Risk Adjustment & Encounter Reporting: What’s New and Where Should MCO’s Focus Their Attention

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Agenda

- Fundamentals of Risk Adjustment
- Impact of efficient and proactive Risk Adjustment
- Trends: Current MCO Environment
- Risk Adjustment Models
- Dual Eligible Initiatives
- Health Insurance Exchanges
- Encounters
- Recap
TWO PILLARS OF RISK ADJUSTMENT
Provider Coding and Encounter Reporting are the two critical components of risk adjustment that plans must address and master if they are to obtain the revenue they deserve and require to ensure their continued viability and success.

<table>
<thead>
<tr>
<th>RISK ADJUSTMENT</th>
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<tbody>
<tr>
<td><strong>MEMBER VISIT &amp; CODING</strong></td>
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<tr>
<td>• Members visit Physicians</td>
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<tr>
<td>• Provider code and report accurately and completely</td>
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<tr>
<td><strong>ENCOUNTER REPORTING</strong></td>
</tr>
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<td>• Plans submit complete, accurate and timely data to state</td>
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TRIANGLE OF EFFICIENCY
Risk Adjustment/Revenue Management, if done in an efficient and proactive manner, has the opportunity to improve the quality of care for a plan’s membership, optimize revenue and become cost effective.

Triangle of Efficiency

Better Quality of Care and Outcomes

Cost Effectiveness

Optimize Revenue

Efficiency
TRENDS
Recession continued to affect State revenues

Medicaid enrollment and spending growth beginning to slow
  > Most States at or below FY 2012 budgets

ARRA stimulus money – Enhanced FMAP expired and States needed to replace lost funds in FY2012 budget

National Health Reform - Greater role for Medicaid, expanded eligibility
  > SCOTUS Ruling - States have decisions to make on expanding eligibility

States expanding their managed care programs
2012 Medicaid Changes

- 39 states cut or froze provider rates in 2011, 46 states in 2012
- 18 states restricted benefits and implemented cost containment strategies (in 2011 and 2012)
  - Dental, medical supplies, and DME (can impact other benefits)
- 14 states raised or implemented copayments in 2012 (5 states in 2011)
  - ER Visits and Rx (challenges by advocacy groups, CMS approval)
- 19 states cut MCO rates
- Seventeen states in FY 2011 and 24 states in FY 2012 reported expanding their managed care programs, primarily by expanding the areas and populations covered
- ACA "maintenance of eligibility" requirements limited options
State Budgets are Still Challenged, Slowly Improving, But…

- The outlook for 2013 and beyond remains difficult with continued pressure to find Medicaid cuts, although few options for additional savings remain

States Medicaid Administrative Resources Stretched

- Medicaid Expansion
- Dual Eligible Initiatives
- Health Information Technology (HIT) Initiatives
  - EMR/ICD-10 / HIPAA 5010 / Eligibility System Upgrades
- Health Care Exchanges
Risk Adjustment Models
Out of 24 States:

- 17 using CDPS or MRx
- 4 using ACGs
- 3 using other models (DxCG, ERG, CRG)

Different models require different data elements

- Diagnoses, Procedure Codes, Rx – Encounter Reporting
- Transparency, Proprietary Model, Licensing
- Categorical, Hierarchical
States with Risk Adjusted Medicaid Payments

- **CDPS or CDPS w/MRx**: Red
- **MRx**: Blue
- **Other Risk Model**: Green
- **Not currently risk adjusted**: Gray

The map illustrates the distribution of risk-adjusted Medicaid payments across the United States, with states color-coded according to their payment models.
Model Nuances State to State

- Aid Categories to Risk Adjust (TANF, ABD, Others)
- Benefit Carve Outs (Mental Health, Disease Categories (AIDs))
- Maternity Care and Deliveries (Case Rates)
- Data Sources (Facility vs. Professional, Primary Diagnoses, other)
- Coefficient Development – State Specific or Base Model
- Regions & Budget Neutrality
- Collection Period, Scoring Period and Re-Scoring Frequency
  - Prospective vs. Concurrent
  - Plan level information – What’s my Score, State reporting
- Implementation Time Frames
  - Completeness of Data
  - Risk Corridors – Phase in Approach
Medicaid Risk Adjustment Trends

- Expansion to 24 States (Kentucky, Louisiana & Missouri recently added to their MCO programs)
- Expansion in Scope
  - More Aid Categories (TANF, ABD, CHIPs)
  - Corridors Being Eliminated / Budget Neutrality
  - Pharmacy Data Being Added
- More Audits of Encounter Data
- MCO’s Adopting Revenue Management Strategies
  - Member Outreach & Assessment
  - Chart Review – What are the State Specific Reporting Requirements
  - Health Risk Assessments – Specific Populations
Conflicting program incentives encourage providers to avoid costs rather than coordinate care, which often results in high spending and low quality.

Only 9 million people, but over $300 billion in annual healthcare spending.

About 6.8 million are “full dual eligibles” who receive hospital care, physicians’ services, prescription drugs, and other acute care services through Medicare and long-term care and other services that Medicare does not cover through Medicaid.

Duals include disabled individuals, nursing home patients, or a senior living in the community with multiple chronic conditions.

They are more likely to be eligible for Medicare because of a serious disability: some 38 percent of dual eligibles are people under 65 with serious disabilities, compared to 12 percent of other Medicare beneficiaries.

Nationally, Duals comprise 20% of the Medicare population and 32% of Medicare expenditures. They comprise 15% of the Medicaid population and 35% of Medicaid expenditures.

Significant fraud, waste, and abuse in caring for this vulnerable population.
The risk-adjustment methods now used in Medicaid managed care were developed to deal with risk primarily among children and adults in low-income families. Methods will need to be modified and refined to take into account the medical needs associated with populations with higher rates and diverse types of disability and chronic disease. Risk-adjustment that relies on diagnostic factors probably will not work very well for individuals whose costs of care largely reflect their functional status or frailty and their needs for long-term services and supports. Risk-adjustment may also need to incorporate non-medical factors, such as homelessness, that affect the cost of care.

GOING WHERE NO OTHER STATE HAS GONE BEFORE
Dual Initiative - Risk Adjustment

Medicare risk adjustment will be based on the Medicare Advantage model for Parts A and B and the Medicare Part D model for prescription drugs. Medicaid risk adjustment will be based on rating categories and high cost risk pools. Beneficiaries will be assigned to one of four rating categories:

<table>
<thead>
<tr>
<th>Facility-Based Care*</th>
<th>• Long-term stay of more than 90 days</th>
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<tbody>
<tr>
<td>Community Tier 3*:</td>
<td>• Skilled need to be met by ICO seven days/week; or two or more ADL limitations and skilled nursing need to be met by ICO three or more days/week; or four</td>
</tr>
<tr>
<td>Community Tier 2</td>
<td>• One or more behavioral health diagnoses reflecting ongoing chronic condition</td>
</tr>
<tr>
<td>Community Tier 1</td>
<td>• All other enrollees</td>
</tr>
</tbody>
</table>

* Category subject to high cost risk pool.

Source: Kaiser Family Foundation
Health Insurance Exchanges
Under the PPACA, state health insurance exchanges must be available for use by consumers to purchase health insurance with an effective date no later than January 1, 2014.

PPACA includes three key strategies intended to mitigate adverse selection and stabilize health insurance premiums:

- Risk Corridors, Reinsurance, Risk Adjustment
- Risk Corridors and Reinsurance are in effect from 2014 - 2016

Risk Adjustment (Sec. 1343). The PPACA requires HHS and states to establish a permanent, ongoing risk adjustment system for health plans in the small and non-group markets.
States certified to operate an Affordable Insurance Exchange (Exchange) have the option to establish a risk adjustment program, but are not required to do so. If a state does not establish a risk adjustment program, HHS will establish the program and will perform the risk adjustment functions for that state.

A federally-developed risk adjustment methodology will be proposed in the annual HHS Notice of Benefit and Payment Parameters in the fall of 2012.

States operating Exchanges may propose an alternative methodology for approval by HHS.
Data Collection Under Risk Adjustment

- States that elect to operate a risk adjustment program can choose the risk adjustment data collection approach that best suits their program.
- HHS will use a distributed approach when operating risk adjustment on behalf of a State.

Risk Adjustment Data Validation Standards

- Validate a statistically valid sample of all issuers that submit data for risk adjustment every year.
- Adjust the average actuarial risk for each plan based on the error rate found in the validation.
ENCOUNTERS OF THE HEALTHCARE KIND
What is Encounter Data?

- Encounter data are records of the health care services for which MCOs pay and—in many states—the amounts MCOs pay to providers of those services.

- Encounter data are conceptually equivalent to the paid claims records that state Medicaid agencies create when they pay providers on a FFS basis.

- States that contract with MCOs to deliver Medicaid services typically require MCOs to report encounter data to the state so that the state has a full record of all the services for which the state is paying, either directly through the FFS system or indirectly through MCOs.
Contractual Obligation of Health Plans

States changing requirements to EDI version 5010 837I & 837P (medical, vision, lab), 837D (dental), and NCPDP version D.0 (Pharmacy)

Standard file layout vs. State specific companion guides

Timely, Complete, and Accurate reporting requirements
  > Performance measures being used in plan evaluations
  > Risk Adjustment scores are calculated from the data
  > Other State performance measures – EPSDT, Immunizations

Encounter Complexity
  > Submission, Reconciliation, Correction, Resubmission
  > Tracking Numbers, Voids and Adjustments
# States Most Common Uses for Encounter Data

Out of 39 states surveyed...

<table>
<thead>
<tr>
<th>Uses</th>
<th>Rate</th>
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<tbody>
<tr>
<td>Quality Assurance</td>
<td>87%</td>
</tr>
<tr>
<td>Rate Setting</td>
<td>85%</td>
</tr>
<tr>
<td>Service Utilization</td>
<td>85%</td>
</tr>
<tr>
<td>EPSDT Reporting</td>
<td>85%</td>
</tr>
<tr>
<td>Program Trending</td>
<td>64%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>59%</td>
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<tr>
<td>Monitoring Immunizations</td>
<td>46%</td>
</tr>
<tr>
<td>Monitoring Expenditures</td>
<td>41%</td>
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Why Is Encounter Reporting Important?

MCO’s that don’t submit good data:

- May not receive appropriate rates
  - Specific Plan Rate
  - Risk Adjustment
- May not meet quality benchmarks
  - EPSDT
  - Immunizations
- May not be portrayed well in state-level reports as compared to peers
So TO
RECAP...
Fewer Dollars to Go Around
RISK ADJUSTMENT MODELS
Health Insurance Exchanges
It's going to be OK.
TWO PILLARS OF RISK ADJUSTMENT
TRIANGLE OF EFFICIENCY
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