Session 65 L, Medicaid Risk Adjustment: Role of Encounter Data and Understanding Model-Specific Nuances

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Session 65
Medicaid Risk Adjustment: Role of Encounter Data and Understanding Model-Specific Nuances
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Much innovation being spearheaded by States!

- Different risk adjustment models have been chosen, although many states have coalesced around two

- Increasing focus on encounter data comprehensiveness and quality
  
  - Many Medicaid states are expanding quality measurement requirements backed up by real financial penalties

- New delivery systems are evolving, such as Medicaid ACOs that will take on full financial risk

- Evolution of risk adjustment to serve new populations, such as Long-Term Services and Supports (LTSS)
The Chronic Illness and Disability Payment System (CDPS) - developed by Richard Kronick at the UC-SD

Adjusted Clinical Groups (ACGs) - developed by Jonathan Weiner and Barbara Starfield and other researchers at the Johns Hopkins University.

Diagnostic Cost Groups (DxCG) – developed by Arlene Ash and Randall Ellis of Boston University

Clinical Risk Groups - developed by DRG team at 3M

MedicaidRx – developed by Richard Kronick and Todd Gilmer at the UC-SD

Episode Risk Groups (ERGs) – developed by Symmetry, now owned by Optum
• 36 states currently have risk-bearing contracts with managed care organizations (MCOs)

• At least 23 states use a risk adjustment model to adjust payments to these MCOs
  • 13 states use CDPS (or a combined CDPS/MedicaidRx model)
  • 4 states use the Johns Hopkins ACG System
  • 1 state uses DxCG
  • 1 state uses CRGs
  • 1 state uses ERGs
  • 4 states use MedicaidRx alone (often as a transition strategy)
WHICH STATES ARE USING WHICH RISK ADJUSTMENT MODEL

Risk Adjustment Model in Medicaid Managed Care States

Current Model (State Color)
- ACOs (TANF/CDPS
- ACGs
- CDPS
- CDPS + MedicaidRx
- CMS-HCC
- CRGs
- DxCGs
- ERG
- Future/TBD
- Medicaid Rx
- NONE

US State Profile-Risk Adjusted Medicaid Status
Northeastern & Mid-Atlantic States

Current as of August 2016
A QUICK COMPARE-AND-CONTRAST OF RISK ADJUSTMENT APPROACHES

• Medicare-Advantage: Not zero-sum. Ultimately the magnitude of the enrollee’s actual risk score directly drives plan revenues. Risk scores are assigned to enrollees using a single model and nationwide rules. Risk-adjusted payments occur at the individual level. An enrollee’s risk score determines the payment on behalf of that enrollee.

• Marketplace: Zero-sum, retrospective transfer payment (issuers do not know their final risk scores until after the payment year has ended). Risk scores are assigned to enrollees using a single model and nationwide rules. Risk-adjusted transfers occur at the issuer level, based on relationship of issuer risk scores to other issuers in the state.
A QUICK COMPARE-AND-CONTRAST OF RISK ADJUSTMENT APPROACHES

- Medicaid: Implementation varies by state. Zero-sum, prospective adjustment to capitation rates (issuers know their risk scores in advance and how they impact their capitation rates). Risk scores are assigned to enrollees using one of at least five models. Program design varies by state.

$100 in Premium From State to Cover Medical Costs across 3 MCOs

If Relative Risk Scores Differ Across the MCOs, then the $100 is Divided Proportionately
**WHY IS ENCOUNTER DATA SOIMPORTANT?**

- Unlike Medicare–Advantage risk adjustment, states don’t give MCOs multiple opportunities to improve the completeness of encounter data
  - In contrast, MA plans get three chances spanning 18 months to achieve full data submission
  - Medicaid states typically rely on encounter data submissions
  - Medicaid states typically do not allow retrospective medical record reviews
- States are beginning to apply sanctions upon MCOs that do not submit complete data
High-quality data are broadly defined as linkable, accurate and valid, objective, reliable and standardized, and timely.

- **Linkability** means that claims can be linked to enrollment and assessment data at the beneficiary level.
- **Accuracy and validity** mean the data measures what it intends to.
- **Objectivity** requires that the data inputs (i.e., model variables) are unbiased and individuals providing the data inputs are not influenced by the model output.
- A **reliable and standardized** data element captures the same concept over time using the same method.
- **Timeliness** means that the data represent the current situation of members, and the current benefits and design of a program to the extent possible.
The new Medicaid rules requires states and plans to meet stronger data submission and reporting requirements.

- Good data must support program oversight, program integrity, and increased transparency.
- To meet these requirements, states and plans must have adequate IT systems to ensure accurate and timely data delivery and reporting.
- Some states and managed care plans will likely need to increase their data collection and analytics capabilities to comply with the new rule.
- Some states are already applying financial sanctions to MCOs for incomplete or inaccurate encounter data.

States are under pressure and MCOs will be under pressure.
“The Contractor’s encounter data submitted and accepted…will be validated against submitted and accepted data captured…and must be within one percent (1%) of what HCA captured”

The Withhold Factor is intended to hold back one percent (1%) of the capitation payments excluding any SNAF, PAP, or Trauma funding…The amount withheld from the monthly premium payment will be released upon successful reconciliation of the Contractor’s encounter data per subsection 5.11.6 of this Contract
MISSOURI ALSO HAS ELABORATE ENCOUNTER DATA REQUIREMENTS AND POTENTIAL SANCTIONS

<table>
<thead>
<tr>
<th>Encounter Data Completeness/Accuracy Specific Performance Metrics</th>
<th>Frequency of Metric Evaluation</th>
<th>Statewide vs. Regional Application</th>
<th>Original Contract Period Withhold Amount</th>
<th>Metrics Applicable during the following Contract Periods:</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1st Renewal Period</td>
</tr>
<tr>
<td>1. Monthly encounter submissions must meet a ninety-eight percent (98%) acceptance rate. If the health plan is new to the MO HealthNet Managed Care Program, the health plan must transmit their first encounter data submission to the state agency by October 31, 2015 and meet a submission acceptance rate of at least eighty percent (80%) for claims incurred from July 1, 2015 to September 30, 2015. Beginning January 1, 2016, if the health plan is new to the MO HealthNet Managed Care Program, the health plan must transmit monthly encounter data submissions and meet the ninety-eight percent (98%) acceptance rate consistent with the measure for all other health plans.</td>
<td>Quarterly</td>
<td>Regional</td>
<td>0.50% (prorated by region) for the Original Contract Period and .17% for the 1st and 2nd Renewal Periods</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Monthly health plan encounter volumes must be within a certain percentage of historical average volumes or regional averages if the health plan is new to the MO HealthNet Managed Care Program.</td>
<td>TBD</td>
<td>Regional</td>
<td>.17%</td>
<td>No</td>
</tr>
</tbody>
</table>
Developed and owned by Johns Hopkins University and the Bloomberg School of Public Health

Based on clinical observations and research performed in the early 1980s when a pediatrician, Dr. Barbara Starfield, examined the relationship between morbidity or "illness burden" and health care services utilization among children in managed care settings.

ACGs were designed as a way to measure the “medical need” of populations – recognizing that patients usually present with “morbidity profiles”, not a single specific disease.

The Johns Hopkins ACG Case-Mix and Predictive Modeling System has been made commercially available since 1992.
ACGs ROLE IN MEDICAID MANAGED CARE

- ACGs were the first risk adjustment model used for Medicaid managed care:
  - Maryland, circa 1997
  - Minnesota, circa 1998
- Maryland “dove right in” and used ACGs for both the TANF and disabled populations
- Minnesota implemented ACGs only in the TANF population
Model Typology #1

Additive Models

- CDPS
  (Chronic Illness and Disability Payment System)
- MedicaidRx
- CDPS + MedicaidRx
- DxCG
  (Diagnostic Cost Groups)
Model Typology #2

Categorical Models

- ACGs (Adjusted Clinical Groups)
- CRGs (Clinical Risk Groups)
- ERGs (Episode Resource Groups)
THE ACG RISK ADJUSTMENT PYRAMID
ACG SYSTEM OVERVIEW

**Input Files**
- Patient File: Patient ID, Age, Gender
- Medical Services File: Diagnoses and Procedures
- Pharmacy File: Medications

**Risk Factors**
- Diagnosis-Based Markers
- Pharmacy-Based Markers
- Diagnosis and Pharmacy Markers
- Utilization/Resource Use Markers
- Coordination Markers

**Models**
- Concurrent Cost Risk
- Predicted Cost Risk
- Predicted Hospitalization Risk
REGRESSION-BASED PREDICTIVE RISK

- Linear Regression model with standard coefficients from reference data
- Dependent variable: Year 2 Total Cost or Year 2 Rx Cost
- Independent Variables
  - Demographics (age and sex)
  - ACG category
  - Pregnancy and delivery
  - Selected EDC markers
  - Hospital dominant morbidity types
  - Frailty
  - Rx Morbidity Groups
  - Optional: Prior cost percentiles
  - Utilization markers are NOT used in predictive cost models
A RECENT EXPERIENCE INTEGRATING ACGS INTO OPERATIONS

• Mile High Healthcare Analytics was engaged by an ACO and its payer partner
• There had been a shared savings arrangement in effect for three years
  • From the ACOs perspective, the contract was not performing to their satisfaction
  • They blamed their ACG risk scores for the poor performance of the payment model
• It turned out that ACGs were the least of their worries!

• But you don’t know what you don’t know!
THE SAGA OF RISK ADJUSTMENT IMPLEMENTED BY NEOPHYTE

• The impact of risk score calculation on the shared-savings paradigm was hampered by many factors related to data preparation and data integrity
  • There was a lack of transparency
  • Misinterpreting the ACG documentation by only utilizing five diagnosis codes per member
  • Failing to investigate the meaning behind the use of “home-grown” procedure codes that were filtered out by the software by default.
  • Not applying the same quarterly parameter files
  • Lack of awareness of the functions the ACG software performed by default
• Diagnosis code filtering based on CPT-4 codes
Rapid Growth in ACOs Across All Sponsor Types

Source: Leavitt Partners Center for Accountable Care Intelligence
Medicaid Accountable Care Organizations (ACOs)

- Currently there are nine state Medicaid programs that operate ACO models, including Colorado, Massachusetts, Iowa, Maine, Minnesota, New Jersey, Oregon, Utah, and Vermont.

- There are two general models of Medicaid ACOs – the first is the traditional shared savings model and the second is a risk based model.
MEDICAID ACOs: TRADITIONAL SHARED SAVINGS MODEL

• States that fall under this model have modified the Medicare Shared Savings Program (MSSP) to meet their population’s need
  • Share the same key programmatic outline as MSSP
  • Changed the quality measures that ACOs must report on
  • Lowered the number of required attributed beneficiaries
  • Expanded the types of providers that may join an ACO

• There are currently four states with this model: Maine, Minnesota, New Jersey, and Vermont
  • Iowa plans to implement this model in the future, but due to a lack of claims histories for attributed beneficiaries, it is currently only offering incentive payments to ACOs for completing tasks
States that fall under this model have created a managed care-ACO model hybrid

- The ACOs are distinct from traditional managed care organizations (MCOs) because the ACOs are often comprised of provider or health plan/provider partnerships
- Risk-based ACOs have an increased focus on meeting quality metrics
There are currently four states with this model: Colorado, Illinois, Oregon, and Utah

- Colorado’s model is a little different, as the state has a primary care case management system and the state’s ACOs receive incentive payments for meeting key performance indicators

- Alabama is trying to go this route, but is experiencing significant blowback from entities that originally wanted to participate as RCOs

- This model was implemented slightly earlier than the traditional shared savings model with most states implementing between 2011 and 2013
LESSONS LEARNED AND IMPLICATIONS

• If the encounter data is not complete, nothing else matters!
  • Accurate encounter data determines accuracy of risk adjustment

• Medicaid states are putting a much greater emphasis on quality improvement than the Marketplace and even MA
  • Financial penalties and some incentives abound
  • Flexible and often changing measure sets

• The use of pharmacy data as a primary source of disease-categories is fraught with danger
LESSONS LEARNED AND IMPLICATIONS

• Provider education and engagement is vital
  • If coding and documentation aren’t right the first time, they may never be right

• Medicaid ACOs are in some states far more advanced than MA ACOs or are on the road toward being more advanced
CONTACT INFORMATION

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