I)(iii) of the Social Security Act (the Act) requires that CMS provide an opportunity for review of the proposed changes and a public comment period of at least 60 days for proposed changes under section 1853(a)(1)(I) to the Part C risk adjustment model. Therefore, we are providing notice and a comment period for these proposed changes in the MA risk adjustment methodology applied under Part C for CY 2022 in accordance with sections 1853(a)(1)(I)(iii) and 1853(b)(2) of the Act, as amended by section 17006 of the 21st Century Cures Act.

For CY 2022, we are proposing to fully transition to the risk adjustment model first adopted in the CY 2020 Rate Announcement that incorporates important changes to the Part C risk adjustment model in accordance with sections 1853(a)(1)(C) and 1853(a)(1)(I) of the Act. This proposal reflects the statutory requirement to phase in changes to the risk adjustment model under section 1853(a)(1)(I) over a three-year period, beginning with 2019, with such changes being fully implemented for 2022 and subsequent years.

Pursuant to section 1853(b)(2) of the Act, we will provide notice of planned changes to the MA capitation rate methodology and other risk adjustment methodologies applied under the Act for CY 2022, along with annual adjustments to the Medicare Part D benefit parameters for the defined standard benefit, in Part II of the Advance Notice of Methodological Changes for CY 2022 MA Capitation Rates and Part C and Part D Payment Policies (Advance Notice). The statute requires that CMS publish Part II of the Advance Notice no fewer than 60 days before the publication of the Rate Announcement and establishes a minimum 30-day period for the public to comment on the proposals in the Advance Notice.

For CY 2022, CMS will announce the MA capitation rates and final payment policies no later than Monday, April 5, 2021, in accordance with the timetable established in section 1853(b)(2), as amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) and the Securing Fairness in Regulatory Timing Act of 2015

(SFRTA) (Pub. L. 114-106).

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. Submitters should not include any confidential or personal information in their comments. 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 must be received by 6:00 PM Eastern Time on Friday, November 13, 2020.

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Demetrios Kouzoukas Principal Deputy Administrator
and Director, Center for Medicare

Introduction: Notice of a Potential Change in the Schedule for Publication of the Rate Announcement for CY 2022

We are issuing Part I of the 2022 Advance Notice on September 14, 2020, earlier than in past practice, in order to accommodate a potential early publication of the CY 2022 Rate Announcement. We are considering publishing Part II of the Advance Notice in the Fall of 2020 and the Rate Announcement mid-January, 2021, about three 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 include this information in this 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 in January 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 are publishing Part I of the Advance Notice in September and, at this time, we intend to publish Part II in the Fall of 2020. We believe that MA organizations and Part D sponsors (including PACE organizations) could potentially benefit from having information about capitation rates, risk adjustment factors, methodologies, benefit parameters, and assumptions earlier in the year so that they have 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.

This accelerated schedule does not result in changes to the data or assumptions we would typically rely on for the calculations and methodologies presented in Part I of the CY 2022 Advance Notice. The same is not true for the policies covered in Part II of the Advance Notice; should we publish Part II early, we will discuss in Part II where the schedule change might affect our Part II calculations and methodologies. 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 February timeframe for publishing Part II of the CY 2022 Advance Notice and/or the typical April timeframe for publishing the CY 2022 Rate Announcement. In addition, 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. These decisions will depend on the progress we make with regard to our internal rate

development efforts, and when determining the timing of the Rate Announcement, we will also take into account stakeholder feedback.

Summary of Proposal for CY 2022

For CY 2022, CMS is proposing to fully phase in the CMS-Hierarchical Condition Categories (HCC) model first implemented for CY 2020 (i.e., the 2020 CMS-HCC model), which meets 21st Century Cures Act (Cures Act) requirements under section 1853(a)(1)(I). CMS uses this model to calculate encounter data-based risk scores. For MA organizations, including certain demonstrations, such as MMPs, CMS will no longer use the 2017 CMS-HCC model used to calculate risk scores based on data submitted to the Risk Adjustment Processing System (RAPS) for Part C risk adjustment. Under the CY 2022 proposal, CMS will calculate 100% of the risk score using the 2020 CMS-HCC model.

Background on the Part C Model

The CMS-HCC risk adjustment models, as discussed in this Advance Notice, are used to calculate risk scores that adjust capitated payments made for aged and disabled beneficiaries enrolled in MA plans and certain demonstrations. A risk score represents a beneficiary's expected medical cost relative to the average expected medical cost of beneficiaries entitled to Part A and enrolled in Part B, excluding those beneficiaries who are in End Stage Renal Disease (ESRD) or hospice status. For beneficiaries enrolled in an MA plan who are not in ESRD or hospice status, CMS calculates risk scores with a distinct set of coefficients depending on the segment, or group of beneficiaries, to which a beneficiary is assigned. Since we implemented the 2017 CMS-HCC risk adjustment model, there have been eight segments in total:

- New enrollees (those with less than 12 months of Part B enrollment in the data collection year)
- Continuing enrollees who are residing in the community in the payment month, with six different segments depending on whether they are:
 - Entitled to Medicare based on age or disability (based on age as of February 1 of the payment year), and
 - Dually eligible for Medicaid with full-benefit dual, partial-benefit dual, or non-dual status (based on the payment month)
- Continuing enrollees who are in a long-term institutional stay (more than 90 days based on the payment month)

CMS estimates coefficients for each segment separately to reflect the unique cost and utilization patterns of beneficiaries within the segment. The CMS-HCC risk adjustment model is prospective in that it uses health status in a base year (i.e., the data collection year) to predict a beneficiary's annual expected cost in the following year (i.e., the payment year).

More background information about the CMS-HCC risk adjustment model, including detailed descriptions of recent improvements, can be found in the 2018 Report to Congress on Risk Adjustment in Medicare Advantage, Part I of the 2019 Advance Notice, and Part I of the 2020

Advance Notice.¹

21st Century Cures Act

Section 1853(a)(1)(I) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(I)), as added by section 17006(f) of the Cures Act, requires CMS to make improvements to risk adjustment for 2019 and subsequent years. CMS is, among other things,² specifically directed to:

- Evaluate the impact of including in the risk adjustment model:
 - (1) Additional diagnosis codes related to mental health and substance use disorders, and
 - (2) The severity of chronic kidney disease.
- Take into account the total number of diseases or conditions of an individual enrolled in an MA plan by making an additional adjustment as the number of diseases or conditions of an individual increases.
- Make separate adjustments for each full-benefit dual eligible individual.
- Phase in any changes to risk adjustment payment over a three-year period, “beginning with 2019, with such changes being fully implemented for 2022 and subsequent years.”

CMS began implementing the risk adjustment requirements in the Cures Act for CY 2019, with a portion of the risk score applied in payments to MA organizations and certain demonstrations calculated with a risk adjustment model that included additional factors for substance use disorder, mental health, and chronic kidney disease (CKD) diagnoses.³ CMS continued implementation by calculating an increasing portion of the risk score used for payments for CY 2020 and CY 2021 using a model that adds HCCs for dementia and pressure ulcers and factors that take into account the total number of diseases or conditions of a beneficiary (making an additional adjustment as the number of diseases or conditions an individual has increases).⁴

Three-year Phase-in and Proposal for 2022

The Cures Act requires that any changes to risk adjusted payments under section 1853(a)(1)(C)(i) resulting from the implementation of section 1853(a)(1)(I) must be phased in over a three-year period, beginning with 2019, with such changes being fully implemented for 2022 and subsequent years. In the CY 2019 Advance Notice, we explained how we interpreted that requirement. The 2020 CMS-HCC model, which was first finalized for CY 2020 payment, incorporates the modifications to meet all of the provisions from section 1853(a)(1)(I).

In order to fully implement a model that meets the statutory requirements, for Payment Year 2022, we propose the complete phase-in of the model changes by calculating risk scores using

¹ Part I of the 2019 and 2020 Advance Notices are available on the CMS website here: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html>. The 2018 Report to Congress is available on the CMS website here: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/RTC-Dec2018.pdf>.

² In connection with Medicare Advantage payment policies, the Cures Act also requires that the Secretary evaluate whether other factors should be taken into account in determining the capitation and risk adjustment payments for ESRD enrollees pursuant to section 1853(a)(1)(H).

³ <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf>.

⁴ <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf>.

100% of the risk score calculated with the 2020 CMS-HCC model.

Source of Diagnoses for Risk Score Calculation for CY 2022

For CY 2021, CMS will calculate risk scores for payment to MA organizations and certain demonstrations by adding 75% of the risk score calculated using risk adjustment eligible diagnoses identified from encounter data, FFS claims, and RAPS inpatient records with 25% of the risk score calculated using risk adjustment eligible diagnoses identified from RAPS data and FFS claims. For CY 2022, CMS proposes to calculate risk scores for payment to MA organizations and certain demonstrations using only risk adjustment eligible diagnoses identified from encounter data submitted by MA organizations and FFS claims, using the 2020 CMS-HCC model.

Under our proposal for CY2022 risk adjustment, we are proposing two changes to the sources of diagnoses used to calculate risk scores: (1) discontinue use of RAPS inpatient diagnoses to supplement encounter/EDS data and (2) end the blending of encounter data-based and RAPS-based risk scores and move to using 100% of the risk score calculated using diagnoses from MA encounter data and FFS claims.

Diagnoses from RAPS Inpatient Data as a Source of Diagnoses for Encounter Data-Based Scores. For CY 2022, we are proposing to discontinue the policy (used for CY 2019, CY 2020 and CY 2021) of supplementing diagnoses from encounter data with diagnoses from RAPS inpatient records. As stated in previous 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. CMS received mixed feedback from stakeholders in response to the CY 2020 and CY 2021 proposals to supplement encounter data-based risk scores with diagnoses from RAPS inpatient records.⁵ Recently, with the continued phase in of encounter data-based risk scores, stakeholders have raised concern over the increased burden placed on plans to maintain two systems, with some noting that supplementing encounter data-based risk scores with diagnoses from RAPS inpatient data adds burden with little added value to the average encounter data-based risk scores at an industry-level. We also believe that CMS has provided ample support to MA organizations during the transition from RAPS to encounter data-based risk scores and that it is no longer necessary in CY 2022.

Encounter Data. Under the CY 2022 proposal, CMS would no longer blend risk scores based on encounter data with risk scores based on RAPS submissions for risk score calculation. Instead, CMS would calculate 100% of the risk score using the 2020 CMS-HCC model and diagnoses from encounter data and FFS claims. Moving to a 100% encounter data and FFS-based risk score is consistent with CMS' proposal to fully phase in the 2020 CMS-HCC model, which is designed to calculate encounter data scores.

Economic Information for Part I of the CY 2022 Advance Notice

The economic information below provides the year-to-year impact (2021 to 2022) of the proposed changes to fully implement the 2020 CMS-HCC risk adjustment model and the transition to calculating risk scores based on diagnoses from encounter data and FFS.

Risk Adjustment Model Impact. The impact of the last phase in the transition of the risk adjustment model for CY 2022 reflects the impact on MA risk scores of fully phasing in the 2020 CMS-HCC model relative to the policy finalized for CY 2021 of blending 75% of the 2020 CMS-HCC model and 25% of the 2017 CMS-HCC model. The CY 2022 impact on MA risk scores of the full transition to the 2020 CMS-HCC model, relative to CY 2021, is projected to be 0.25%, which represents a \$633.8 million net cost to the Medicare Trust fund in 2022. This estimate takes into account the portion of the difference between benchmarks and bids that the government retains and the portion of the program costs covered by Part B premiums.

Encounter Data Transition. The CY 2022 impact on MA risk scores of the transition to a greater percent of the risk score being calculated with encounter data and FFS claims is 0.00%. In the CY 2021 Advance Notice, CMS projected the differential between the RAPS-based risk score and the encounter data-based risk score, calculated using the risk adjustment models proposed, to be 0.00%. 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, the impact of the transition to a risk score based entirely on diagnoses from encounter data in CY 2022 is 0.00%.

RAPS Inpatient Supplementation. The contribution of RAPS inpatient diagnosis supplementation to encounter data-based 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.