

Risk Adjustment & Medicaid Managed Care

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Three ACA Risk-Sharing Provisions

2014 2015 2016 2017 2018 2019 2020 2021 ...

1

Reinsurance
(Section 1341)

2

Risk Corridors
(Section 1342)

3

Risk Adjustment
(Section 1343)



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Overarching Design Considerations

- Goals:

- Reduce premiums and “risk premiums”
- Encourage competition on price and quality
- Stabilize plan participation in the individual and small group markets
- Maintain viability of the Exchange



Overarching Design Considerations-Continued

- **Strategies are complementary**
 - **Reinsurance**
 - Addresses high-cost outliers (in the individual market)
 - Reduces premiums in the individual market
 - **Risk corridors**
 - Protect plans and the government from inaccurate rate setting/bids
 - Must account for reinsurance and risk adjustment payments
 - **Risk adjustment**
 - Accounts for systematic selection and differences in chronic disease burden among plans in the individual and small group market
 - Operates inside and outside of the Exchanges



Criteria in Choosing a Risk-Adjustment Grouping System

- Predictive accuracy
- Susceptibility to gaming
- Desirable incentive effects
- Transparency

Choosing or creating a grouping system is a small part of creating a risk-adjustment system that accomplishes program goals

Source: Winkelman R, Mehmud S. A Comparative Analysis of Claims-Based Tools for Health Risk Assessment. Society of Actuaries. 2007



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Model Related Questions

- Dx, Rx, or both?
- Variation in relative weights across bronze, silver, gold, and platinum?
- Low-income adjustment?
- Concurrent vs. prospective weights (and how to deal with pregnancy and neo-nates)?
- Age factors in the context of 3:1 rating bands?



Payment Related Questions

- Individual vs. plan level adjustment?
- What does a plan with a score of 0.9 pay 10% of?



Timing and Phase-In Questions

- What information on expected RA charges or payments will plans have when they set premiums for 2014? 2015?
- Implications of limited information on phase-in of RA?
- Consider six-month data collection period in 2014 in order to have information available for 2016 bids?



Federal-State Questions

- If there are states in which the federal government operates the Exchange, HHS will need to answer the questions on previous slides for those Exchanges
- How much flexibility, and for which elements, should be given to states in the selection, development, and implementation of a risk adjustment approach?
- What does this mean for Medicaid?



Estimating the Cost of the Newly Eligible

- Urban Institute analysis estimates the per enrollee cost for the newly eligible population will be \$3,775 annually.¹
- Cost per non-disabled adults in 2007 was \$2,541.²

1. Source: Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid, Urban Institute, March 2011.

2. Source: Kaiser Family Foundation Fast Facts Chart Book, <http://facts.kff.org/chart.aspx?ch=466>.



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HHS Research & Innovation

- HHS is engaged in improving quality and efficiency in Medicaid, through both research and innovation.
- CMS is engaged in many important Medicaid program innovations as a result of the Affordable Care Act.
- ASPE is involved in a number of Medicaid related research projects. Projects are housed in:
 - the Office of Health Policy, and
 - the Office of Disability, Aging, and Long-Term Care Policy.
- The Federal Coordinated Health Care Office has several key projects.



Selected Projects

- Evaluation of Health Homes
- Increased Payments for Primary Care Services
- Medicaid Atlas on Health Care
- Interstate Variation in Medicaid Long-Term Care Use and Expenditures
- Dual Eligibles Demonstrations
- Provider Participation in Medicaid
- Medicaid Long-Term Care (LTC)
- Chart books: Elderly & Disabled
- Trends in Medicaid Managed Care Rates



Evaluation of Health Homes

- New Medicaid optional benefit authorized by the Affordable Care Act (beginning Jan 2011)
- Focus on improving care coordination for individuals with multiple chronic conditions or serious mental health disorder alone
- State survey and interim report to Congress by 2014 (CMS) and evaluation by 2017 (ASPE)
- Assessing impact on inpatient and ER use, chronic disease management, care coordination, quality and clinical outcomes, patient-centeredness, cost-savings
- Likely to use a quasi experimental design applied to Medicaid claims and survey data



Increased Payments for Primary Care Services

- The Affordable Care Act increases Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rate
- Effective Calendar years 2013 and 2014
- 100% FMAP



Medicaid Atlas of Health Care

- Using MAX data to evaluate how much and why Medicaid utilization and spending vary across and within states
- Phase 1: Acute Care, Long-Term Care, Mental Health Care
- Medicaid Atlas Website with Maps, Tables, Trend Graphs, and Report to be available to public, September 2012
- Phase 2: Chronic Conditions (diabetes, one other TBD), Provider Participation in Medicaid, Racial and Ethnic Disparities



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Interstate Variation in Medicaid Long-Term Care Use and Expenditures

- Study #1: Performance of the long-term care (LTC) System
 - How does LTC performance vary by beneficiary characteristics, by state?
 - How are state policies associated with LTC performance?
- Study #2: Characteristics of institutional stays in nursing homes and ICF/MRs
 - How do people become eligible, how long do they stay?



Dual Eligibles Demonstrations

- Current: Design contracts of up to \$1 million each to 15 states for demonstrations to integrate care for Medicare-Medicaid participants
 - CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC, VT, TN, WA, WI
 - Proposals range from expansion of current coordinated services to dually eligible population to comprehensive integration of Medicare and Medicaid financing and administration for duals
- Future: Implementation of state integration proposals
 - Will require state decision to move forward and CMS approval
 - Additional grants
 - External evaluation contract



Provider Participation in Medicaid

- Analysis of National Provider ID (NPI) variable in 2008-2010 MSIS data
- Phase 1: Analyze MSIS variable and match to NPPES to assess data quality
- Phase 2: Where MSIS NPI is valid organizational NPI, use Medicare data to match with NPIs of individual performing physicians
- Phase 3: Divide numerator of participating providers by denominator of potential providers



Medicaid Long-Term Care (LTC)

- CMS-Census Inter-Agency Agreement to share Medicaid MSIS and MAX Data, 2006-2012
- ASPE to match 2007 and 2008 MAX data with same years from American Community Survey (ACS)
 - MAX data identify Medicaid LTC participants—both institutionalized and receiving Home- and Community-Based Services (HCBS)—and record services and diagnoses
 - ACS provides economic and demographic data on individuals residing in private homes and group quarters (both institutional and non-institutional)
- Analysis of matched data set will provide understanding of variation across states in functional status and informal supports



Chart books: Disabled and Elderly

- Individuals Living in the Community with Chronic Conditions and Functional Limitations: A Closer Look, January 2010

<http://aspe.hhs.gov/daltcp/reports/2010/closerlook.pdf>

- Chart book on the elderly – under development



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Trends in Medicaid and CHIP Managed Care Rates

- Estimate annual rates of increase in Medicaid and CHIP managed care capitation rates in 20 states from 2001 to 2010, including possible effects on provider network adequacy and access to care.
- Methodology includes:
 - Twenty state case studies,
 - Analysis of data from 2001 to 2010 on Medicaid and CHIP capitation rates by eligibility categories and covered services, and
 - Comparison with increases in employer-sponsored premiums.



Medicaid Managed Care Organizations – Future Role?

- Medicaid managed care plans will have an opportunity to participate in the Exchange.
- Potential for establishing competitive plans that could put pressure on commercial plans



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