Pulse8
EVERY NUMBER IS A LIFE.

21st Century Cures Act

Medicare Advantage Impact

Review of Relevant Provisions with Expert Insight

March 2017

PULSE8 is privileged to bring you a summary of key Medicare Advantage program requirements within the 21st Century Cures Act. The bill was signed into law on December 13, 2016 by President Barack Obama.

Key Medicare Advantage Requirement Update Announcements

- Issuance of Risk Adjustment Methodology Change Requirements (Expanded Detail Below)
- Order for a Temporary (through 2018) Stay of Plan Termination for 5-Star Program Underachievers
- Mandate to Allow Medicare Advantage Enrollment for ESRD Beneficiaries
- Implementation of a 3-Month Open Disenrollment Option for All Beneficiaries

RISK ADJUSTMENT METHODOLOGY CHANGE REQUIREMENTS

Full Impact to be Phased-In over Payment Years 2019 through 2022

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. In practice, these changes will raise risk capitation payments, on a sliding, "HCC count per beneficiary" scale.

- Pulse8 foresees the development of a multiplier variable applied to an individual's calculated HCC risk factor. The multiplier would serve to increase an individual's base risk factor incrementally by a member's total condition count.
- The impact of this methodological risk score augmentation will be to spike capitation payments for beneficiaries carrying multiple conditions. Plans with relatively high "average conditions per beneficiary" will see higher PMPM capitation revenue.

Pulse8 Insight: The value of capturing all of a beneficiary's risk-adjusted conditions will become that much more valuable with this update. MA plans should make sure their HCC diagnosis targeting analytics include co-morbid clinical rules to adjust intervention lists accordingly. For example, plans should have analytics programming to account for the following scenario: Beneficiary X and Y have different HCC gaps with nearly equal risk factor potential. Beneficiary X's associated conditions have a relatively high HCC co-morbidity rate, whereas beneficiary Y's disease profile is not indicative of overlapping conditions. In this scenario, with all other variables equal, beneficiary X's potential risk score value is now (due to the changes of the Cures Act) higher than that of beneficiary Y. The plan's gap closure analysis and reporting should reflect this valuation to realize the higher risk to beneficiary X's well-being.

Expand Date Range from One to, At Least, Two Calendar Years of Diagnosis Data

The Cures Act very simply states, "The Secretary may use **at least** 2 years of diagnosis data."

- Pulse8 assumes that CMS will implement an official, "acute/chronic" indicator convention, either at the HCC or ICD level, to restrict the application of episodic (acute) diagnoses to just one payment year risk score adjustment. For example, bone fracture diagnosis risk factors should will only be applied to the capitation payment of a single year to offset the one-time costs of fracture treatment.
- Again, assuming CMS develops distinct acute and chronic rules, and assuming the Secretary increases the years of diagnostic data to only two, the chronic HCC model diagnoses will "be good for" 24 months' worth of risk score adjustment. As a result, MA plans' HCC gap closure activity should decrease as more gaps close "naturally" due to the increased subset of professional and facility claims data from which to draw and match.

Pulse8 Insight: The expanded service date range will require MA plans to include algorithmic analysis for predictive modeling of natural gap closure. Plans that do not account for the doubling of gap-closing claims data will see their intervention program ROI rates plummet due to the wasted expense of needless chart pulls and in-home assessment visits.

Evaluation of Mental Health and Substance Use Disorders

From the 21st Century Cures Act text, "Secretary shall evaluate the impact of including additional diagnosis codes related to mental health and substance use disorders in the risk adjustment model."

- Pulse8 clinical coding experts interpret this requirement as a possible reference to an ICD9 to ICD10 discrepancy within the diagnosing and coding of depression. The old ICD9 convention recognized the diagnosis of "depression, not elsewhere classified". Conversely, ICD10 does not acknowledge depression-NEC as a valid diagnosis; as result, physicians must use one of the ICD10 "major depression" family of codes.

- CMS' HCC ICD9 methodology excluded depression-NEC and included all major depression diagnoses. CMS' ICD10 HCC methodology includes almost all the major depression diagnoses; the most notable exception is the ICD10 code identified as the major depression equivalent of ICD9 depression-NEC.
- The net impact of the ICD9/ICD10 discrepancy is a significant decrease in depression HCC volume under the ICD10 model. CMS' maneuvers to work-around the ICD10 rejection of depression-NEC has incorrectly excluded many true major depression conditions from being identified and treated within the risk adjustment system.

***Pulse8 Insight**: The act only orders the Secretary to evaluate the impact of additional behavioral health ICD10 codes to the HCC model: It certainly is not a given that CMS will add the ICD10 equivalent of ICD9 depression-NEC into the model. Pulse8 recommends that plans continue to educate physicians on depression diagnosis accuracy, specifically in regards to 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.*

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."

Pulse8 clinical coding experts have hypothesized two potential interpretations this requirement:

- Evaluating the preventative value of CKD disease progression tracking by bringing back the CKD Stage 3 diagnosis into the HCC model.
- Determining the actuarial value within and between CKD Stages 3, 4, and 5 by using comorbidity as a gauge for severity: Are the combined risk scores for CKD-comorbid conditions and CKD 3, 4, and 5 risk scores accurate reflections of these patient cohorts? Or, are adjustments to the model factors/methodology required?

***Pulse8 Insight**: Pulse8 experts believe that a return of CKD Stage 3 diagnosis to the HCC model, in and of itself, will have a very small yield due to the low cost of treatment and management; however, CMS may find that severity within and between CKD Stages 3, 4, or 5 is directly tied to specific comorbid conditions, thus creating the need for a bump in risk score for the CHF+CKD/Renal Group interaction bonus, or adding a new interaction bonus category for CKD and other common comorbid HCCs.*