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# Big Ideas in the Proposed 2021 Notice of Benefit & Payment Parameters for the ACA Market

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The Department of Health and Human Services (HHS) recently released the Proposed Rule for the 2021 Notice of Benefit and Payment Parameters for the Affordable Care Act (ACA) market (Proposed 2021 Payment Notice).

This article provides Pareto Intelligence's initial summary of key provisions related to the HHS-operated risk adjustment program, as well as our initial perspective and takeaways.

## Initial Summary and Perspective for Health Plan Revenue Management Programs

In line with recent guidance and rulemaking, HHS reiterated its intention to reduce administrative burden and costs for issuers, consumers and other stakeholders. However, as part of its commentary, it reiterated the importance of the risk adjustment program as a "...core program in the individual and small group markets..." In accordance, the Proposed 2021 Payment Notice includes the most significant changes to the HHS-operated risk adjustment program since the addition of pharmacy data in 2017. While HHS has indicated that the industry should not expect significant changes every year, it did mention several significant potential changes to the HHS-operated risk adjustment program for future benefit years.

We recommend health plans pay close attention to these proposed changes and developments, especially in terms of the impact to revenue management programs. Below are a few of the most important aspects of the Proposed Rule, including proposed changes for 2021, as well as items for future consideration:

### Various updates to the 2021 ACA risk adjustment model

- Discontinued MarketScan® Data
- Major changes to HCCs
- Adjustments to RXCs
- No change to 65+ population

### Changes to RADV

- Reducing the impact of outliers
- Second pilot for pharmacy RADV

 

## Key Provisions for the 2021 ACA Risk Adjustment Model

**No More MarketScan® Data:** 2021 will be the first year where the HHS-operated model is calibrated using only EDGE data, capping off a phased shift which began in 2019. The draft notice includes model factors calibrated on 2016 and 2017 EDGE data, while we anticipate the final model factors to also include 2018 EDGE data.

***Impact to Health Plans:*** *We don't anticipate explicit changes to model factors beyond the trends we started seeing with the 2019 model and better alignment to the Individual and Small Group markets (as MarketScan® uses a broad commercial market data set). At this juncture, the biggest impact comes from HHS' increased use of Individual and Small Group data and actual health plan experience to inform its research and development into improving the program and model.*

**Major, Major Changes to HCCs:** HHS is proposing major updates and revisions to HCCs across the Adult, Child and Infant models. According to HHS' commentary, most of these changes are driven by the shift to ICD-10 and analysis of recent data trends with the goal of improving the predictive power of its models (especially with the availability of EDGE data). The proposed changes include the addition of HCCs, deletion of HCCs, changes to groups and hierarchies, changes and reclassification of underlying ICD-10 codes, and the additional of a *priori constraints* to certain HCCs. (In a *priori constraints*, the HCC estimates are constrained to be equal to each other. These are applied to stabilize high cost estimates that may vary greatly due to small

***Impact to Health Plans:*** *We expect this to not only alter member-level risk scores, prevalence of conditions, etc., but also potentially how issuers manage their efforts to ensure accurate, complete and compliant management of their risk-based revenue. Table 1 below summarizes the proposed changes from HHS.*

| Condition | Payment HCC Proposed Change* |
|---|---|
| Substance Use Disorders | +3 |
| Pregnancy | +3 |
| Diabetes: Type 1 | +1 |
| Asthma | +1 |
| Fractures | -1, +1 |
| Third Degree Burns and Major Skin Conditions | +2 |
| Coma and Severe Head Injury | +1 |
| Traumatic Amputations | +1 |
| Narcolepsy and Cataplexy | +1 |

| Condition | Payment HCC Proposed Change* |
|---|---|
| Exudative Macular Degeneration | +1 |
| Congenital Heart Anomalies | New to Audit |
| Severe Illness Interactions | +17, -1 |
| Transplant A Priori Constraints | +12 |
| Infant Model Changes | +8 |
| *+/- indicates added or dropped HCCs | |

**Changes in HCC Groups**

- Metabolic and Endocrine Disorders
- Necrotizing Fasciitis
- Blood Disorders
- Mental Health
- Cerebral Palsy and Spina Bifida
- Pancreatitis
- Liver

See the Proposed Rule for a full summary of changes.

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**RXCs (Minor Adjustments):** There are no proposed changes to RXCs currently; however, HHS is proposing minor changes to coefficients and classification of drugs to reflect recent market trends—namely Hepatitis C drugs and the use of pre-exposure prophylaxis (PrEP) for HIV.

**Over 65 Population (No Change):** As part of its review, HHS considered adding new age-sex coefficients for members over the age of 65 driven by the fact that the Individual and Small Group markets tend to contain over 65 members (while the MarketScan® data did not). However, based on its analysis of the population, HHS decided not to propose any changes in this notice.

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## ANTICIPATED IMPACT TO REVENUE MANAGEMENT PROGRAMS: A GREATER EMPHASIS ON SPECIALISTS

While most Revenue Management programs in the ACA market are built on the foundation of retrospective chart reviews and PCP-oriented prospective strategies, through our work with health plans, we've seen a greater emphasis on targeting specialists for prospective gap closure. This is primarily driven by the desire to proactively target broader swathes of member populations (once the *low hanging fruit* was addressed with strategies rolled out in the first few years after the ACA launch).

When analyzing HHS' commentary and rationale for the proposed changes to HCCs within the HHS-operated risk adjustment model, we see a greater emphasis on the specificity and nuances of the HCCs modified (in line with the overall objectives of ICD-10). This is evidenced by the fact that most of the changes are due to existing HCCs being split out into more specific HCCs or changes in hierarchies driven by the interaction between different conditions. For example, HHS propose adding two new *Substance Use Disorders* HCCs to include a larger number of substance use diagnosis codes and differentiate between severities. We also see a change with *Traumatic Amputations* to better distinguish between different phases of treatment. Based on this trend, as well as historical challenges in ensuring accurate and complete documentation for certain HCCs (e.g., Behavioral Health), we anticipate leading plans to continue their efforts to build out specialist-oriented revenue management strategies and tactics.

## Changes to RADV Beginning in 2019

With the two pilot years and the first year with financial implications now under its belt, HHS proposes two key updates to the Risk Adjustment Data Validation (RADV) program.

**Reducing the Impact of Outliers:** As we saw in HHS' Report on 2017 Benefit Year RADV Results (which impacted 2018 Benefit Year risk scores and transfer payments), the initial year of the program saw a higher number of outliers and rate of outliers, which were skewed towards the positive side (i.e., health plans with higher than average HCC capture rates vs. peers). This had the impact of certain markets having larger than expected risk score and transfer payment adjustments. Consistent with prior commentary, HHS proposes changes to reduce the impact of outliers going forward (in line with its overall intentions for the RADV program). Specifically, HHS proposes excluding issuers with fewer than 30 HCCs in an HCC Group from the outlier failure rate calculation (while still including those issuers in the national statistics calculation) for the 2019 Benefit Year.

***Impact to Health Plans:*** *We believe this change is favorable to most health plans as it will reduce the risk of outliers creating an outsize impact to RADV results and adjustments. We expect this will reduce the magnitude and prevalence of risk score and transfer payment adjustments in comparison to what was seen for the 2018 Benefit Year.*

**Another Pilot Year for Pharmacy RADV:** HHS proposes that the 2019 befit year will serve as a second pilot year for prescription drug data submissions (i.e., RXC calculations). As finalized in the 2020 NBPP, HHS uses an approach for its validation of RXCs that is similar to how enrollment data is validated (versus how HCCs are validated). It states, through its 2018 RADV experience, it found and recognized there are yet still significant differences between the validation of HCCs and RXCs. Accordingly, the validation of RXCs will not result in a risk score or transfer payment impact for 2019 Benefit Year.

***Impact to Health Plans:*** *This will give HHS and health plans another year to refine their processes related to their validation of Pharmacy Data submissions to EDGE. Plans should be proactive in leveraging existing audit controls and strengthening internal processes before Pharmacy RADV has a financial impact.*

## Conclusion

The Proposed 2021 Payment Notice presents a number of changes for health plans to consider. Given the significant changes to HCCs, Pareto intends to follow up this discussion with a more detailed article on potential impacts health plans can expect through in-depth simulation and analysis using data from the Pareto Community.

Beyond that, there are also several updates proposed for future benefit years that require health plans to begin planning now. Pareto will also share additional analysis and commentary on what health plans can expect, how to approach the proposed changes and discussion on additional potential future changes in the notice as part of a sequential article in this series.

To discuss these proposed changes in more detail, contact us.