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# Implementing Medical Frailty Under Community Engagement (Section 71119 of WFTC Legislation)

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# Provisions of the Interim Final Rule with Comment Period (IFC)

# Background

- The definition of **specified excluded individuals** who do not need to meet the community engagement requirement in section 1902(xx)(9)(A)(ii) of the Social Security Act (the Act) includes **an individual who is medically frail** or otherwise has special medical needs (as defined by the Secretary) including an individual:
  - Who is **blind or disabled** (as defined in section 1614 of the Act);
  - With a **substance use disorder (SUD)**;
  - With a **disabling mental disorder**;
  - With a **physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living (ADL)**; or
  - With a **serious or complex medical condition**.
- CMS **interpreted the medically frail exclusion** in the community engagement IFC at 42 CFR 435.554(c)(5).

# Medically Frail Definition in the IFC (slide 1 of 3)

- CMS **defined** medically frail or otherwise has special medical needs (henceforth referred to as medically frail) at 42 CFR 435.554(c)(5)(i).
- While there is similarity between how medically frail is defined in the community engagement IFC and Alternative Benefit Plan (ABP) regulations, the definitions are not identical. The IFC definition must be used to define medical frailty for the purpose of determining exclusion from the community engagement requirement.
- CMS is **not providing** states with **the flexibility to include populations beyond the five categories** included in the statute.
- The IFC provides that an individual in one of the five categories is considered medically frail only if the individual's **physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirement**. This requirement applies to all the medically frail categories.

# Medically Frail Definition in the IFC (slide 2 of 3)

- CMS further **defined an individual with an SUD** in the IFC as **excluding individuals in stable recovery** (which means, an individual in recovery for 5 or more years).
  - The IFC definition **includes individuals in early and sustained recovery** (less than 5 years).
- CMS also defined **a serious or complex medical condition** in the IFC consistent with the Institute of Medicine's (IOM) report "Definition of Serious and Complex Medical Conditions":
  - A **serious or complex medical condition is a medical condition that is** life threatening, seriously disabling without necessarily being life threatening, causing significant pain or discomfort that can cause serious interruptions to life activities, requiring a major time or effort commitment from caregivers for a substantial period of time, requiring frequent monitoring, associated with severe consequences or negative consequences for someone else, affecting multiple organ systems, requiring management to tight physiological parameters, requiring coordination of multiple specialties, requiring treatment that carries a risk of serious complications, or requiring adjustment in non-medical environments.

# Medically Frail Definition in the IFC (slide 3 of 3)

- CMS did **not further define** in our regulation **the following medically frail categories** identified in the community engagement statute:
  - An individual who is **blind or disabled** (as defined in section 1614 of the Act);
  - An individual with a **disabling mental disorder**; and
  - An individual with a **physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more ADL**.

# Medically Frail Lists of Conditions

- At 42 CFR 435.554(c)(5)(ii) CMS required that **states must develop a list of diseases, diagnoses, disorders, or other health conditions (henceforth referred to as conditions) to identify individuals who are medically frail**.
  - The list **must be auditable, justifiable, and consistent** with the definition of medically frail established at 42 CFR 435.554(c)(5)(i)(A) through (E).
  - The list **must be revised on a regular basis** to add or remove conditions based on the state's experience applying this exclusion.
- If an individual does not have a condition on this list, **states must have reasonable processes and criteria in place for individuals to request consideration for the medically frail exclusion**.

# Medically Frail Verification

- States must attempt to verify medical frailty using reliable information available to the state, which includes claims relevant to the individual that were adjudicated in the prior 12 months (including claims that were paid, pended or denied), encounter data relevant to the individual from the preceding 12 months, as well as any other health data (e.g., health information exchange (HIE) data) for an individual *(ex parte* verification).
- If there are no reliable data available to the state to verify medical frailty or the data are not reasonably compatible with the information provided by or on behalf of the individual:
  - **Before January 1, 2028**, the state may require documentation or may accept a statement or other information provided under penalty of perjury (hereinafter referred to as a "self-declaration") each time the state verifies the individual's medically frail status.
  - **Beginning on January 1, 2028**, the state may accept a self-declaration provided under penalty of perjury *only once* during the beneficiary's period of enrollment (defined as continuous period of enrollment in coverage under the state plan or waiver without the individual being disenrolled). At the individual's first renewal thereafter and each subsequent verification, the individual's medically frail status must be verified using reliable information available to the state or documentation submitted by (or on behalf of) the individual.
- After verifying medical frailty using reliable information or documentation, states must reverify an individual's medical frailty status at least every 12 months.

# Medically Frail Identification Example: A Tiered Medical Frailty Framework

# Medical Frailty Implementation (slide 1 of 2)

- As noted in the IFC, states must, where possible, verify medical frailty on an *ex parte* basis using reliable information available to the state without requiring the individual to submit additional information.
- The following slides provide examples of how a state could implement the medically frail exclusion via a tiered medical frailty framework using reliable information primarily from adjudicated claims or encounter data.
- States are not required to use this example tiered medical frailty framework. There are a number of data-driven approaches that states could take to implement the IFC.
- We also recognize that medical frailty is one of several exclusions states will be evaluating to determine if an applicant or beneficiary qualifies as a specified excluded individual and encourage states to design their process in such a way that minimizes administrative burden, considering factors such as the availability of data and the likelihood an individual has reasonably available documentation if data are not available.
  - States may wish to first look at exclusions for which reliable information is readily available in the state's system (e.g., status as a parent of a dependent child 13 years of age or under, pregnancy status or American Indian status) before evaluating qualification for exclusions that require other data sources or are more likely to require documentation, which may include medical frailty.

# Medical Frailty Implementation (slide 2 of 2)

- We encourage states to categorize their list of conditions required under 42 CFR 435.554(c)(5)(ii) consistent with how they implement their medical frailty framework (e.g., if a state adopts the tiered medical frailty framework, then Tier 1 conditions should be categorized separately from Tier 2 conditions, etc.).
- We remind states that whether they use this example tiered medical frailty framework or another approach in implementing the IFC, an individual must have a condition that falls under one of the five categories described at 42 CFR 435.554(c)(5)(i) and the individual's physical, mental, or other behavioral health condition must significantly impair the individual's ability to comply with the community engagement requirement in order for the individual to be determined medically frail.

# Tiered Medical Frailty Framework

*Discussed in more detail later*

- States could utilize a tiered approach building on available coding and data sets to better organize a list of qualifying conditions for medical frailty.
- For example, states could utilize a three-tiered framework to identify individuals who may qualify as medically frail based on their conditions:
  - **Tier 1** conditions are those from which the state can confirm that the individual's ability to comply with the community engagement requirement is significantly impaired based on the information included in readily available International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) code data.
  - **Tier 2** consists of conditions that <u>may indicate</u> an individual is medically frail but additional information is needed to determine if the condition significantly impairs the individual's ability to comply with community engagement, such as by assessing severity or functional status (e.g., elevated acute care utilization, high-risk polypharmacy, use of certain durable medical equipment) or other factors indicating impairment (e.g., co-morbidities, chronic conditions, acute or temporary conditions like injuries or surgery).
  - **Tier 3** means there is insufficient <u>OR</u> no information or data to assess medical frailty based on Tier 1 / Tier 2 criteria alone. This should trigger a manual individualized review process where additional documentation may be required prior to deciding on exclusion.

# Step-wise Approach for Implementing Tiered Medical Frailty Framework

| Identify the universe of applicable conditions | Match applicable conditions to relevant code sets | Develop methodology using tiered framework | Apply methodology against available beneficiary data |
|---|---|---|---|
| • Identify which conditions support a finding that the individual is medically frail, **OR** could, in select circumstances, be significantly impairing (e.g., Type 2 diabetes with foot ulcer).<br>• We remind states they must have reasonable processes and criteria in place for individuals with conditions not identified to request consideration for the medical frailty exclusion. | • For each applicable condition, identify all types of data and codes that could relate to the presence of the condition.<br>• Relevant data may include fee-for-service (FFS) claims, managed care encounters, HIEs, health data utilities, and / or all-payer claims.<br>• Codes may include ICD-10, Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), National Drug Codes (NDCs), place of service codes, etc. | • Using existing codes and datasets, develop a set of rules that would determine whether an individual would meet Tier 1 or Tier 2 criteria.<br>• Develop and apply a methodology on historical claims and other data used to verify medical frailty to assess percentage deemed medically frail and validate with clinicians. | • Apply the methodology to the individuals identified as potentially being medically frail to make a determination for purposes of community engagement exclusions.<br>• Establish a cadence to re-run the logic (at least once every 12 months) and update medical frailty determination as beneficiary health status and data change over time. |

# Implementing the Medically Frail Exclusion: Data Sources and Codes (slide 1 of 4)

- States should consider using administrative and clinical data sources to identify individuals who are medically frail, such as:
  - FFS claims;
  - Managed care encounters;
  - HIEs/electronic health records;
  - Health data utilities;
  - Worker's compensation claims;
  - Short-term disability claims; and/or
  - All-payer claims databases.
- These data sources and any logic or methodologies need to be linked to eligibility and enrollment systems, which involves significant coordination among clinical, IT, policy, data systems, and eligibility operations staff.
- States may phase-in data sources (e.g., HIEs, etc.) to complement more readily available administrative data sources (e.g., claims and encounter data) to improve data matching processes for identifying medically frail individuals.

# Implementing the Medically Frail Exclusion: Data Sources and Codes (slide 2 of 4)

- We encourage states to use the ICD-10 code set to identify diseases, diagnoses, disorders, or other health conditions (conditions) that are likely to identify individuals who may qualify as medically frail in conjunction with functional- and utilization-related code sets that may more accurately identify the severity of a condition, such as:
  - CPT codes;
  - HCPCS codes;
  - Claims for specific services such as inpatient services, pharmacy services, durable medical equipment, and personal care services;
  - NDCs;
  - Place of service codes; and
  - Revenue codes.

# Implementing the Medically Frail Exclusion: Data Sources and Codes (slide 3 of 4)

- States could use existing data sources to identify the specific codes to include in their process for identifying individuals who are medically frail, such as:
  - Codes used for Alternative Benefit Plan (ABP) medically frail determinations, if they meet the definition at 42 CFR 435.554(c)(5)(i);
  - The Chronic Conditions Data Warehouse (CCW);
  - The HEDIS Frailty and Advanced Illness criteria; and
  - Existing SUD and serious mental illness (SMI) 1115 demonstrations.
- States could also consider convening workgroups or other partnerships with clinicians, vendors, managed care plans, and stakeholders to help develop or refine their code sets.
- We remind states that non-medical coding on its own cannot be used to determine that an individual is medically frail (e.g., a Z code for homelessness could not be used on its own to determine that an individual is medically frail, but other coding that shows the individual has a disabling mental disorder that significantly impairs the individual's ability to comply with the community engagement requirement could).

# Implementing the Medically Frail Exclusion: Data Sources and Codes (slide 4 of 4)

- The example tiered medical frailty framework outlined in this deck primarily relies on ICD-10 codes for Tier 1 and then ICD-10 codes in conjunction with functional- and utilization-related codes for Tier 2.
- States can follow this approach or choose to use a combination of codes at different tiers in developing their own methodology.
- The following slides provide more detailed information on the application of data sources and codes to the example tiered medical frailty framework.

# Application of Medical Frailty Framework (slide 1 of 5)

- Tier 1
  - Are those conditions from which the state can confirm that the individual's ability to comply with the community engagement requirement is significantly impaired based on the information included in readily available ICD-10 code data.
  - Individuals with existing claims can be identified largely from medical claims and managed care encounters using ICD-10 codes that demonstrate a condition significantly impairs an individual's ability to comply with the community engagement requirement.
    - States may use codes other than ICD-10 diagnosis codes (e.g., revenue codes) to determine medical frailty where diagnosis codes are not available.
  - Examples of ICD-10 codes that could exclude an individual include, but are not limited to:
    - ICD-10-CM C25.0: Malignant neoplasm (cancer) of the head of the pancreas;
    - ICD-10-CM G12.21: amyotrophic lateral sclerosis (ALS);
    - ICD-10-CM N18.6: end-stage renal disease (ESRD); and
    - ICD-10-CM B22.0 (Human Immunodeficiency Virus (HIV) disease resulting in encephalopathy).

# Application of Medical Frailty Framework (slide 2 of 5)

- Tier 2
  - Individuals who have an identified condition on the state's list, but it cannot be determined from the ICD-10 diagnosis code, or other coding when ICD-10 codes are not available (e.g., revenue codes, etc.), if their condition significantly impairs their ability to comply with the community engagement requirement.
  - States may use multiple data points, such as additional diagnosis (e.g., co-morbidities) and utilization data available to the state (e.g., pharmacy claims or HIE data) and methodologies to identify individuals for the exclusion.
  - States could use the diagnosis codes in conjunction with functional- and utilization-related code sets that may more accurately reflect whether a condition significantly impairs an individual's ability to comply with the community engagement requirement, such as CPT, HCPCS, NDCs, etc.
  - This tier could include individuals with multiple serious chronic conditions in conjunction with high service utilization or repeated inpatient admissions for serious or complex conditions.

# Application of Medical Frailty Framework (slide 3 of 5)

- Tier 3
  - For individuals where there is insufficient data OR no data for Tier 1 or 2, this triggers a manual individualized review where states may seek documentation from the individual to verify whether the individual qualifies as medically frail.
  - The type of documentation may include, but is not limited to:
    - Health records such as medical history, treatment records, progress notes, discharge paperwork, medication lists, and lab or other diagnostic test results;
    - Provider documentation or certification;
    - Managed care plan care management information; and/or
    - Level of care or functional assessment information that is not in a state's administrative data.
  - Subject to the state option to accept self-declaration under penalty of perjury before January 1, 2028, and thereafter one declaration of medical frailty per period of enrollment, the state is ultimately responsible for using documentation to determine if an individual qualifies as medically frail.

# Application of Medical Frailty Framework (slide 4 of 5) – Key Points

- Because an exclusion on the basis of medical frailty depends on whether a health condition or conditions significantly impairs an individual's ability to comply with the community engagement requirement, determining whether an individual qualifies for the exclusion may require consulting multiple data sources.
- The aim of a data-first approach is to limit the need to rely on manual verification by a clinician or caseworker to determine medical frailty.
- In the following slides, we identify several clinical conditions as fictional illustrative examples to demonstrate the nuance in determining medical frailty for a beneficiary:
  - Coronary artery disease;
  - Type 2 diabetes;
  - Breast cancer;
  - Anxiety; and
  - SUD.

# Application of Medical Frailty Framework (slide 5 of 5) – Key Points

- For each of these conditions, we will discuss various clinical vignettes and how datasets would put each individual into Tier 1, Tier 2, or Tier 3.
- The clinical vignettes are meant to convey a fuller picture of each fictional individual's circumstances but are **not** meant to imply that a state needs to know all of the circumstances captured in the vignettes to determine medical frailty.
- Accompanying the clinical vignettes is a non-exhaustive set of actual data that might be available to a state; these codes are what would form the basis for determining medical frailty for a potential individual in each of the illustrative examples.

# Coronary Artery Disease – Tier 1 Example

**Clinical vignette**

Sam is a 50-year-old man with a past medical history of hyperlipidemia, type 2 diabetes, and obesity who has developed increasing shortness of breath and chest discomfort with exertion. His wife calls an ambulance after he almost passes out at home and EMS takes him to his local community emergency department, where he is admitted for further workup. A cardiac echo demonstrates an ejection fraction of 30%, and he is found to have multivessel coronary artery disease on coronary angiogram.

He is seen by the inpatient cardiology and cardiac surgery teams and is consented for a coronary artery bypass graft surgery. After 2 weeks in the hospital, he is discharged home with home physical therapy and skilled nursing. He is also asked to adhere to a cardiac regimen to manage his condition.

**Data availability for State Medicaid Agency (*Red* = qualifying codes on a standalone basis)**

| Data source | Select codes available based on 12-month look back (not exhaustive) |
|---|---|
| Medical claims | ***ICD-10-CM I50.21**: Acute systolic (congestive) heart failure* |
| Pharmacy claims | **NDC 16103-351-11**: Aspirin<br>**NDC 0078-0659-20**: Sacubitril-valsartan<br>**NDC 10631-008-30**: Metoprolol<br>**NDC 30698-060-10**: Furosemide<br>**NDC 0597-0152-07**: Empagliflozin<br>**NDC 0615-8008-05**: Atorvastatin |

**Determination:** Tier 1 medical frailty based on recent ICD-10-CM code, which demonstrates acute systolic (congestive) heart failure. Please note that there could be other data elements in an actual claim that could support a determination of medical frailty (e.g., MS-DRG indicating major cardiovascular procedure).

# Coronary Artery Disease – Tier 2 Example

**Clinical vignette**

Maria is a 54-year-old woman with hypertension, obesity, osteoarthritis, hyperlipidemia, and type 2 diabetes who underwent complex percutaneous coronary intervention 2 years ago for triple vessel coronary artery disease since she was deemed not a surgical candidate. Her recent echo demonstrated an ejection fraction of 40% and a stress test indicated no reversible ischemia that would require intervention but she had multiple regional wall motion abnormalities.

She has been adherent to her medications, and she is on maximally tolerated doses of guideline-directed medical therapy. She has been able to avoid ED visits and hospitalizations over the past year but cannot walk more than 30 feet without feeling short of breath and uses a rolling walker to assist. Her cardiologist documents that her functional decline is due to her coronary artery disease and refers her to complete an intensive cardiac rehabilitation program.

**Data availability for State Medicaid Agency (*Orange* = qualifying codes only in combination and set by state)**

| Data source | Select codes available based on 12-month look back (not exhaustive) |
|---|---|
| Medical claims | ***ICD-10-CM R00.89**: Dyspnea, other*<br>**CPT 93306**: Transthoracic echocardiography (TTE)<br>***E0135**: Walker, folding, wheeled, adjustable or fixed height*<br>***G0422**: Intensive Cardiac Rehabilitation (ICR) that includes exercise, w/ or w/o continuous ECG monitoring* |
| Pharmacy claims | ***NDC 00093-7314-98**: Clopidogrel*<br>***NDC 16103-351-11**: Aspirin*<br>***NDC 0078-0659-20**: Sacubitril-valsartan*<br>***NDC 10631-008-30**: Metoprolol*<br>***NDC 30698-060-10**: Furosemide* |
| HIE / clinical data | **LP35943-7**: Walking speed < 1.5 m/s |

**Determination:** Tier 2 medical frailty based on combination of need for walker and intensive cardiac rehabilitation, despite nonspecific ICD-10-CM codes

# Type 2 Diabetes – Tier 1 Example

**Clinical vignette**

James is a 45-year-old man with longstanding poorly controlled type 2 diabetes and hypertension.

He has been on insulin for 10 years and his most recent HbA1c is 10.2%. His problem list reflects diabetic chronic kidney disease stage 4 with a creatinine of 3.6 (GFR 22), requiring nephrology monitoring for dialysis planning; bilateral proliferative diabetic retinopathy for which he has undergone multiple rounds of laser photocoagulation and now has significant visual impairment in his left eye; and a below-knee amputation of his right leg two years ago following a non-healing diabetic foot ulcer.

Because of his amputation, the patient now uses a wheelchair. He has started to develop a new ulcer on his left leg, and he has home health services to help with wound care.

**Data availability for State Medicaid Agency (*Red* = qualifying codes on a standalone basis)**

| Data source | Select codes available based on 12-month look back (not exhaustive) |
|---|---|
| Medical claims | ***ICD-10-CM E11.3519**: Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye* |
| Pharmacy claims | **NDC 0088-2219-05**: Insulin glargine<br>**NDC 0169-2100-11**: Insulin aspart<br>**NDC 0591-0408-01**: Lisinopril<br>**NDC 72865-260-01**: Torsemide<br>**NDC 58468-0130-1**: Sevelamer carbonate<br>**NDC 0378-3952-05**: Atorvastatin |

**Determination:** Tier 1 medical frailty based on the ICD-10-CM code, which demonstrates a significant complication of type 2 diabetes. Please note that there could be other data elements in an actual claim that could support a determination of medical frailty (e.g., CPT code indicating treatment of diabetic retinopathy).

# Type 2 Diabetes – Tier 3 Example

**Clinical vignette**

Joyce is a 52-year-old woman with type 2 diabetes. Her most recent HbA1c was 8.0%, reflecting mild dysregulation despite being on metformin and empagliflozin. Her blood pressure is reasonably controlled on lisinopril and amlodipine.

She reports intermittent tingling and numbness in her fingertips and toes bilaterally, and at her last primary care physical, she was told this was likely consistent with early diabetic peripheral neuropathy. She has no skin ulcers, wounds, or lesions. Her pedal pulses are intact, and her basic metabolic panel demonstrated a normal creatinine of 1.1.

She lives with her husband and kids, performs all activities of daily living without assistance, and has no recent ED visits or hospitalizations.

**Data availability for State Medicaid Agency**

| Data source | Select codes available based on 12-month look back (not exhaustive) |
|---|---|
| Medical claims | **ICD-10-CM E11.65**: Type 2 diabetes with hyperglycemia<br>**ICD-10-CM I10**: Essential hypertension<br>**CPT 99213**: Office visit, established patient<br>**G0245**: Initial evaluation, diabetic sensory neuropathy with loss of protective sensation |
| Pharmacy claims | **NDC 67877-221-10**: Metformin hydrochloride<br>**NDC 0597-0152-30**: Empagliflozin<br>**NDC 0591-0408-01**: Lisinopril<br>**NDC 59762-2010-9**: Amlodipine<br>**NDC 0378-3952-05**: Atorvastatin |

**Determination:** Medical frailty cannot be determined based on administrative data as severity is indeterminate or not likely. Manual review would be required before the beneficiary could be classified as medically frail based on diabetes or neuropathy.

# Breast Cancer – Tier 1 Example

**Clinical vignette**

Diana is a 47-year-old woman with limited past medical history who presents to her oncologist for follow-up after a recent diagnosis of HER2-positive, hormone receptor-negative invasive ductal carcinoma of the right breast, staged at IIIC based on involvement of four ipsilateral axillary lymph nodes and a 4.2 cm primary tumor.

She completed neoadjuvant chemotherapy with paclitaxel, trastuzumab, and pertuzumab followed by right modified radical mastectomy with axillary lymph node dissection.

Residual disease was found on pathology so now she must undergo adjuvant chemoradiation, requiring transportation to appointments 3 -5 days a week.

She reports significant fatigue, lymphedema of the right arm requiring a compression garment to the chest wall, and neuropathy in her hands and feet from chemotherapy.

**Data availability for State Medicaid Agency (*Red* = qualifying codes on a standalone basis)**

| Data source | Select codes available based on 12-month look back (not exhaustive) |
|---|---|
| Medical claims | ***ICD-10-CM C77.3**: Secondary and unspecified malignant neoplasms (metastatic cancer) of the axilla and upper limb lymph nodes* |
| Pharmacy claims | **J9267**: Paclitaxel<br>**J9355**: Trastuzumab<br>**J9307**: Pertuzumab |

**Determination:** Tier 1 medical frailty based on the ICD-10-CM code, which demonstrates a recent diagnosis of advanced breast cancer. Please note that there could be other data elements in an actual claim that could support a determination of medical frailty (e.g., CPT indicating modified radical mastectomy for breast cancer).

# Breast Cancer – Tier 3 Example

**Clinical vignette**

Patricia is a 54-year-old woman with a history of stage IIA, hormone receptor-positive, HER2-negative invasive ductal carcinoma of the left breast diagnosed ten years ago, for which she underwent a left lumpectomy with sentinel lymph node biopsy followed by adjuvant radiation therapy and initiated adjuvant endocrine therapy with anastrozole.

She completed her course of anastrozole five years ago with no recurrence identified. She has no evidence of active disease on her most recent annual surveillance mammogram and is seen by her oncologist once yearly for clinical follow-up. She is otherwise up to date on her cervical cancer screening, colorectal cancer screening, bone density scan, lipid panel, HbA1c, and annual primary care visit.

**Data availability for State Medicaid Agency**

| Data source | Select codes available based on 12-month look back (not exhaustive) |
|---|---|
| Medical claims | **ICD-10-CM Z85.3**: Personal history of malignant neoplasm of breast<br>**ICD-10-CM Z13.820**: Encounter for screening for osteoporosis<br>**CPT 99213**: Office visit, established patient, moderate complexity<br>**CPT 77067**: Screening mammography, bilateral<br>**CPT 80061**: Lipid panel<br>**CPT 83036**: Hemoglobin A1c |
| Pharmacy claims | **NDC 63044-401-01**: Vitamin D supplement |

**Determination**: Medical frailty cannot be determined based on administrative data as severity is indeterminate or not likely. Manual review would be required before the beneficiary could be classified as medically frail based on breast cancer diagnosis.

# Anxiety – Tier 1 example

**Clinical vignette**

Marcus is a 51-year-old man with a longstanding history of panic disorder with agoraphobia that has failed low dose sertraline, venlafaxine, and buspirone.

He is now on a combination regimen of high-dose SSRI plus scheduled clonazepam under close psychiatric supervision. Despite treatment, he continues to experience multiple panic attacks weekly, accompanied by chest pain and tachycardia, prompting two additional ED visits in the past 6 months (both with negative cardiac workups).

He is currently unable to leave his home unaccompanied and requires his brother (his primary caregiver) to accompany him to all medical visits, including his twice-weekly outpatient intensive psychiatric program.

**Data availability for State Medicaid Agency (*Red* = qualifying codes on a standalone basis)**

| Data source | Select codes available based on 12-month look back (not exhaustive) |
|---|---|
| Medical claims | ***ICD-10-CM F40.01**: Agoraphobia with panic disorder* |
| Pharmacy claims | **NDC 68180-0353-06**: Sertraline<br>**NDC 00093-0832-01**: Clonazepam |

**Determination**: Tier 1 medical frailty based on ICD-10 code, which demonstrates particularly severe form of psychiatric co-morbidity. Please note that there could be other data elements in an actual claim that could support a determination of medical frailty (e.g., HCPCS code indicating intensive outpatient psychiatric services).

# Anxiety – Tier 3 example

**Clinical vignette**

Priya is a 32-year-old woman with past medical history of anxiety who is followed by her primary care physician for routine adult health maintenance.

In the past, she has described chronic, low-grade worry and occasional difficulty sleeping that has waxed and waned over roughly a decade, attributing flare-ups to various overlapping stressors, including caring for an aging parent and general financial strain.

She denies panic attacks and has never required additional behavioral health care beyond a low-dose SSRI that is managed by her PCP. There is no record of any ED visits or inpatient visits.

**Data availability for State Medicaid Agency**

| Data source | Select codes available based on 12-month look back (not exhaustive) |
|---|---|
| Medical claims | **ICD-10-CM F41.9**: Anxiety disorder, unspecified<br>**CPT 99213**: Office visit, established patient, moderate complexity<br>**CPT 80061**: Lipid panel<br>**CPT 83036**: Hemoglobin A1c |
| Pharmacy claims | **NDC 60687-231-11:** Sertraline |

**Determination**: Medical frailty cannot be determined based on administrative data as severity is indeterminate or not likely. Manual review would be required before the beneficiary could be classified as medically frail based on anxiety diagnosis.

# SUD Medically Frail Category and Recovery

- 42 CFR 435.554(c)(5)(i)(B) excludes individuals in stable recovery from the SUD category of medically frail, which means an individual who is in recovery from an SUD for 5 or more consecutive years would not be considered medically frail under the SUD category.
- To determine an individual in recovery for less than 5 years is medically frail, the state must determine that the SUD significantly impairs the individual's ability to comply with the community engagement requirement.
- 42 CFR 435.557(f)(1) specifies that states may verify an individual's medical frailty by looking back at claims adjudicated in the "preceding 12 months."
- This 12-month lookback period complicates the verification of medical frailty on the basis of an SUD, due to the 5-year timeframe specified in regulation.
- As of the date of this presentation, CMS anticipates allowing states to verify that an individual is not in recovery from an SUD for 5 years or more by using claims and encounter data from the preceding 5 years, notwithstanding the requirement that adjudicated claims and encounter data be from the preceding 12 months.

# Substance Use Disorder – Tier 1 Example

**Clinical vignette**

Raymond is a 51-year-old man with a known history of severe alcohol use disorder and alcoholic cirrhosis who had achieved sobriety for approximately 6 months. He is brought to the hospital by EMS after being found altered and severely intoxicated due to alcohol use relapse.

On arrival, he is altered and also jaundiced, with his liver function tests severely elevated consistent with alcoholic hepatitis. He also has abdominal distention as well as metabolic derangements that are likely consistent with decompensated alcoholic cirrhosis. His wife was called by the medical team, and she reports he has not been taking any of his liver medications.

He is started on steroids for his alcoholic hepatitis, benzodiazepines to manage his eventual withdrawal, and a paracentesis is performed for his abdominal ascites. He remains in the hospital for 3 weeks before being discharged to a skilled nursing facility.

**Data availability for State Medicaid Agency (*Red* = qualifying codes on a standalone basis)**

| Data source | Select codes available based on 5-year look back (not exhaustive) |
|---|---|
| Medical claims | ***ICD-10-CM F10.231**: Alcohol dependence with withdrawal delirium* |
| Pharmacy claims | **NDC 00009-0041-01**: Methylprednisolone<br>**NDC 00641-6001-25**: Lorazepam<br>**NDC 0121-1154-06**: Lactulose<br>**NDC 65649-301-03**: Rifaximin |

**Determination**: Tier 1 medical frailty based on the ICD-10-CM code or MS DRG, which demonstrates that patient has severe features of alcohol use disorder (withdrawal). Please note that there could be other data elements in an actual claim that could support a determination of medical frailty (e.g., MS-DRG indicating admission for alcoholic hepatitis).

# Substance Use Disorder – Tier 2 Example

**Clinical vignette**

Diane is a 39-year-old woman with a history of opioid use disorder and PTSD that started after a motor vehicle accident 4.5 years ago. Following the accident, she was prescribed a prolonged course of oxycodone which triggered her substance use disorder.

Due to her substance use disorder, she requested increasing doses of opioids. Eventually her prescribing physician stopped due to concerns about dependence and encouraged her to seek care.

She connected with a substance use peer counselor 18 months ago who convinced her to get linked in with a methadone clinic, which she visits daily to receive her medication.

Despite her ability to avoid acute care over the past 12 months, she reports that she struggles with significant cravings that interfere with ability to work and she calls her peer counselor 7x per week and engage in group counseling.

**Data availability for State Medicaid Agency (*Orange* = qualifying codes only in combination and set by state)**

| Data source | Select codes available based on 5-year look back (not exhaustive) |
|---|---|
| Medical claims | ***ICD-10-CM F11.21**: Opioid dependence, in remission*<br>***ICD-10-CM F43.10**: Post-traumatic stress disorder, unspecified*<br>***H0020**: Alcohol and/or drug services; methadone administration and/or service*<br>***H0038**: Self-help/peer services* |
| Pharmacy claims | ***NDC 68094-031-59**: Methadone hydrochloride*<br>**NDC 68084-617-01**: Escitalopram |
| HIE | **LOINC 91393-9:** Opioid Risk Tool panel |

**Determination**: Tier 2 medical frailty due to significant time commitment of ongoing daily visits to methadone clinic and weekly frequency of self-help / peer services.