Pulse8
EVERY NUMBER IS A LIFE.

Medicare Advantage 2019 Advance Notice – Part 1

21st Century Cures Act Methodological Changes

Review of Relevant Provisions with Expert Insight

January 2018

PULSE8 is privileged to bring you a summary of key Medicare Advantage program changes for Payment Year 2019 resulting from the 21st Century Cures Act of 2016.

Key Risk Adjustment Methodology Changes Addressed in the 2019 Advance Notice

- Member Risk Score Calculation Changes
  - Advent of "HCC count per member" additive variable within member risk score calculus, i.e. members with higher counts of HCCs would have higher risk score adjustments
    - Includes re-calculated, diminished risk adjustment factors for all HCCs.
    - The proposed "Payment Condition Count" model is estimated to increase risk scores by an average of 1.1% across all plans; however, the experience of individual plans would vary.
  - RAPS & EDPS
    - Risk score blend moving to a 75/25 split for PY19 from an 85/15 split for PY18 (RAPS/EDPS).
    - For PY 2019, CMS proposes to calculate the EDPS risk scores amended with RAPS inpatient diagnoses.
- Clinical CMS-HCC Model Changes
  - Augmentation to the set of Behavioral Health Conditions
    - Addition of opioid (and other substances) overdose ICD10 diagnosis codes to HCC 55 Drug/Alcohol Dependence.
    - Addition of HCC 56 Drug Abuse, Uncomplicated, Excluding Cannabis, includes opioid dependence diagnoses (among other narcotics).
    - Addition of mental health HCC 59, Reactive and Unspecified Psychosis, and HCC 60, Personality Disorders
  - Addition of HCC 138, Chronic Kidney Disease Stage 3 (Moderate Only)

- The 2019 Advance Notice proposes to blend risk score calculation using a progressive 2017 model to 2019 model ratio schedule:

Payment Year	Proposed 2019 Model Blend Rate	Current 2017 Model Blend Rate
2019	25%	75%
2020	50%	50%
2021	75%	25%
2022	100%	NA

Member Risk Score Calculation Changes

Account for an Individual's Total Number of Conditions

The Cures Act instructs the Secretary of Health and Human Services to improve the determination methodology of a beneficiary's health status by factoring in the count of an individual's total conditions. Furthermore, additional adjustments are to be applied as an individual's total number of conditions increases.

- The 2017 CMS-HCC Model includes 79 distinct Hierarchical Condition Codes (HCCs). These 79 HCCs are a subset of a master convention of 201 Condition Codes, of which 186 are relevant to Medicare beneficiaries.
- CMS ran two distinct model calculations that counted Conditions by Member using both the seventy-nine 2017 CMS-HCC model HCCs (known as Payment Conditions) and the 186 Medicare-relevant master list of Condition Codes (known as All Conditions):
    - In the final analysis, the Advance Notice states, "… adding either "Payment Condition" or "All Condition" count variables to the model did not change the mean MA risk score appreciably."
    - The Advance Notice released specifications and risk score coefficients for both the 79-Payment Condition analysis and the 186-All Conditions analysis.
    - **The official proposal is for adoption of the 79-Payment Conditions methodology**; however, it specifically asks for commentary and feedback on both methodologies.

Payment Condition Count Risk Factor Values (Single Segment Example)

Payment HCC Count	Community NonDual, Aged Risk Factor
1 Payment HCCs	-
2 Payment HCCs	-
3 Payment HCCs	-
4 Payment HCCs	0.012
5 Payment HCCs	0.043
6 Payment HCCs	0.088
7 Payment HCCs	0.136
8 Payment HCCs	0.242
9 Payment HCCs	0.282
10 or more Payment HCCs	0.567

***Pulse8 Insight**: Regardless of which methodology (Payment Conditions vs. All Conditions), the inclusion of an HCC-per member count risk score variable lowers the risk score coefficient and thereby the financial impact of any individual HCC. In terms of HCC gap closure, the ROI of any intervention campaign will drop if plans do not adjust their strategy away from narrow individual condition opportunity targeting to a broader, sub-population approach.*

The All Condition methodology (currently NOT favored by CMS) would require plans to target and close diagnosis gaps for roughly twice as many conditions (79 to 186). In this scenario, the 107 "Non-Payment HCCs" (e.g. hypertension, hyperlipidemia, dementia, etc.) would have to be added to the targeting analytics data science process. These Non-Payment HCCs would not have direct, additive impact to members' risk scores; however, capturing these HCCs would increase a member's total condition counts, thereby increasing risk scores. The workload and costs involved with adding targeting analytics for the Non-Payment HCCs would be very high.

Clinical CMS-HCC Model Changes

Evaluation of Mental Health and Substance Use Disorders

Mental Health

CMS has classified seven total HCCs from mental health diagnosis mappings. Two of the seven HCCs are included in the 2017 CMS-HCC model:

- HCC 57 Schizophrenia
- HCC 58 Major Depressive, Bipolar, and Paranoid Disorders

Five HCCs classified as mental health are not included in the 2017 CMS-HCC model:

- HCC 59 Reactive and Unspecified Psychosis
- HCC 60 Personality Disorders
- HCC 61 Depression
- HCC 62 Anxiety Disorders
- HCC 63 Other Psychiatric Disorders

For the payment year 2019 model, CMS is proposing to add HCC 59 Reactive and Unspecified Psychosis and HCC 60 Personality Disorders, per the Advance Notice:

> "HCC 59, Reactive and Unspecified Psychosis is a mix of acute and chronic conditions that cover a range of psychotic episodes with varying duration. In many cases, the diagnoses associated with HCC 59 are related to, but do not meet, the full criteria for schizophrenia or other specific psychotic disorders."
>
> "HCC 60, Personality Disorders, includes a variety of personality disorders that are clinically-related and well defined. When included in the model, the HCC predicts reasonable costs and the coefficient is statistically significant. Additionally, on average, costs for HCC 60 are underpredicted by the updated 2017 CMS-HCC model in the community population… "

CMS also notes that because HCC 59 diagnoses predict higher costs than HCC 58 Major Depressive, Bipolar, and Paranoid Disorders, the hierarchical sequence order must be flipped to HCC 58 Reactive and Unspecified Psychosis and HCC 59 Major Depressive, Bipolar, and Paranoid Disorders.

The Advance Notice further states that an ICD9 to ICD10 discrepancy within the diagnosing and coding of depression exists. CMS states that when coefficient calibration analysis is conducted on claims data with ICD10 codes, a more encompassing classification will be developed among HCC 58 (now 59) Major Depressive, Bipolar, and Paranoid Disorders and HCC 61 Depression.

***Pulse8 Insight**: Pulse8 experts see the addition of two more mental health HCCs as continued progress towards "filling-in" the mental health risk adjustment gap. Declining mental health status strongly correlates with poorer health outcomes and higher cost. Heart Failure, ESRD, Dementia, CAD, acute MI and CVAs are just a few of disease states highlighted this year in peer-reviewed journals linking depression with worse health outcomes. Subjectivity in the diagnosis of Major Depression vs. Depression remains core to the under-realized risk factor scoring for mental health. Pulse8 recommends that plans continue to educate physicians on depression diagnosis accuracy, specifically regarding the 'Major depressive disorder, single episode' code group. The key is for the physicians to be as specific as possible and avoid using the catch-all, "unspecified" qualifier. Instead, physicians should detail the episode as mild, moderate, severe, in partial or full remission, and with or without psychosis.*

Substance Abuse Disorders

Two substance use disorder HCCs are included in the 2017 CMS-HCC model:

- HCC 54 Drug/Alcohol Psychosis
- HCC 55 Drug/Alcohol Dependence

For payment year 2019, the Advance Notice proposes to augment HCC 55 to, "better account for the costs related to accidental (unintentional) or undetermined overdose." ICD10 codes will be added for overdoses from Heroin, Cocaine, Methadone and Other Synthetic Narcotics, LSD and Other Hallucinogens, Psychostimulants, Alcohol and, most notably, Opium and Other Opioids.

A third substance abuse HCC, 56 Drug/Alcohol Abuse, Without Dependence, is not included in the 2017 CMS-HCC model; however, the Advance Notice has proposed to add a subsection of HCC 56 to the 2019 model. The CMS-HCC methodology would restrict HCC 56 diagnoses to include only those described as "Drug Abuse, Uncomplicated, Excluding Cannabis".

Pulse8 Insight: Substance abuse and related sequelae remain a major cost multiplier and HCCs 54 and 55 act to capture that risk. As political momentum gains to address the Opioid Epidemic, expect more focus on substance-related disorders and treatment of those disorders. With increased focus of identification, we can expect increased treatment demands. This increased cost in addition to the comorbidity of these conditions necessitates the need to correctly identify this cohort. Given the sensitive nature of these diagnoses, most activities to close these gaps will need to be in the form of retrospective chart review accompanied with heavy provider education efforts.

Evaluation of Chronic Kidney Disease

From the 21st Century Cures Act text, "The Secretary shall evaluate the impact of including the severity of chronic kidney disease in the risk adjustment model."

The payment year 2019 Advance Notice states that HCC 138 Chronic Kidney Disease, Moderate (Stage 3) will be added to the 2019 CMS-HCC model. The Advance Notice notes that Stage 3 CKD has two subsets, 3a Mild to Moderate and 3b Moderate to Severe, only CKD 3b Moderate to Severe will be included in CMS-HCC model.

Pulse8 Insight:

The addition of HCC 138 CKD Stage 3 Moderate to the model will add volume to the overall condition count; however, the risk score values proposed in the Advance Notice are low. HCC 138 has also been added to the CHF/CKD Disease Interaction group, which will raise the overall average risk score impact. Messaging to providers on Glomerular Filtration Rate (GFR) lab results interpretation and transposition to ICD10 coding and documentation is critical for HCC 138 realization and CKD progression tracking.