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Medicare Advantage

Payment Year 2020 Advance Notice – Part 1

Review of Key Proposals with Expert Insight

January 2019

PULSE8 is privileged to bring you a summary of key Medicare Advantage program changes for Payment 2020. This year's changes continue the implementation of improvements to the risk adjustment program as required by the 21st Century Cures Act of 2016.

Bullet-Point Key Changes Proposed in Part 1 of the 2020 Advance Notice

- Payment Condition Count (PCC) Methodology
  - Application of an HCC-count-per-member* grouping to risk score coefficient schedule designed to increase risk scores of members with multiple conditions. PCCs help account for the added costs arising from the complexity of their treatment.
    **Count of hierarchy-imposed HCCs*
  - Only for use within the EDPS & RAPS inpatient submissions data risk score calculation.
- Alternative CMS-HCC Model with PCC Methodology
  - Increase from 83 to 86 Condition Codes
  - CMS internal analysis and research for PCC implementation led to the consideration of 10 additional chronic HCCs, CMS conclusion is a proposal to add 3 new HCCs:
    - HCC 51 – Dementia with Complications
    - HCC 52 – Dementia without Complications
    - HCC 159 – Pressure Ulcer of Skin with Partial Thickness Skin Loss
- RAPS / EDPS Risk Score Calculation
  - Risk score calculation: 50% RAPS submissions data, plus 50% EDPS & RAPS inpatient submissions data.
  - RAPS submissions data risk score calculated using the 2017, Version 22 CMS-HCC model
  - EDPS + RAPS Inpatient data risk score calculated using the 2020, Version 23 CMS-HCC Model with PCC methodology applied.

Expanded Review of the Proposed Changes

Payment Condition Count (PCC) Methodology

The PCC concept was introduced within Part 1 of the PY2019 Advance Notice released in December 2017. The PY2019 Final Notice (released in April of 2018) proposed a postponement of the PCC model to PY2020, with CMS noting their internal vetting analyses would continue throughout 2018. Finally, in December

2018, the Part 1 PY2020 Advance Notice was released, confirming the adoption of PCC methodology with one last twist: CMS will adopt either the PY2019 PCC model or an Alternative PCC Model, detailed in the notice and bullet-pointed above. Please note this critical distinction regarding counting HCCs: A member's count of HCCs is calculated *after* the imposition of the hierarchy rules. For example, a member with both HCC 18 and HCC 19 would be grouped as "1 Payment HCCs" – hierarchy rules state that HCC 18 trumps 19 for member risk score determination.

Pulse8 Insight: *It's important to note that PCC methodology is not a supply of additional risk score – it's a shifting of the available risk score from specific HCCs to an HCC-count-by-member risk adjustment function. In Figure 1 below, the additive risk scores for both proposed PCC models are listed. On the other hand, Figure 2 reveals the reduction in base risk score for three prevalent HCCs: available risk score is shifting from Figure 2 (individual HCCs) into Figure 1 (HCC-count-by-member).*

The drop in base HCC risk scores will reduce the average financial impact of individual HCC gap closures. To maintain and improve ROI, health plans will need to build gap closure campaign strategies and analytics to target sub-populations as well as individuals.

Figure 1: PCC Risk Score Coefficients

Payment HCC Count	PY2019 Hold-Over PCC Model for PY2020	PY2020 Alternative PCC Model
1 Payment HCCs	-	-
2 Payment HCCs	-	-
3 Payment HCCs	-	-
4 Payment HCCs	0.012	0.009
5 Payment HCCs	0.043	0.047
6 Payment HCCs	0.088	0.083
7 Payment HCCs	0.136	0.134
8 Payment HCCs	0.242	0.224
9 Payment HCCs	0.282	0.270
10 or more Payment HCCs	0.567	0.522

Community Non-Dual Aged Coefficients

Figure 2: Example Base HCC Risk Score Coefficient Reduction

HCC Code and Description	Current PY2019 "No Count" Model	PY2019 Hold-Over PCC Model for PY2020	PY2020 Alternative PCC Model
HCC 18 - Diabetes with Complications	0.307	0.305	0.302
HCC 19 - Diabetes without Complications	0.106	0.105	0.104
HCC 59 - Major Depression	0.353	0.343	0.308

Community Non-Dual Aged Coefficients

Pulse8 Insight: *Figure 3, below, provides estimates to average PMPM risk adjustment payment changes for both PY2020 PCC models. The estimates in Figure 3 are 50% of the original results in accordance with the PY2020 RAPS 50% plus EDPS 50% risk score method. A default average benchmark payment rate of $750/month was applied to annualized member months to project the dollar amounts. The actual PY2020 PMPM impact for a health plan will be the product of afore mentioned variables (EDPS submission completeness, county benchmark rate, member months), a plan's level of disease burden and the six-sided Community Risk Model distribution of the plan's membership. The estimates in Figure 3 are median calculations between a member population with high disease burden and higher six-sided model distribution and a low disease burden member population made up of primarily Community Non-Dual Aged beneficiaries.*

We found that the additive risk payment impact of the HCC Count function was the nearly equal for both PCC models – about $3.00 PMPM. The reduction in risk payment due to the lowering of Individual HCC risk scores is roughly twice as impactful (-$4.40 to -$2.10) in the PY2019 Hold-Over model than in the PY2020 Alternative model. This offset of $2.30 PMPM is primarily due to an estimated increase of $7.50 PMPM from the Dementia and Skin Ulcer HCC additions to the Alternative PCC model. Lastly, the Demographic risk score variables show the greatest delta between the two models: PY2019 Hold-Over average of $3.10 to the PY2020 Alternative model's -$0.25.

Figure 3: PMPM Change Estimates by Risk Payment Component

Risk Payment Components	PY2019 Hold-Over PCC Model	PY2020 Alternative PCC Model
HCC Count	$ 3.00	$ 3.00
Individual HCC	$ (4.40)	$ (2.10)
Net HCC-Derived Risk Payment	**$ (1.40)**	**$ 0.90**
Demographic	$ 3.10	$ (0.25)
Net Total Risk Payment	**$ 1.70**	**$ 0.65**

Payment Year 2020 Alternative HCC Model

The PY2020 Advance Notice describes how CMS research of the PY2019 PCC model found that some beneficiaries with multiple chronic conditions had under-predicted costs. The notice goes on to say that stakeholder-submitted comments of the PY2019 PCC model opined that it did not meet the Cures Act requirement to improve predictive costs for "high needs beneficiaries with multiple chronic conditions." The confluence of CMS' own research results and stake-holder comments was enough to prompt the agency to test the impact of adding HCCs for chronic conditions not included in the current Version 23 Community CMS-HCC model.

The Advance Notice describes, in detail, the process used to analyze non-payment HCCs that would merit further analysis for eventual inclusion. To summarize, the four basic criteria applied were:

1. Chronicity of the HCC
   Determined by application of the empirical data analysis methodology detailed in the PY2019 Part 1 Advance Notice and in the CMS December 2018 publication, Report to Congress.
2. Clinical Meaningfulness of the HCC
   Per the Advance Notice, the ICDs mapped to an HCC, "…should relate to a reasonably well-specified disease or medical condition…"
3. Medical Expenditure Predictability of the HCC
   Again, quoting from the Advance Notice, "The condition category should produce a reasonable and statistically significant estimate of medical expenditures for Medicare Part A and B benefits." This criterion also states that HCCs whose costs are covered by related or co-morbid payment HCCs should not be added.
4. Definitively Diagnosable ICDs of the HCC
   Only HCCs comprised of ICDs with "minimal clinical discretion" should be added to the payment model.

The final filtering metrics applied to non-payment HCCs for consideration were 1) sample size greater than 30,000 beneficiaries, 2) annual average cost above the mean, and 3) predictive ratio of less than 0.9.

The net result of the four criteria and three metric filters yielded ten potential non-payment HCCs for inclusion in risk adjustment payment:

1. HCC41 Disorders of the Vertebrae and Spinal Discs
2. HCC42 Osteoarthritis of Hip or Knee
3. HCC51 Dementia with Complications
4. HCC52 Dementia without Complication
5. HCC89 Coronary Atherosclerosis/Other Chronic Ischemic Heart Disease
6. HCC95 Hypertension
7. HCC102 Cerebrovascular Atherosclerosis, Aneurysm, and Other Disease
8. HCC113 Asthma
9. HCC140 Unspecified Renal Failure
10. HCC159 Pressure Ulcer of Skin with Partial Thickness Skin Loss

The PY2020 Part 1 Advance Notice broke down the final adjudication of the ten considered HCCs as follows:

- HCCs 89, 102, 113, and 140 were clinically too vague and/or made-up of ICD codes with too high a level of diversity.
- HCCs 41, 42, and 95 are so prevalent within the Medicare population that their inclusion would not increase the predictive accuracy of the average medical expenditure.

- HCCs 51, 52, and 159 were found to have met the conditions for inclusion, "… in that they are well-specified, predict medical expenditures, are definitively diagnosed and can indicate significant disease burden."

Pulse8 Insight: *Pulse8 endorses the proposed changes, as we do any improvements to the CMS-HCC Risk Adjustment model, and is proud to share with our customers the following projections for their impact:*

- *Dementia*
  - *Pulse8's analyses estimate that HCCs 51 Dementia with Complications and 52 Dementia without Complications combine to between 3.5% and 5.5% of plan-established members.*
  - *The average risk score for members with either or both dementia HCCs (they carry the same base risk score coefficient) is estimated to be between 0.340 and 0.355 based on the six-sided Community Risk Model distribution of the plan.*
  - *The average estimated, annualized increase to risk adjustment payment for the combined dementia HCCs is $6.75 PMPM as calculated using the parameters listed in Figure 3 above.*

- *Pressure Ulcer / Partial Thickness Skin Loss*
  - *Pulse8's analyses estimate that HCC 159 Pressure Ulcer of Skin with Partial Thickness Skin Loss is diagnosed for about 0.2% of plan-established members after the CMS-HCC hierarchy is applied.*
  - *The average risk score for members with HCC 159 is estimated to be between 0.630 and 0.675 as per the six-sided Community Risk Model distribution of the plan.*
  - *The average estimated, annualized increase to risk adjustment payment for the combined dementia HCCs is $0.75 PMPM as calculated using the parameters listed in Figure 3 above.*

With each passing year, CMS continues to advance the predictive accuracy of its model. However, these improvements usually infuse added complexity. The latest proposed changes are no exception. Plans looking to optimize their performance, under such a complex and nuanced model, need to dedicate themselves to rigorous data analytics, whether internally or with their vendor partner.