Recent Developments in Medicaid Risk Adjustment and Implications for Actuarial Soundness
Presentation to AHIP Conference

September 24, 2008

AmeriChoice: A UnitedHealth Group Company
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Purpose and Topics

- Brief overview of UnitedHealth Group and AmeriChoice
- Describe my work while at the University of Maryland (1998-2003) where the University consulted with states and CMS on risk adjusted payment programs
- Summarize AmeriChoice/United’s experiences with state risk adjusted payment programs
- Document the importance of complete and validated data to achieve the policy goals of risk adjustment, describe the tools and analytics our Company uses to support risk adjustment and provide a brief state snapshot on implementation
- Identify recent developments and risk adjustment in the context of actuarial soundness
- Summarize lessons learned from early adopters and keys to success that would both achieve state goals and recognize health plan financial realities
Through its family of businesses, UnitedHealth Group provides a highly diversified and comprehensive array of health and well-being products and services.

**UnitedHealth Group**
- Serves 70 million individuals
- Ranks #21 on Fortune 500
- Generates ~$80 billion in annual revenue

**Commercial Benefits Market**
- Risk and fee-based solutions for employers of all sizes and individuals

**Public & Senior Markets**
- Health and well being products for people 50+ and state-sponsored programs

**Enterprise Services**
- Personalized health mgmt solutions, technology, and integrated Pharmacy Benefits
AmeriChoice is UnitedHealth Group’s business unit focused on health care benefits and resources for people in state-sponsored health programs.

Key Facts

- Serves 2.1 million members - 70% children, high proportion of disabled adults, pregnant women
- Operates 18 Health Plans; also offers Management Services/Disease Management programs in 4 states and Medicare products in 5 states
- Employs over 3,000 individuals
Noteworthy Recognitions

AmeriChoice/UnitedHealth - Leaders in the Field


- **High Performer on Key HEDIS Measures**: AmeriChoice’s plans score **Above the National Average** among its competitors in 7 key child and adolescent health measures. In our Michigan plan, 91% of children completed the recommended 6 or more well child visits during their first 15 months of life, compared to a national plan average of 56%.

- **Provider Strength**: “U.S. physician offices accept UnitedHealth more than any other insurance plan,” reports independent health research firm SK&A Information Services, Inc. AmeriChoice builds on that vast ongoing network of doctors in serving Medicaid enrollees.

- **NCQA Award for Multicultural Outreach, 2007**: UHG was awarded for its work in developing innovative solutions to reduce health disparities in the communities with minority populations. This award focused on UHG efforts to make more Asian providers available to the community of Los Angeles.

- **South Florida Hispanic Chamber of Commerce** named UnitedHealth as it’s “2007 Health Care Provider of the Year.” This was due to “extraordinary local and national health care initiatives” that provide “culturally relevant and linguistically accurate products and services that address Hispanics unique health care needs.”
AmeriChoice operates 18 Health Plans that offer Medicaid, SCHIP, ABD, Medicare, and Uninsured products.

**AmeriChoice Products**

- **Medicaid**
  - Temporary Asst. to Needy Families (TANF)
  - Primarily mothers / children under 185% of FPL

- **SCHIP**
  - State Children Health Insurance Programs
  - Children above Medicaid but less than 250% of FPL

- **ABD**
  - Aged, Blind & Disabled Persons

- **Medicare**
  - Medicare / Medicaid dual eligible members in Special Needs Plans
  - 5 current markets

- **Uninsured**
  - New product in IN designed to reduce uninsured
  - Program being leveraged for other states

- **Care Management**
  - Provide Integrated Chronic Care Management (ICCM) in Washington, Georgia, and California (San Diego).

*Most Medicaid offerings also include an SCHIP benefit*
Academic studies and state experiences in Medicaid managed care demonstrate that the health status of health plans’ enrollees varies, and where states operate competing fee for service type programs, variations in enrollee health status can exist when compared to managed care plans.

Some of the variation can be explained by the type of provider networks offered by health plans in a given geographic area.

Risk adjustment can improve the fairness of the state’s capitation rate setting system and make it more efficient.

Risk adjustment can promote the participation of plans and providers that serve disproportionately more members with higher acuity and health needs.
Among people with disabilities, health expenditures are strongly related to recent diagnoses, and health plans are well aware that attracting too many people with costly problems can lead to large financial losses. If a State Medicaid program does not pay more to health plans whose members have above average levels of need, it will penalize plans attractive to people with greater needs and jeopardize quality of care. The greater predictability of expenditures among people with disabilities compared with a general population both increases the importance of health-based payment and makes it easier to do well.

- Richard Kronick, Ph.D., Todd Gilmer, Ph.D., Tony Dreyfus, M.C.P., and Lora Lee, M.S., Health Affairs, Spring 2000
Challenges of Early Adopters

- While a consensus emerged that risk adjusted payment systems would address the issues described on the previous slides, early adopters – both the states and the affected health plans – experienced implementation challenges.

- Incomplete diagnostic data, resulting in part from immature encounter systems were reported by early adopters.

- Surprises in financial results, including material payment swings, represented an overall rate setting challenge and barrier to adoption.

- A perception of the complexity and technical resources necessary also affected states’ decisions on whether to move to a risk adjustment system.

- This environment laid the groundwork for 2 major efforts to document experiences and lessons learned from early adopters:
  - RWJ grant
  - CMS leadership
While at the University based research center, the Center, in conjunction with Actuarial Research Corporation, was awarded two CMS contracts aimed at providing technical assistance to states on risk adjustment payment systems for state Medicaid programs.

The scope of work began with documenting state experiences with risk adjustment from 1997 to 2003 and culminated in a manual published by CMS which documents the key steps for implementing risk adjusted rates.

- Key chapters include selecting a system, identifying the necessary data, determining the validity and completeness of the data, readiness for MMIS system and all financial and rate setting components.

The first deliverable, documenting experiences of all states using risk adjusted rates (over 10 at that time) formed the basis for the lesson learned and keys to success components of the manual.
Key themes and lessons learned include:

- A key to success in risk adjustment is the importance of complete and valid data on both the part of the health plans’ submissions and the state’s subsequent use of the data.

- States should work closely with health plans throughout the preparation and implementation phases.

- States should simulate results so there are no surprises or business disruptions in the implementation cycle (this also serves as an important validation step where data anomalies can be identified and remedied).

- Recognize that risk adjustment is part of a larger financing and program context to drive better quality care for Medicaid beneficiaries. Indeed, as data submission completeness and quality improves under risk adjustment, states are better positioned to drive a data driven quality agenda.

- Risk adjustment alone is not a panacea for over rate adequacy.
The majority of states AmeriChoice contracts with use some type of diagnostic risk adjuster

- There has been a growing trend to adopt risk adjustment in state Medicaid managed care programs.
- Risk adjustment has emerged as the predominant model for state payments for Medicaid managed care.
- While certain risk adjustment groupers are common across the states, how states apply risk adjustment varies widely (frequency of updates, populations covered, corridors).
- While CDPS is the dominant model followed by ACGs, recently we have observed new models being adopted by states (Medicaid Rx, CRGs).

For states that AmeriChoice contracts with, the following slide provides a quick summary on populations, frequency of updates, type of model used and unique state polices such as phase ins and corridors.

As we go through the slide, I’ll describe important payment policy and data issues with the states.
## States Using Risk Adjustment (those contracting with UHG)

<table>
<thead>
<tr>
<th>State</th>
<th>Risk Adjustment Model</th>
<th>Population Risk Adjusted</th>
<th>Update Frequency</th>
<th>Special Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pennsylvania</td>
<td>CDPS</td>
<td>TANF &amp; SSI</td>
<td>Semi-annually</td>
<td></td>
</tr>
<tr>
<td>New Jersey</td>
<td>CDPS</td>
<td>TANF &amp; SSI</td>
<td>Annually</td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>CDPS</td>
<td>TANF &amp; SSI</td>
<td>Annually</td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td>CDPS</td>
<td>TANF &amp; SSI</td>
<td>Annually</td>
<td></td>
</tr>
<tr>
<td>Michigan</td>
<td>CDPS</td>
<td>SSI</td>
<td>Annually</td>
<td>Risk Corridor</td>
</tr>
<tr>
<td>Ohio</td>
<td>CDPS</td>
<td>ABD</td>
<td>Semi-annually</td>
<td></td>
</tr>
<tr>
<td>Maryland</td>
<td>ACG</td>
<td>TANF &amp; SSI</td>
<td>Annually</td>
<td>Encounter Completeness Factor for the first four years</td>
</tr>
<tr>
<td>Tennessee</td>
<td>ACG</td>
<td>TANF &amp; SSI</td>
<td>Annually</td>
<td>Risk Corridor</td>
</tr>
<tr>
<td>New York</td>
<td>CRG</td>
<td>TANF &amp; SSI</td>
<td>Annually</td>
<td>Phase-in</td>
</tr>
<tr>
<td>Florida</td>
<td>Medicaid Rx</td>
<td>TANF &amp; SSI</td>
<td>Quarterly</td>
<td>Phase-in, Risk Corridor</td>
</tr>
<tr>
<td>Delaware</td>
<td>Medicaid Rx</td>
<td>TANF &amp; SSI</td>
<td>Annually</td>
<td></td>
</tr>
<tr>
<td>Arizona</td>
<td>ERG</td>
<td>TANF &amp; SSI</td>
<td>Annually</td>
<td>Phase-in, 80%</td>
</tr>
<tr>
<td>Medicare</td>
<td>HCC &amp; RxHCC</td>
<td>Medicare Eligible</td>
<td>Semi-annually</td>
<td>Phase-in for the first four years</td>
</tr>
</tbody>
</table>
Most of the risk adjustment methodologies rely on ICD-9 codes mainly from professional and institutional claims/encounters (with the exception of Florida which uses drug information).

Diagnostic information must be received from our providers, processed through our claims system and then sent to the state and be accepted.

Each step in this process could result in data loss.

Missing data will result in a “healthier” measure of our members’ acuity.
Risk Adjustment Timeframes

Step 1: Service Provided to the Member
Step 2: Claim Submitted to Health Plan
Step 3: Claim Paid
Step 4: Encounter Extracted & Submitted per State Rules
Step 5: State Creates Risk Adjustment File
Step 6: State Runs Grouper

18 to 24 Month Time Horizon
One of the key features of Florida’s innovative Medicaid Reform program which began in July 2006, was the introduction of a risk adjustment payment program.

The reform program included traditional MCOs and new Provider Sponsored Organizations.

At the time of the reform program implementation, the State was not collecting complete encounter data so traditional diagnostic based risk model (CDPS, ACG) was not an option.

The state studied alternatives that would allow this critical policy goal to move forward and ultimately selected *Medicaid Rx*

- a system that classifies a subset of the National Drug Codes into categories that can be used for risk-assessment and risk-adjusted payments. (T Gilmer, et al)
The legislation authorizing the Medicaid Reform program required the state to establish a Technical Advisory Panel (TAP).

- **Risk-Adjusted-Rate Setting:**

  The Advisory Panel will investigate and guide AHCA on the development of risk adjusted rate methodology to be used. It will make recommendations on mechanisms for determining the risk of Medicaid participants and for the transition to a risk adjustment system, including recommendations for phasing in risk adjustment and risk corridors. The Panel will also examine administrative issues relating to the use of risk-adjusted rates like cost, simplicity, client privacy, data accuracy and data exchange. Implementation of an encounter data system to be used for risk adjusted rates will also be considered by the Advisory Panel.
Lessons learned and Experiences:

- The use of a Technical Panel has proven to be of great value to both the state and the plans as well as the many stakeholders in the Florida Medicaid program.

- The regular meetings, accompanied by thorough preparation and data simulations allowed important technical issues to be vetted and minimized surprises.

- For example, the state presented very detailed analyses of Rx drug data to test completeness and timeliness of submissions, allowing health plans to take appropriate actions to assure complete data.
Some of the considerations and factors we believe are important include:

- Lag/Run Out

- Inaccurate/Incomplete coding

- Disease Persistency
Health Plans need to measure and assess the completeness of their encounter data submitted to the state.

- Quantitative Analysis of Claim Information
  - e.g. Claim Counts

- Quantitative Analysis of Diagnostic Information
  - e.g. Unique Diagnostic Counts

- Qualitative Analysis of Diagnostic Information
  - e.g. Illness Burden Measurement
Both the state and the plan should simulate disease burden distributions using the appropriate risk adjustment model.

Ideally, all plans results (blinded) could be shared so plans can see and understand the variations among plans. This can serve as an important validation step and whether corridors or phase ins may be appropriate.

Ideally, the state simulations should be available prior to finalizing scores and use this for both validation, forecasting and estimating the financial impact on the health plans.
Recent Developments and Looking to the Future

- Risk adjustment is now mainstream and represents a predominant feature in the overall financing of Medicaid managed care in a significant number of states covering a large number of enrollees.

- Large, established and mature Medicaid managed care programs offered in New York State and Arizona have moved to, or have announced plans to move to risk adjustment, and as previously described, Florida’s groundbreaking Medicaid reform program features a risk adjustment model.

- In both cases, some type of phase in mechanism will be applied in recognition of the potential payment swings among plans.

- Despite the success and widespread availability and understanding of both CDPS and ACGs, new states adopting risk adjustment have chosen other models—CRGs and ERGs—demonstrating the confidence these states possess in their analytic capabilities and a desire to synch up financing aspects of risk adjustment with broader analytical applications supported by these groupers.
Recent Developments and Looking to the Future

- States are applying risk adjustment beyond the disabled beneficiaries
  - New Jersey and Wisconsin, for example, began risk adjustment on the disabled and now risk adjust the TANF population

- Risk Adjustment has provided strong incentives for health plans to provide timely and complete encounter data
  - States are now using that information for broader analytic efforts to demonstrate the value provided by managed care plans

- Understanding risk adjustment, combined with advances in the groupers, have empowered health plans and a states to implement effective disease management and care coordination programs relying on predictive model tools
  - These are embedded within health plan offerings and also offered in stand alone fee based models
Context

- From a health plan’s perspective, these tools should be viewed within an overall philosophy geared to care coordination and improved health outcomes for members.

- Sophisticated models to identify at risk enrollees is only the first step to effectively coordinating care and improving health outcomes.

- United’s data analytics subsidiary Ingenix, has developed ImpactPro, a sophisticated predictive modeling tool that we use in many markets and in stand alone Disease Management and Care Coordination programs.
Most states apply risk adjustment in a budget neutral manner, that is to say risk adjustment distributes payments among plans—pie slicing.

As such, risk adjustment can not be a substitute for a strong, data driven capitation rate setting process that also considers the appropriate size of the pie.

Risk adjustment operates within an overall rate setting process that must meet the requirements of actuarial soundness:

- CMS has developed a detailed checklist
- American Academy of Actuaries Practice Note
- Regional and Central Office dialogue
Careful attention to the base data (called for by the regulation), trending that reflects the realities of the local market, accurately incorporating program, benefit, population changes and efficiency goals in a transparent manner are essential for a successful rate setting process.

Many of the states we contract with utilize some type of State/Health Plan workgroup as an important component of the rate setting process.

These groups recognize the long term business partnerships plans enjoy with states as they work cooperatively to achieve state goals for improved health care for Medicaid beneficiaries.

These groups serve to promote transparency, validate assumptions and data sets to be used and can minimize surprises thus promoting more stable financial planning.
State budgetary challenges resulting from a combination of overall Medicaid spending growth and slowing revenues stemming from current economic conditions represents a significant challenge now and in the immediate future.

As states scrutinize their rate setting processes, we think it's important that benefits and value derived from Medicaid managed care be viewed as part of the solution to state budget challenges.

Indeed with a significant proportion of state Medicaid spending not covered by managed or coordinated models, the risk identification, stratification and predictive model tools currently deployed as part of mainstream managed care programs should be leveraged to improve the cost effectiveness and quality of overall Medicaid programs.
Lessons Learned

- My experience with state risk adjustment programs demonstrates that it is common for states to experience implementation challenges in the early years.

- Many states have chosen to limit payment swings by using corridors or other phase in devices.

- This allows plans to adjust to the new payment systems and recognizes some of the variation in observed illness burden may be the result of data issues or other implementation realities.
Lessons Learned

- Implementation of risk adjustment necessarily results in payment changes among health plans.

- For states considering the adoption of risk adjustment, they should consider creating a state/health plan work group with a specific agenda to analyze, vet and resolve implementation issues. A critical component of the work should involve analyzing the completeness of the data that will be used in the risk adjustment grouper.

- This will result in a successful program that supports the state’s overall policy goals and recognizes the partnership it has with the plans in achieving these goals.
QUESTIONS

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