UNDERSTANDING CHANGES TO THE MEDICARE ADVANTAGE 2019 RISK ADJUSTMENT MODEL

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For the majority of medical groups across the country that contract with Medicare Advantage (MA) plans, the early release draft of 2019 Proposed Changes to the CMS-HCC Risk Adjustment Model, and subsequent releases from CMS have put them on notice. These significant and complex proposed changes to the MA model will require plans—and their contracted medical groups—to make financial and clinical adjustments that will impact fiscal and operational processes.

MODEL REVISION TO COMMUNITY MA POPULATIONS

Based on the 21st Century Cures Act signed by President Obama in December 2016, the new MA community model (v23) and risk scores must be modified to account for evaluating the addition of mental health, substance use disorder, and chronic kidney disease conditions. MA plans will also be required to consider the total count of conditions indicated. CMS is reviewing with the industry two methods counting all applicable condition categories or only categories used for payment in the risk adjustment model. CMS has indicated they will implement changes phased in over 3 years (2019-2022) for enrolled community members.

Updates

Anticipated changes include the addition of new Hierarchical Condition Categories (HCCs) and remapping of ICD-10 codes to HCCs based on a new model. New Risk Score Attributes for Payment Condition Count add-ons may consider two approaches: (1) All HCCs to count or consider all applicable diagnoses that map to a condition, even if it is not used in the Risk Score Model, and (2) payment model HCCs may only consider diagnoses that map to conditions in the Risk Adjustment Model HCCs.

New Risk Model

Concurrently updating the risk model for community members, CMS is still transitioning the data collection method from the Risk Adjustment Payment System (RAPS) to the Encounter Data Processing System (EDPS), further complicating the impact of the model change to MA Plans.

Twenty-five percent of the 2019 payment year risk scores for community members will be attributed to the new v23 model and the EDPS data collection method. The other 75% will be attributed to data collected under RAPS, and will continue to use the current v22 risk model.

Additionally, CMS is proposing to combine the RAPS inpatient data with the EDPS data when used with the v23 model, providing a more robust inpatient data set. In short, the majority of the first-year value will be from the RAPS data collection method and the v22 2017 risk model for community members.

MODEL RECALIBRATION

Model coefficients may require updates at least every three payment years to maintain accuracy. The proposal uses Date of Service (DOS) 2014 to predict costs in 2015, resulting from the ICD-10 introduction in 2015 which caused a serious data quality issue; the next calibration will use DOS 2016 or later. Changes propose new coefficients based on more current data collected.

OVERALL COMPLEXITY

The new v23 HCC clinical model will expand the suspecting and targeting for community populations to conditions and specialties that have not been previously targeted, such as behavioral specialists and drug and substance care. Targeting expansion is required to ensure accurate counts, and complexity will increase because all will be phased in concurrent to phasing in EDPS over RAPS.

GOING FORWARD WITH A FOCUS ON QUALITY MEASURES

All changes will be reviewed for their impact on technology/analytics, provider training/engagement, overall operational strategies, and the readiness of the plans to adjust to impending 2019 changes.

This will include improving quality measure reporting overall by following best practices based upon input from medical groups on how to meet the challenges to accurately deliver quality care, document outcomes, and report them accurately—with responsibilities spanning both the health plans and the providers.

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The three common themes in successful quality programs include:

- Alignment of incentives and objectives between patients, providers, payers, and the government to ensure awareness and incentives for all to work toward the same outcomes.
- Integrating risk assessment, care management, and quality reporting into a holistic care program. Eliminating silos or departments fosters efficiency, as well as an integrated view of the population and outcomes.
- Deploying a technology infrastructure that supports an integrated program from start to finish and year-round to allow for continuous data exchange and the ability to deliver actionable information to the point of service.

The complexity of the CMS-HCC risk adjustment changes will increase the burdens on MA plans, and medical groups will feel the impact. Ultimately, the changes will be beneficial as the entire health care system works to improve the quality of patient care across the board.