E-BRIEF SERIES

2020 CMS-HCC Risk Adjustment Model 2021 Changes

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As we have learned to adjust to the challenges that 2020 has brought, it is time to once again dive into the updates and changes for the next period of the 2020 CMS-HCC model (previously known as the Alternative Payment Condition Count "APCC" model) for the 2021 CY.

CMS is phasing in the changes over a three-year period, starting in 2019, with final implementation in 2022. This is a gradual transition as a small change in risk scores can lead to significant reimbursement outcomes.

Major changes have been released in the HHS Notice of Benefit and Payment Parameters for 2021 published May 20th of this year; and now is the time to proactively address the next phase. Additional information and resources can be found in the responses to the more than 1,000 public comments to the Advanced Notice Part I and Part II published April 6th in the Announcement of Calendar Year (CY) 2021 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. The MA capitated payment rate methodology can be found in the Advanced Notice Part II. The 2021 Medicare Advantage and Part D Rate Announcement Fact Sheet is available for review as of April 6, 2020 to address comments regarding the Advanced Notice Part I and II. This fact sheet also features a chart of the expected impact of the updated methodologies to plan payments.

RAPS Transition

The 2020 CMS-HCC Risk Adjustment model will continue to be phased in as required by the 21st Century Cures Act in accordance with section 1853(a)(1)(I) of the Social Security Act. Prior to the implementation of the model, diagnoses were submitted for payment by MA organizations to CMS' Risk Adjustment Processing System (RAPS), which has been transitioning from RAPS to encounter data beginning in CY 2015. CMS then began blending the RAPS-based scores with encounter-based scores

- **2016** - 90% of the RAPS-based risk scores with 10% of the encounter data-based risk scores
- **2017** - 75% of the RAPS-based risk scores with 25% of the encounter data-based risk scores
- **2018** - 85% of the RAPS-based risk scores with 15% of the encounter data-based risk scores
- **2019** - 75% of the RAPS-based risk scores with 25% of the encounter data-based risk scores
- **2020** - 50% of the RAPS-based risk scores with 50% of the encounter data-based risk scores

What is changing for CY 2021?

For 2021, the 2020 CMS-HCC model will be used with the 2017 CMS-HCC model for the blended risk score. This will be calculated as the sum of 75% of the 2020 CMS-HCC model using diagnoses from encounter data, RAPS inpatient records and FFS along with 25% of the 2017 CMS-HCC model data-based risk scores using diagnoses from RAPS and FFS. This is a shift from last year's 50% blend of the 2020 CMS-HCC model and 50% of the 2017 CMS-HCC model. In addition to publishing the new blended model, the 2021 MA coding pattern difference adjustment of 5.90% and the Final Normalization

Factors have also been made available:

2020 CMS-HCC Model: 1.097

2017 CMS-HCC Model: 1.106

CMS-HCC 2019 ESRD dialysis model & 2020 ESRD dialysis model: 1.079

CMS-HCC 2019 ESRD functioning graft model & 2020 ESRD functioning graft model: 1.118

2020 RxHCC model: 1.063

Changes in HCC Groupings/Hierarchies:

Metabolic and Endocrine Disorders

- Group HCCs 26 and 27 together and ungroup HCCs 29 and 30 Necrotizing Fasciitis
- Ungroup the necrotizing fasciitis HCC (HCC 54)

Blood Disorders

- Revise groups to move HCC 69 from its previous grouping with HCCs 70 and 71 to the group with HCCs 67 and 68 and reconfigure HCCs 69 and 71

Mental Health

- Move delusional disorders/psychosis HCC above major depressive disorders/bipolar disorders HCC in the hierarchy (the HCCs switch position in the hierarchy). Renumber the two highest HCCs in the hierarchy: HCC 87_1 Schizophrenia (had been 87) and HCC 87_2 Delusional and Other Specified Psychotic Disorders, Unspecified Psychosis (had been 89). HCC 88 Major Depressive Disorder, Severe, and Bipolar Disorders retains its same number

Cerebral Palsy and Spina Bifida

- Refine hierarchies to exclude paralysis HCCs for enrollees with cerebral palsy HCCs, as ICD-10 coding guidelines prohibit these conditions from coding together in addition to refining hierarchies to exclude hydrocephalus HCC for enrollees with spina bifida

Pancreatitis

- Reconfigure the acute pancreatitis HCC to move pancreatic disorders and intestinal malabsorption out of the acute pancreatitis HCC to differentiate higher cost condition
- Revise the hierarchy for pancreas transplant HCC to remove exclusion of pancreatitis HCCs because pancreas transplants are done primarily for diabetes and insulin conditions rather than pancreatitis

Liver Diseases/Disorders

- Reconfigure codes in liver HCCs to reflect clinical distinctions
- Move acute liver failure HCC above chronic liver failure HCC in the hierarchy and renumber HCCs to address cost implications of chronic versus acute liver failure

Payment HCC Changes:

Substance Use Disorders

- Added 2 new HCCs for alcohol use disorders to risk adjust for a larger number of substance use diagnoses
- Group the drug use HCCs (81 and 82) together. Group the alcohol use HCCs (83 and 84)
- Reconfigure drug dependence HCC to include drug use disorders with non-psychotic complications and a subset of drug poisoning (overdose) codes to reflect the revised conceptualization of substance use disorders in ICD-10

Pregnancy

- Add 3 (ongoing) pregnancy-without-delivery HCCs
- Revise two existing pregnancy HCC Groups

Diabetes

- Add a diabetes type 1 additive HCC
- Remap hyperglycemia and hypoglycemia codes from the "chronic complications" HCC to the "without complication" HCC

Asthma

- Split current asthma HCC into two severity specific HCCs

Fractures

- Delete an HCC (pathological fractures)
- Reconfigure an existing HCC (hip fractures)
- Add a new HCC (vertebral fractures)

Third Degree Burns and Major Skin Conditions

- Reconfigure and add 2 HCCs (extensive third-degree burns; major skin burns or conditions)

Coma and Severe Head Injury

- Add a new severe head injury HCC above the coma/brain compression HCC

Traumatic Amputations

- Add a new HCC in a hierarchy with the current amputation status HCC for all models and reconfigure codes between the new HCC and current amputation status

Narcolepsy and Cataplexy

- Add a new HCC

Exudative Macular Degeneration

- Add a new HCC

Congenital Heart Anomalies

- Add 3 new HCCs

**Additional information on updates to the child and infant models can be found in the HHS Notice of Benefit and Payment Parameters for 2021.*

PACE (Programs of All-Inclusive Care for the Elderly) Organizations

In CY 2021, CMS determined that calculation of risk scores and payment amounts will be used with the 2017 CMS-HCC model and associated frailty factors for the following year for non-ESRD aged/disabled participants. The model will utilize diagnoses from encounter data, RAPS, and FFS claims with no weighting. The CY 2020 frailty factors for the 2017 CMS-HCC model will be used again for FIDE-SNPs (Fully Integrated Dual Eligible- Special Needs Plans) in 2021. For calculation of risk scores of ESRD status participants enrolled in a PACE organization, CMS proposes the continued use of the 2019 ESRD dialysis and ESRD functioning graft models. Lastly, it is proposed to blend the frailty score with the frailty factors as a calculation of 75% of the 2020 CMS-HCC model with 25% of the 2017 CMS-HCC model to be used a comparison to CY 2020 to establish if that FIDE-SNPs maintains a frailty average similar to PACE.

ESRD

For the calculation of ESRD risk scores, CMS proposes that 75% of the score will be calculated with 2020 ESRD models (ESRD dialysis and ESRD functioning graft models) summed with 25% of the 2019 ESRD models using diagnoses from RAPS and FFS. This is a change from last year's 50% 2020 ESRD models with 50% of the 2019 models risk scores. Another update to be aware of relating to ESRD is that starting January 1, 2021, all Medicare-eligible individuals with ESRD can enroll in MA plans due to the 21st Century Cures Act amending the Social Security Act. This also brings into effect a major change for MA organizations as they will no longer hold responsibility for kidney transplant organ acquisition costs. These costs will be excluded from the MA benchmarks and are now covered by the FFS program. However, PACE organizations will continue to be responsible for kidney transplant organ acquisition costs. These costs will be still be included in the PACE payment rates going forward.

RxHCC

The 2020 RxHCC model will continue to be used for Part D risk score calculations with a blend of 75% from encounter data supplemented with RAPS inpatient records and FFS claims added with 25% of the risk score using diagnoses from RAPS and FFS. It should also be noted that for PACE organizations, the 2020 RxHCC model will also be utilized with diagnoses from encounter and RAPS data as well as FFS claims for a singular non-weighted risk score.

CMS Impact Analysis

As stated in the Advanced Notice Part I, the expected impact on MA risk scores for CY 2021 — in comparison to the prior year — as we transition to the next phase of the 2020 CMS-HCC model is 0.25%. This is a $565.5 million net cost to the Medicare Trust fund. Furthermore, according to CMS, there is not expected to be an impact on risk scores due to a larger percentage of the scores being calculated with encounter data, FFS claims, and RAPS inpatient records.

Areas of Opportunity in 2021

- Review and update your organizations data submission policies and procedures from CY 2020. Is the submitted data correct, free of preventable regulatory or coding errors, and being applied from the appropriate data sources?
- Educate providers on the pertinent upcoming changes in the 2020 CMS-HCC model as it relates clinically and financially placing value on accurate documentation for appropriate payment.
- Implement documentation best practices, including at least one qualifying encounter per year, to review patient conditions, diagnosis support with at least one MEAT/TAMPER, an updated patient problem list, EMR alerts, and the use of coding experts, such as professionals with the CRC (Certified Risk Adjustment Coder) certification.
- Ensure accurate and compete coding to the highest documented specificity. As we move into a new year with new HCC changes, identify codes that require more specific documentation from providers or may need additional review, such as mental disorders, drug and alcohol diagnoses, chronic kidney disease, or other prevalent codes frequently submitted within your organization.
- Perform audits (which can include mock RADV audits) to ensure compliance and discover areas of improvement to correct and track moving into CY 2021. AAPC Services typically recommends an audit of a minimum of 10 dates of service.

Stay ahead of the curve and ensure accurate and complete reimbursement with quality documentation and coding accuracy, paired with data integrity processes. Don't leave money on the table for your organization. Make sure you team is prepared for the next phase of the 2020 CMS-HCC model.

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AUTHOR BIO

Laura Brink, RHIT, CRC began her career as an outpatient medical coder and auditor. Following her work in outpatient services, she moved to specializing in HCC Risk Adjustment preforming provider and coder auditing with experience working in multiple models such as HCC, RxHCC, ACO, and QHP. Additionally, she assisted in provider education and training to ensure accurate risk scores utilizing query processes.

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