Session 77, Medicaid Risk Adjustment: Understanding State Specific Design & Application for Effective Program Management

2019 Health Meeting

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Session 077 Medicaid Risk Adjustment: Understanding State Specific Design & Application for Effective Program Management

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Session Overview

- Explore the national landscape of state Medicaid risk adjustment program design and application and the key differences that drive effective managed care organization program management.
- Although many states utilize this mechanism, the application of risk adjustment can vary significantly across states. The primary differences include state-specific nuances, population, risk score models and data collection.
- These state application nuances affect the strategies and tactics utilized by MCOs for effective risk adjustment program management including provider financial alignment, encounter data submission and the capture of accurate diagnosis codes.
- Topics included are Beginner and Intermediate Level

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Agenda

- Introduction
- History of Risk Adjustment in Medicaid
- Current “State”
- Using Risk Adjustment in Rate Setting
- Predictive value of CDPS and other national models
- Limitations in Predictive Values of Risk Scores
- Operational considerations

Introduction – *State Implementation Considerations*

- Risk Adjustment (or not) by Category of Aid
- Data Sources & Timeline
- Model Selection
- Risk Weights: Prospective / Concurrent, Standard / Calibrated, Population Level (?)
- Eligibility Requirements: Base Period & Concurrent Payment Period Enrollment (?)
- Data Exclusions & Limitations
- Risk Score Measurement Period and Payment Application Lag
- Encounter Data Submission (Supplemental Data Feeds?)
- State Reporting

Goals of Risk Adjustment

- To make equitable comparisons among health plans that take the health status of their enrolled members into consideration
- To minimize the incentives for plans and providers from selectively enrolling healthier members
- To provide adequate financing for those who treat individuals with higher-than-average health needs
- For Medicaid, provide a budget-neutral (zero-sum) mechanism to allocate capitated payments between contracted managed care organizations

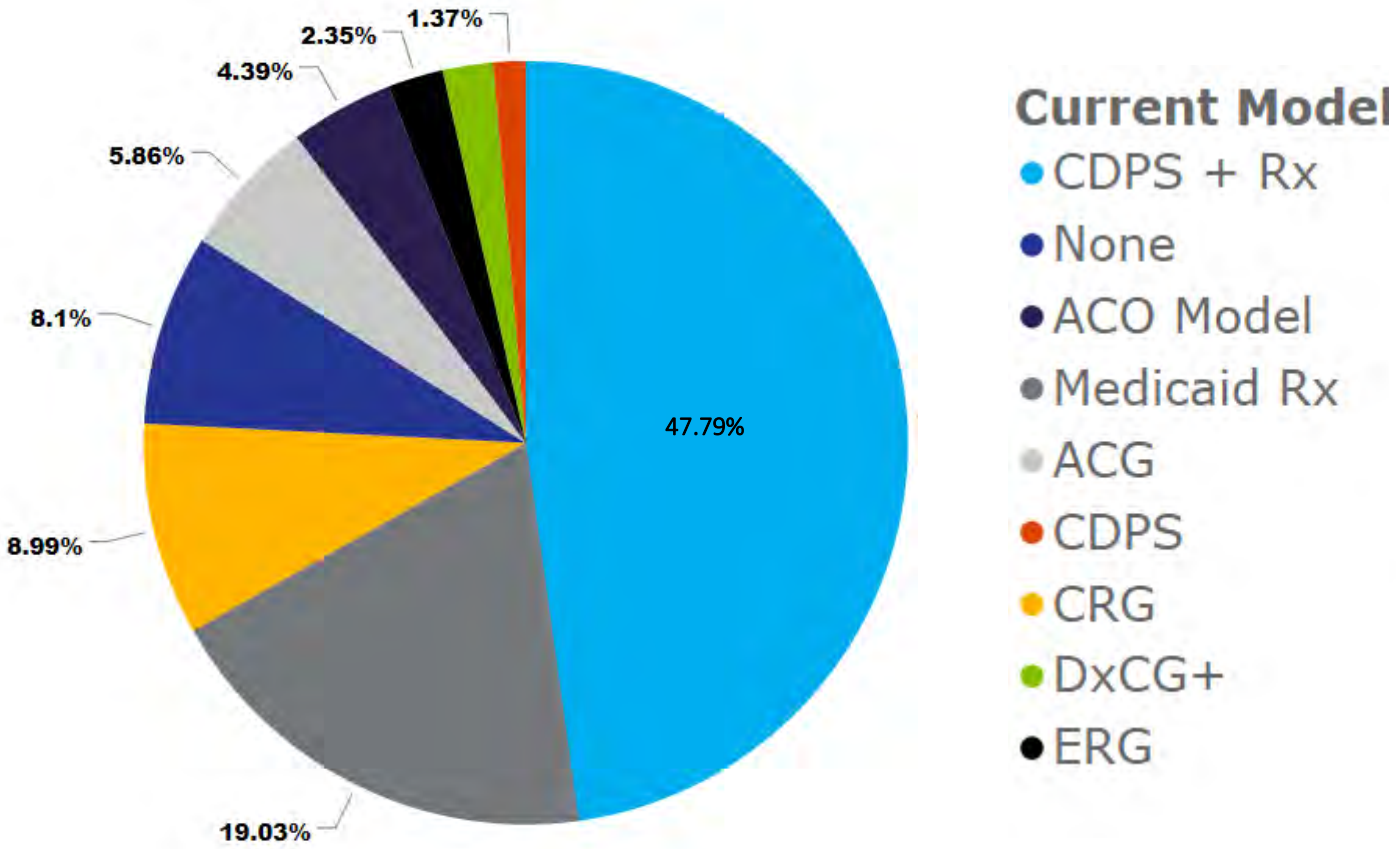
Source: ResDAC

Medicaid Risk Adjustment Overview

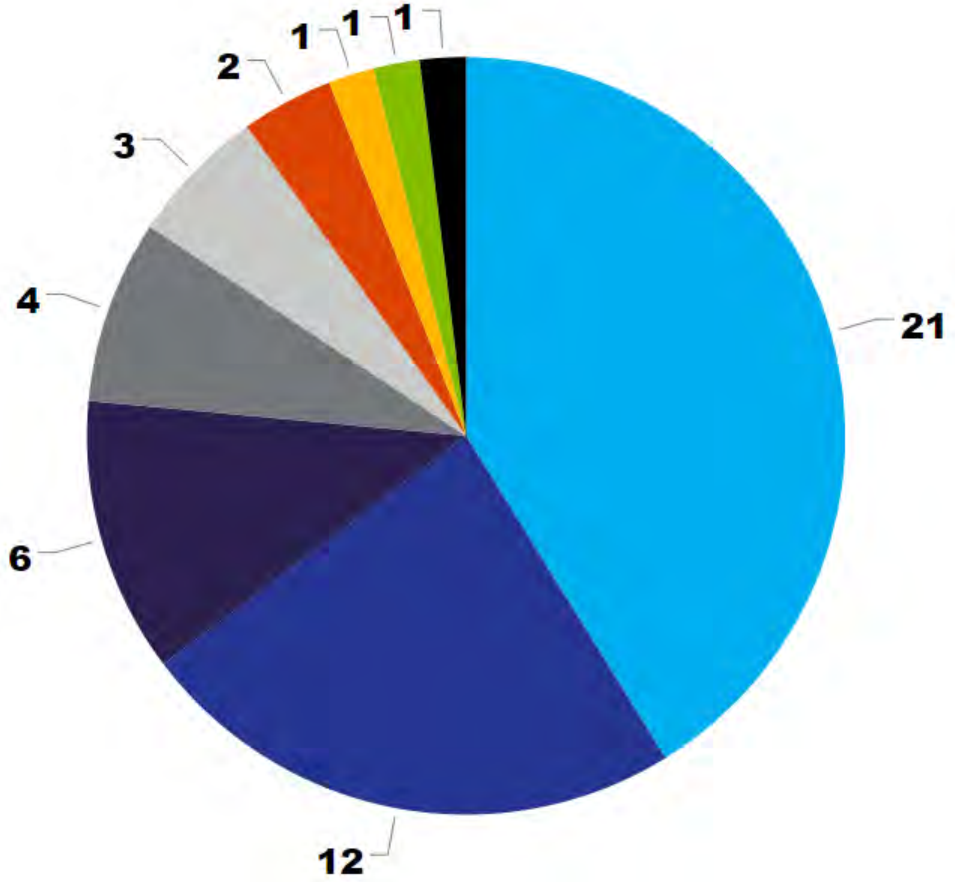
- Programs vary by state
- Zero-sum, budget neutral approach
- Prospective adjustment (issuers know their risk scores in advance)
- Member-level risk scores calculated using encounter data
- Five most common risk-adjustment models: CDPS/MedicaidRx, CRG, ACG, ERG, DxCG
- Some states have developed state-specific risk weights

Medicaid Risk Adjustment Overview

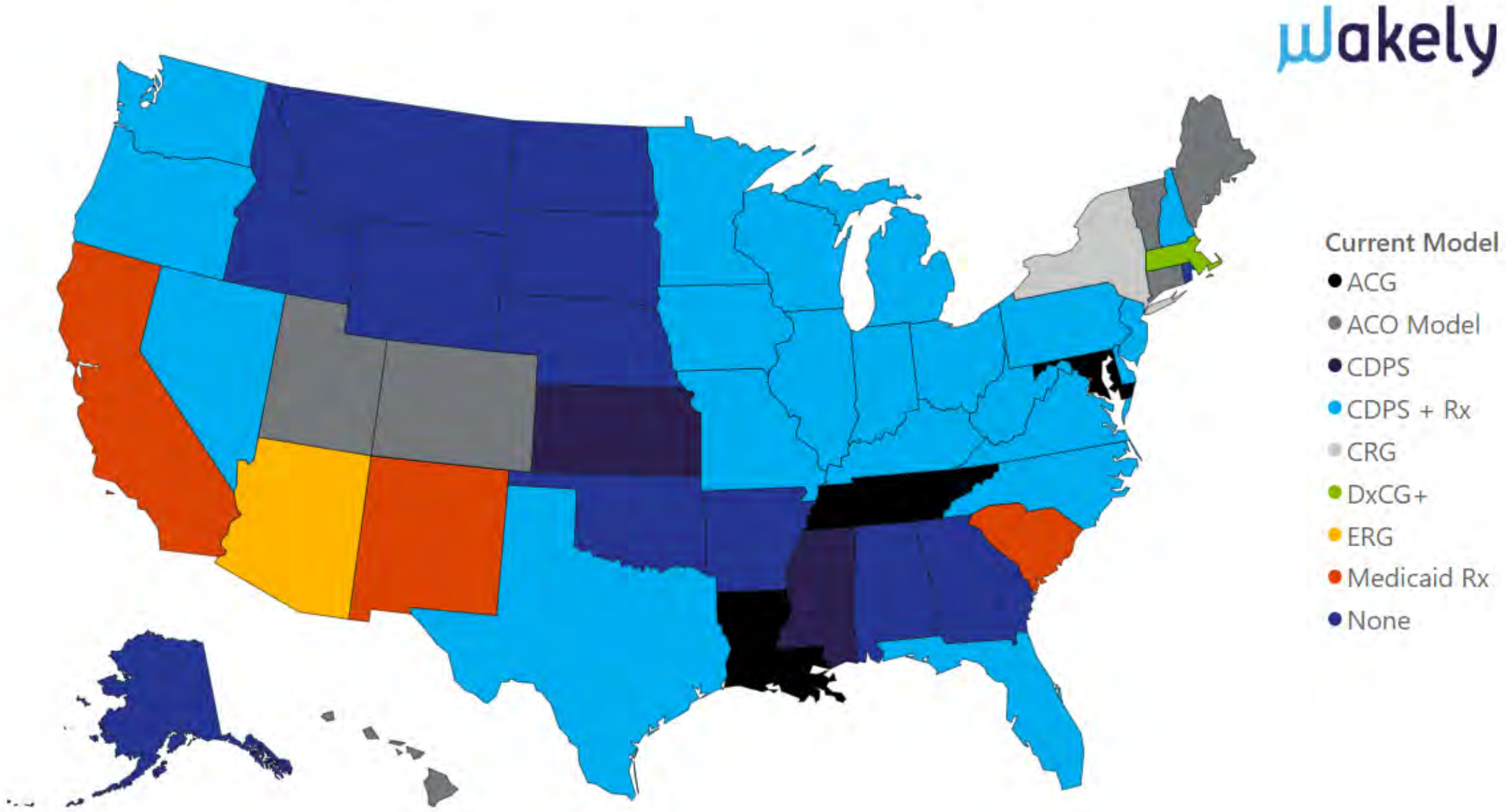
% of Total Medicaid Enrollment by Model



Number of States with Each Model



Risk Adjustment Models in Medicaid Managed Care States



Medicaid Risk Adjustment Models

- Chronic Illness and Disability Payment System (CDPS) – developed by Richard Kronick at UC San Diego
- MedicaidRx – developed by Richard Kronick and Todd Gilmer at UC San Diego
- Clinical Risk Groups (CRG) – developed by DRG team at 3M
- Adjusted Clinical Groups (ACG) – developed by Jonathan Weiner and Barbara Starfield at Johns Hopkins University
- Episode Risk Groups (ERG) – developed by Symmetry, now owned by Optum
- Diagnostic Cost Groups (DxCG) – developed by Arlene Ash and Randall Ellis of Boston University

Risk Adjustment Using CDPS

- CDPS begins with an intercept factor, adds demographic components
- CDPS maps diagnoses to 67 CDPS categories corresponding to major body systems or chronic diseases
- The CDPS model is similar to HCC models used for Medicare, but places greater emphasis on less common, more costly conditions that are more prevalent among disabled Medicaid beneficiaries
- CDPS has different sets of risk weights for disabled, adults, and children
- Conditions are hierarchical within major categories
    - For example, in the major category cardiovascular:
        - CARVH, very high (e.g. heart transplant)
        - CARM, medium (e.g. heart failure)
        - CARL, low (e.g. AMI)
        - CAREL, extra low (e.g. hypertension)

Risk Adjustment Using CDPS

- Weights are additive across categories
- Within major categories, only the most severe diagnosis counts
- Example: if a beneficiary has both diabetes and depression, both count towards the risk score
- Example: if a beneficiary has heart failure and hypertension, only heart failure (CARVH) counts towards the risk score

Risk Score Adjustments

- Risk scores are calculated for each beneficiary
  - Adjustments for region, category of aid, etc may be applied
- Most programs calculate an average case-mix score for each health plan
  - The same capitation amount is paid for each member
- Plan-base risk adjustment advantages:
  - Reduced IT burden
  - Easier to account for new members without claims history
  - Easier to monitor plan payments and adjust if necessary

Actuarial Adjustments

- Partial capitation
- Partial risk adjustment
- Members without sufficient claims history
- Risk corridors
- Reinsurance
- Carve-outs (removing risk weights)
  - Behavioral health
  - Pregnancy and delivery
  - Pharmacy

Should Health Based Risk Adjustment be used in Rate Development?

Medicaid Program Background

- Comprised of many populations, Categories of Aid (COA)
- Each COA must have an actuarially sound rate
- Typically, multiple MCOs participate in a program
- Equal distribution of risk across MCOs/COAs is not likely
- Goal of rate development is “Payment matching Risk”

Widely Accepted Risk Score Tool Implies Actuary can Use it Within a Program, Right?

What about ASOP 45 – Use of Health Status Based Risk Adjustment Methodologies?

- Intended Use – The actuary should consider whether the model was designed to estimate what the actuary is trying to estimate.
- Population and Program - The actuary should consider whether the population and program to which the model is being applied is reasonably consistent with those used to develop the model.
- Predictive Ability—The actuary should consider the predictive ability of the model and the characteristics of the various predictive performance measures commonly used and published.
- Input Data—The input data needs to be consistent with the data used to develop the model and also needs to undergo significant data validation prior to implementing risk score tool.
- Program Specifics—The specifics of the program for which risk adjustment is being used should be considered.
- Recalibration—The actuary should consider the necessity and advantages of recalibration in the context of available resources, materiality of expected changes in results, appropriateness of the unadjusted model risk weights, and limitations in the data available

Predictive Value of Various Risk Score Tools

Based on SOA study: Accuracy of Claims Based Risk Scoring Models, October 2016

- Concurrent Diagnosis Only Models – 24.2% to 52.7%
- Concurrent Pharmacy Only Models – 12.9% to 30.1%
- Concurrent Diagnosis/Pharmacy Models – 25.6% to 55.4%
- Prospective Diagnosis Only Models – 9.1% to 20.7%
- Prospective Pharmacy Only Models – 8.6% to 15.1%
- Prospective Diagnosis/Pharmacy Models – 10.0% to 22.0%

Limitations of Predictive Value – Example of Unintended Consequences

Situation

- Your state program is going through a redesign requiring members to be reassigned to MCOs
- An attribution policy is designed by state to ensure member continuity of care when assigning members to MCOs.
- The attribution policy allows chronic members to stay with their existing and be excluded from random assignment between MCOs.
- CDPS+Rx has historically been utilized within the program to assist with matching payment to risk.

Question

- Should the actuary continue to use CDPS+Rx to ensure payment matches risk under the redesigned program?

Limitations of Predictive Value – Example of Unintended Consequences

Results

	Excluded Members			Included Members			% Difference	
COA	MMs	PMPM	Risk Score	MMs	PMPM	Risk Score	PMPM	Risk Score
TANF	57,163	$ 812.04	2.50	204,727	$ 195.33	0.82	315.7%	205.8%
CHILD 06-18	49,780	$ 611.39	2.53	942,450	$ 98.22	0.74	522.4%	243.0%
Aged/Disabled	103,199	$ 1,786.61	2.10	104,915	$ 377.20	0.62	373.6%	238.4%
CAF	4,475	$ 1,112.58	5.33	50,654	$ 307.30	1.64	262.1%	224.8%
Expansion	96,354	$ 1,136.11	3.48	135,381	$ 192.38	0.89	490.6%	290.4%

% Difference shows that using risk scores would have underestimated acuity level for Excluded Members. Excluded Members include members with chronic conditions that have high annual total cost of care.

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Medicaid Risk Adjustment

Provider Engagement Consideration

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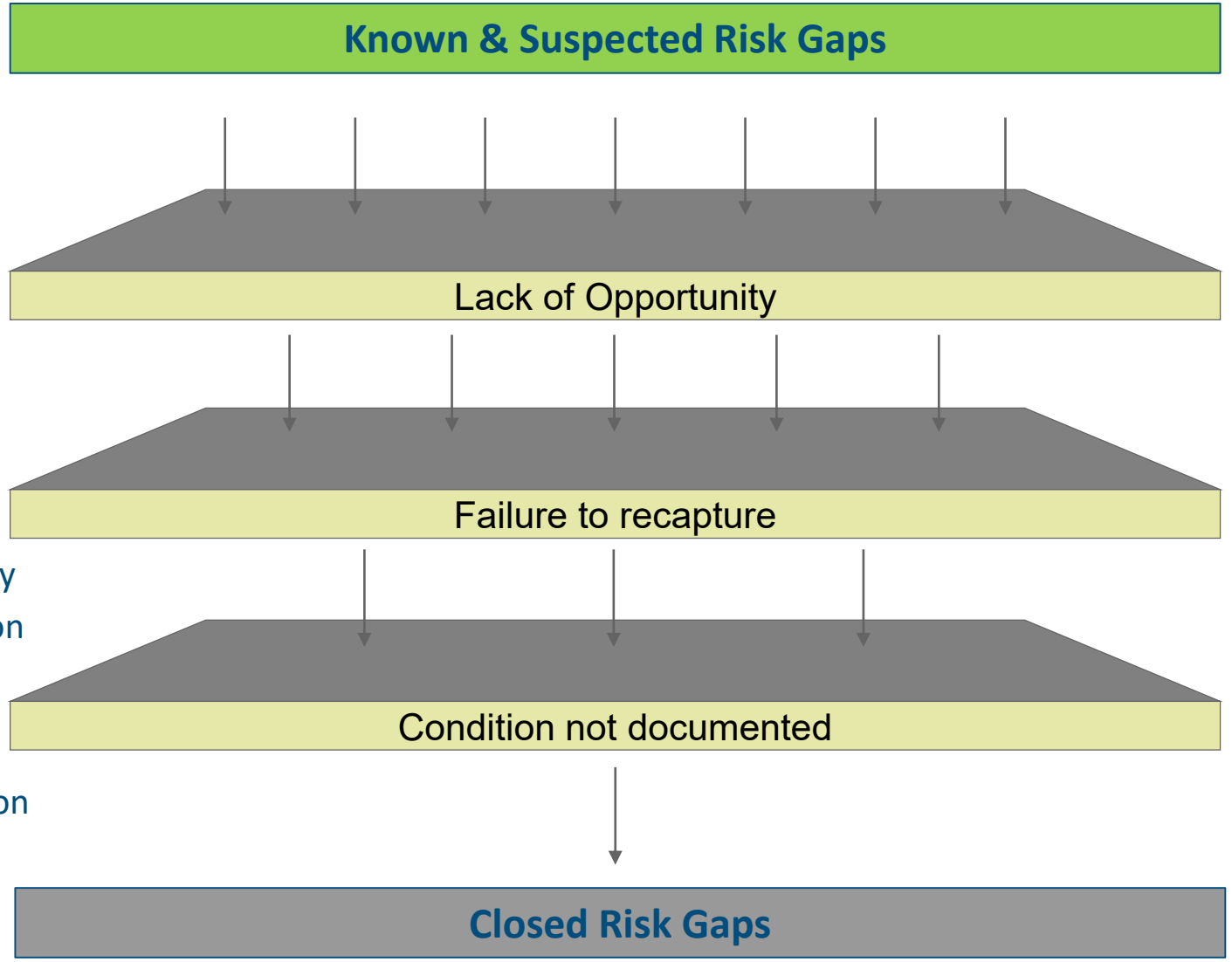
Simplify for Success – RA Operations

Inform RA operations strategy with output from analytical models to ensure risk adjustment programs are aligned with specific opportunities identified:

1. Increase opportunity:
   - Direct engagement with members
   - Provider engagement with members
   - Wait and chase
2. Improve recapture:
   - Prospective - integrate gap data into care delivery
   - Retrospective - chart reviews and data submission
3. Improve documentation:
   - Embed clinical support to facilitate documentation and education
   - Monitor and educate as needed



Potential Provider Roles in Medicaid Risk Adjustment

- Member Engagement
- Medical Management & Services Rendered
- Health Risk Assessment / Annual Health Assessment
- Social Determinants of Health Data Capture
- Clinical Data Accuracy
- Complete & Accurate Claims Submission
- State Reporting
- Medical Record Retrieval
- Claims Re-Submission

Provider Engagement

1. Reimburse providers for quality of care and quality of coding work or include in value-based payment model **easy to understand and measure**

2. Leverage existing workflows or have flexible workflows that **minimize workflow disruptions** for practitioners

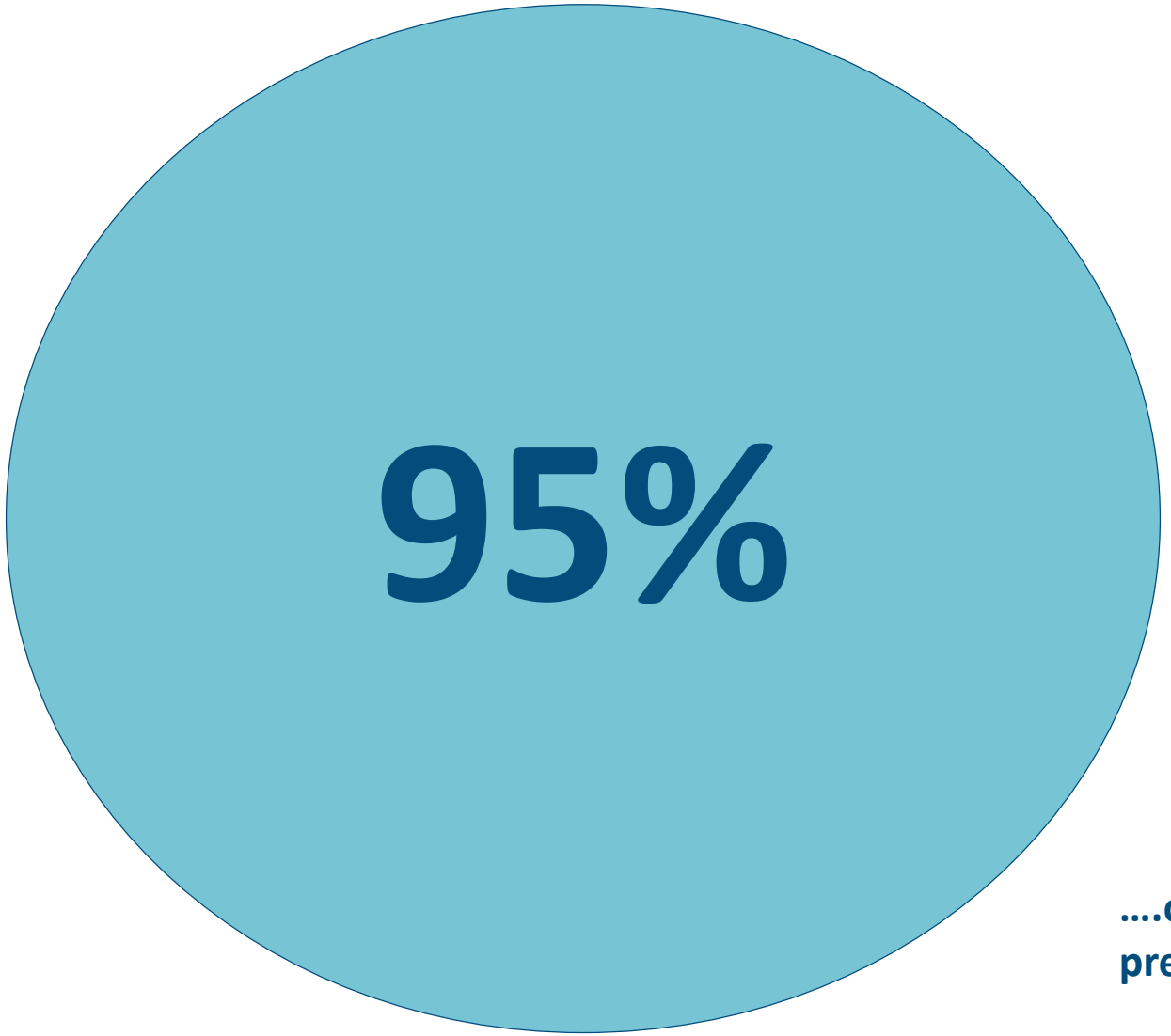
3. Attribution is key for practitioners – **give them credit for the work they perform** and to **not penalize** them for work they cannot perform

4. Embed Clinical and administrative support at systems where you have critical mass and **empower them with actionable data**

5. Refine suspected gap data with embedded staff or **get clear alignment on what suspected gaps are being pushed**

6. **Listen and modify** – success sounds like "I like this program because I don't have to…"

Provider Engagement – when we get it right



….of risk adjusted conditions presented are addressed