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Using prescription drug data for identifying missing diagnoses and for medical management in the Medicare Advantage market

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Background

Since the implementation of the CMS-HCC model in 2004, risk adjustment (RA) has been a core component of how insurers that offer Medicare Advantage (MA) plans receive revenue from the Centers for Medicare and Medicaid Services (CMS). CMS utilizes two sets of risk scores in determining payments to MA plans that also offer prescription drug benefits: the Hierarchical Condition Categories (HCC) model that predicts medical claims cost and the RxHCC model that predicts prescription drug claim costs. CMS's goal through the RA process is to align payments to plans with the expected claim costs each plan will incur for a given population. Both the HCC and RxHCC models assign risk scores to individual members based on current year demographics and prior year ICD-10 diagnoses submitted through the Risk Adjustment Processing System (RAPS) and the Encounter Data System (EDS). CMS calculates the revenue for a given year based on diagnoses from the prior year submitted through the end of the January of the year following the revenue year (i.e., 2017 revenue is based on 2016 diagnoses submitted through January 2018). CMS does *not* currently use prescription drug data to develop risk scores.

Analyzing prescription drug data can be a key to success for MA plans

Even though CMS does not use prescription drug data in assigning risk scores, Rx data can still be a valuable resource for MA plans in identifying:

- Potential missing ICD-10 diagnoses
- Members who may benefit from disease management programs
- Suboptimal drug adherence
- Coding of diagnoses for conditions that members do not actually have

Potential missing ICD-10 diagnoses

Unless providers are incentivized by an MA plan to code completely and accurately or their practice/facility requires them to do so, they may not have the time or resources to ensure that the diagnosis codes submitted to the MA plan through claims are complete and accurate. For physicians in particular, reimbursement is generally based on the procedure codes submitted with the claim and not the diagnoses. Reviewing the prescription drug claims for each member can help MA plans understand the health conditions of their members. For example, if a beneficiary is regularly filling prescriptions for insulin, the patient has a very high likelihood of having diabetes, since insulin is almost exclusively used to treat diabetes. In this example, an MA plan could do the following:

- Review the prescription drug claims data for each member to determine which members utilize insulin drugs
- For the subset of members taking insulin, review the diagnoses for those members to determine if any of those members do not have a diagnosis that "maps" to a diabetes HCC already submitted by a medical provider
- Review medical charts (for prior years) or work with the member's primary provider or a home visit nurse to determine if the member has diabetes and submit an appropriate diagnosis code for that member if it is appropriate

Assuming that the member who took insulin does have diabetes and it can be appropriately documented, the MA plan could see an increase in revenue for the member of $500 or more per year. The actual revenue change would depend on a number of factors, including the severity of the diabetes, whether the member is over or under age 65, and whether the member is also eligible for Medicaid.

While insulin is almost exclusively used for diabetes, other drugs do not necessarily map exclusively to "disease states" associated with HCCs. For example, a member taking albuterol sulfate may have chronic obstructive pulmonary disorder (COPD); alternatively, he or she may be using the drug for an elongated

bout of bronchitis. While the process for reviewing whether the member is missing diagnoses is similar to that for diabetes, there may be many "false positives" where the medical records or medical status of the member do not support COPD.

One additional benefit of this type of review is that the MA plan can use the information regarding a member's health status to identify members with certain diseases and encourage them to enroll in disease management programs. By increasing the number of members enrolled in successful disease management programs, the MA plan can potentially reduce the incidence of costly inpatient stays or emergency room visits and improve the quality of care for the beneficiary.

Drug adherence

MA plans can also use drug data to help promote drug adherence. When members take the appropriate drugs on the proper schedule, the result can be a reduction in future medical claim costs as well as a positive impact on an MA plan's CMS star rating. To assist in ensuring proper drug adherence, MA plans can examine existing diagnoses/HCCs for their population in order to confirm that members with specific diseases are using the appropriate drugs. For example, if a member has consistently had diagnoses associated with COPD, the MA plan can review the drugs the member is taking on a monthly basis to ensure that the member is regularly filling a prescription (such as albuterol sulfate) in order to reduce the likelihood of emergency room visits or inpatient stays. While some pharmacy benefit managers (PBMs) perform this function, they require access to the medical diagnosis data (which the PBMs do not have directly) in order to target individuals. Hence, it may be more efficient for the MA plan to do this analysis because the MA plan has access to all of the required data.

Ensuring accurate (and not over-) coding

Lastly, over the last few years, there have been at least a couple instances of litigation between the federal government and MA plans for "over-coding" in order to increase revenue.[1] While these articles tend to focus on alleged intentional over-coding in order to "game" the system, CMS has also stated in the Medicare Managed Care Manual that "[i]f upon conducting an internal review of submitted diagnosis codes, the plan sponsor determines that any diagnosis codes that have been submitted do not meet risk adjustment submission requirements, the plan sponsor is responsible for deleting the submitted diagnosis codes as soon as possible." Hence, an MA plan would be in violation of CMS requirements if it did not remove diagnoses that cannot be supported by medical charts that the MA plan or its downstream entities reviewed. Over-coding *and* not removing diagnoses that are not supported by the medical chart both result in overpayment from CMS and are areas that MA plans are actively trying to avoid. Not only is the bad press a deterrent for potential enrollees, but over-coding also can result in legal action and sanctions from CMS.

Reviewing diagnosis data to determine whether members with certain diseases (i.e., diabetes or specified heart arrhythmias) are taking drugs associated with those conditions can help identify whether the diagnosis code is valid or might be incorrectly submitted. For example, members with diabetes should be regularly filling prescriptions for diabetic test strips or other types of diabetic drugs, so if a member has a diagnosis code associated with diabetes and is not filling any prescriptions, this could be an indication of an inappropriate diagnosis. This review of the diagnosis data can be done concurrently with the drug adherence review to ensure that members with certain conditions are taking the appropriate drugs. Whether it is an incorrect diagnosis or a lack of adherence, the situation requires the MA plan to be proactive in ensuring either accurate coding or appropriate care for the member.

Conclusion

Since the revenue for an MA plan each year is based on member diagnoses incurred in the prior year and submitted within 13 months of the end of that period, MA plans have a meaningful period of time to ensure complete and accurate coding as well as identify members for disease management and potential drug adherence outliers. During that time period, MA plans must collect data, analyze it, and take all appropriate action to ensure that their revenue reflects the underlying health status of their members and whether there are opportunities to manage medical costs. Because each year's revenue is based on diagnoses only for the prior year (and not multiple years) and the health status of members and their diseases can change every year, MA plans need to continually analyze their medical diagnoses and corresponding prescription drug data. MA plans cannot rely only on prior years' experience to ensure appropriate revenue and disease management due to the ever-changing health status of their population.

1 Dinerstein, C. (February 2017). The Department of Justice believes United Healthcare is defrauding Medicare. The American Council on Science and Health. Accessed September 4, 2017, at **https://www.acsh.org/news/2017/02/21/department-justice-believes-united-healthcare-defrauding-medicare-10885**.

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