

January 6, 2020

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

SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies – Part I, CMS-HCC Risk Adjustment Model

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

A key element in the success of Medicare Advantage 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 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. Therefore, we are notifying you of the proposed changes in the Medicare Advantage risk adjustment methodology applied under Part C for CY 2021 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 2021, we are proposing to continue the transition of the risk adjustment model adopted in the CY 2020 Rate Announcement that incorporated important changes to the Part C risk adjustment model based on section 1853(a)(1)(I) of the Act. This proposal reflects the requirement in the 21st Century Cures Act (Pub. L. 114-255) to phase in changes to the risk adjustment model under section 1853(a)(1)(I) over a 3-year period, beginning with 2019, with such changes being fully implemented for 2022 and subsequent years.

The proposed changes include continued phasing in of the model that includes changes adopted under subsections (a)(1)(C) and (a)(1)(I) of section 1853.

Pursuant to section 1853(b)(2) of the Act, we will provide notification of planned changes in the Medicare Advantage capitation rate methodology and other risk adjustment methodologies applied under the Act for CY 2021, along with annual adjustments to the Medicare Part D benefit parameters for the defined standard benefit, in the Advance Notice of Methodological Changes for CY 2021 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies to be released on or before February 6, 2020. The statute requires CMS to publish the Advance Notice of Methodological Changes 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 2021, CMS will announce the Medicare Advantage capitation rates and final payment policies no later than Monday, April 6, 2020, 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-2020-0003” 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 April 6, 2020 release of the final CY 2021 Rate Announcement, comments must be received by 6:00 PM Eastern Standard Time on Friday, March 6, 2020.

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Demetrios Kouzoukas
Principal Deputy Administrator
and Director, Center for Medicare

Summary of Proposal for CY 2021

For CY 2021 CMS is proposing to continue using the CMS-HCC model that was implemented in CY 2020 (i.e., 2020 CMS-HCC model). CMS is proposing to continue using the 2020 CMS-HCC model to calculate encounter data-based scores and the 2017 CMS-HCC model to calculate RAPS-based scores. Under this proposal, 75% of the risk score would be calculated with the 2020 CMS-HCC model and 25% of the risk score would be calculated with the 2017 CMS-HCC model.

Background on the Part C Model

The CMS-Hierarchical Condition Categories (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, as well as participants in Programs of All-Inclusive Care for the Elderly (PACE) organizations. 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 who are enrolled in an MA plan, and who are not in ESRD or hospice status, risk scores are calculated with a distinct set of coefficients depending on which segment or group of beneficiaries a beneficiary is assigned to. Starting with the 2017 CMS-HCC risk adjustment model, there are 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 as full-benefit dual, partial-benefit dual, or non-dual (based on the payment month)
- Continuing enrollees who are in a long-term institutional stay (more than 90 days based on the payment month)

Coefficients are estimated 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., data collection year) to predict a beneficiary's annual expected cost in the following year (payment year).

More background information about the CMS-HCC risk adjustment model, including detailed descriptions of the recent improvements that have been made, can be found in Part I of the 2019 Advance Notice and Part I of the 2020 Advance Notice, as well as the 2018 Report to Congress on Risk Adjustment in Medicare Advantage.¹

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>.

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 21st Century 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 3-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 21st Century Cures Act for CY 2019, when a portion of the risk score applied in payments to MA organizations and certain demonstrations was calculated with a risk adjustment model that included additional factors for substance use disorder, mental health, and chronic kidney disease (CKD) diagnoses. CMS finalized that risk adjustment model in the CY 2019 Rate Announcement, published April 2, 2018.³ The implementation of the 21st Century Cures Act’s risk adjustment requirements will continue in CY 2020. CMS finalized the Alternative Payment Condition Count (APCC) CMS-HCC risk adjustment model for payment to MA organizations and certain demonstrations in the CY 2020 Rate Announcement, published April 1, 2019.⁴ In addition to the changes implemented in CY 2019, the APCC CMS-HCC model takes into account the total number of diseases or conditions of an individual enrolled in an MA plan by including a count variable that makes an additional adjustment as the number of diseases or conditions an individual has increases. This risk adjustment model also has additional HCCs for dementia and pressure ulcers. We hereafter refer to the APCC CMS-HCC risk adjustment model that was implemented for CY 2020 as the 2020 CMS-HCC model.

Proposal for 2021 and Three-year Phase-in 2019 - 2022

The 21st Century 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. The statute thus requires a three-year phase-in over a four-year period. In the CY 2019 Advance Notice, we explained how we interpreted the statute’s direction to mean that the proposed changes to the risk adjustment model under section 1853(a)(1)(C)(i) could be implemented in 2019 without all the required provisions from section 1853(a)(1)(I), and could be further modified and implemented fully consistent with provisions from section

² In connection with Medicare Advantage payment policies, the 21st Century 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>.

1853(a)(1)(I) for 2020. The model finalized for 2020 included modifications to meet all of the provisions from section 1853(a)(1)(I), and will be phased in over three years such that 100% of risk adjusted payments to MA organizations and certain demonstrations for 2022 are based on a risk adjustment model that complies with the statutory requirements in section 1853(a)(1)(I) of the Act.

In order to phase in a model that meets the statutory requirements, risk score calculation for payment to MA organizations and certain demonstrations during the phase-in period reflects the transition as follows:

For Payment Year 2019, we are calculating risk scores using the sum of:

- 25% of the risk score calculated with the 2019 CMS-HCC model and
- 75% of the risk score calculated with the 2017 CMS-HCC model.

For Payment Year 2020, we are calculating risk scores using the sum of:

- 50% of the risk score calculated with the 2020 CMS-HCC model and
- 50% of the risk score calculated with the 2017 CMS-HCC model.

For Payment Year 2021, we propose to continue the phase in of the changes to the model by calculating risk scores using the sum of:

- 75% of the risk score calculated with the 2020 CMS-HCC model and
- 25% of the risk score calculated with the 2017 CMS-HCC model.

For PACE organizations, we propose to continue to use the 2017 CMS-HCC model to calculate risk scores in CY 2021, as described in the CY 2020 Advance Notice Part II and CY 2020 Rate Announcement.

Encounter Data as a Diagnosis Source for 2021

For CY 2020, CMS is calculating risk scores for payment to MA organizations and certain demonstrations by adding 50% of the risk score calculated using risk adjustment eligible diagnoses identified from encounter data, FFS claims, and RAPS inpatient records with 50% of the risk score calculated using risk adjustment eligible diagnoses identified from RAPS data and FFS claims. For CY 2021, CMS proposes to 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 with risk adjustment eligible diagnoses identified from all RAPS data and FFS claims.

Specifically, we propose to calculate the encounter data-based risk scores as follows:

- With the 2020 CMS-HCC model,
- Using risk adjustment eligible diagnoses from encounter data, FFS claims, and RAPS inpatient records.

RAPS-based risk scores would be calculated as follows:

- With the 2017 CMS-HCC model,
- Using risk adjustment eligible diagnoses from RAPS data and FFS claims.

Thus, as proposed, encounter data-based risk scores would only be calculated with the 2020 CMS-HCC model.

For PACE organizations for CY 2021, we propose to continue the same method of calculating risk scores 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.

Impact Analysis for Part I of the CY 2021 Advance Notice

The impact of the transition of the risk adjustment model revision for CY 2021 is the effect of changes in the blend of risk scores calculated under the 2017 CMS-HCC model and the 2020 CMS-HCC model. This is the effective impact on MA risk scores of blending 75% of the 2020 CMS-HCC model and 25% of the 2017 CMS-HCC model, consistent with the policy proposed in the 2021 Advance Notice, relative to the policy finalized for 2020, 50% of the 2020 CMS-HCC model and 50% of the 2017 CMS-HCC model. The CY 2021 impact on MA risk scores of the transition to the 2020 CMS-HCC model, relative to CY 2020, is 0.25%, which represents a \$565.5 million net cost to the Medicare Trust fund in 2021. 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.

The CY 2021 impact on MA risk scores of the transition to a greater percent of the risk score being calculated with encounter data, FFS claims, and RAPS inpatient records is 0.00%. This impact is 0.00% because we project that the differential between the RAPS-based risk score and the encounter data-based risk score, calculated using the risk adjustment models proposed for 2021, is projected to be 0.00%.