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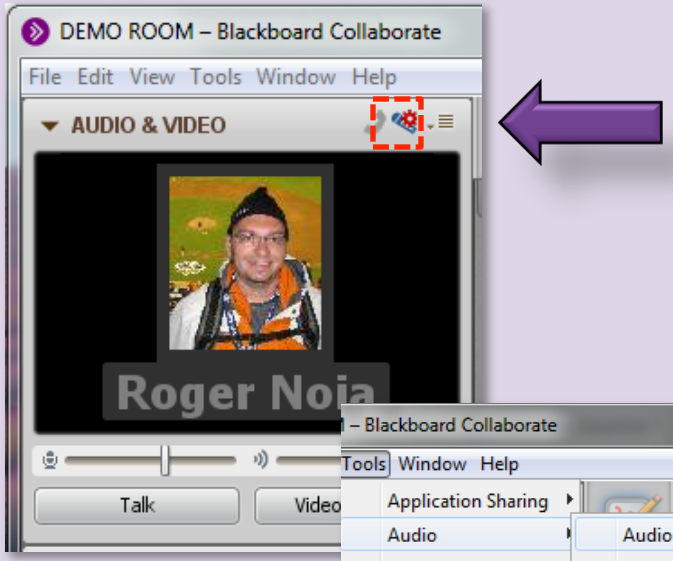

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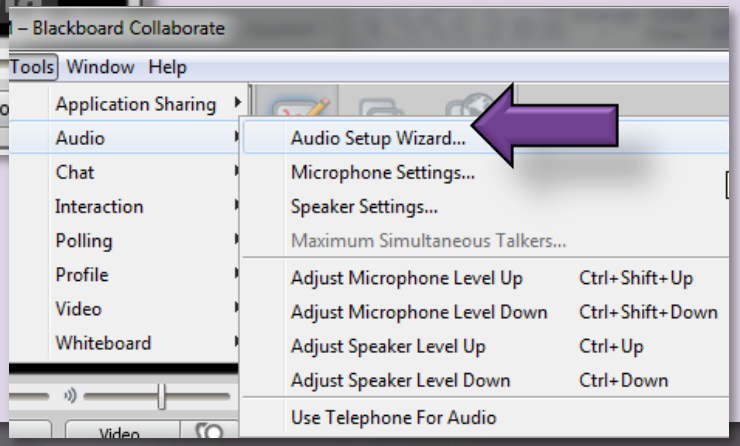

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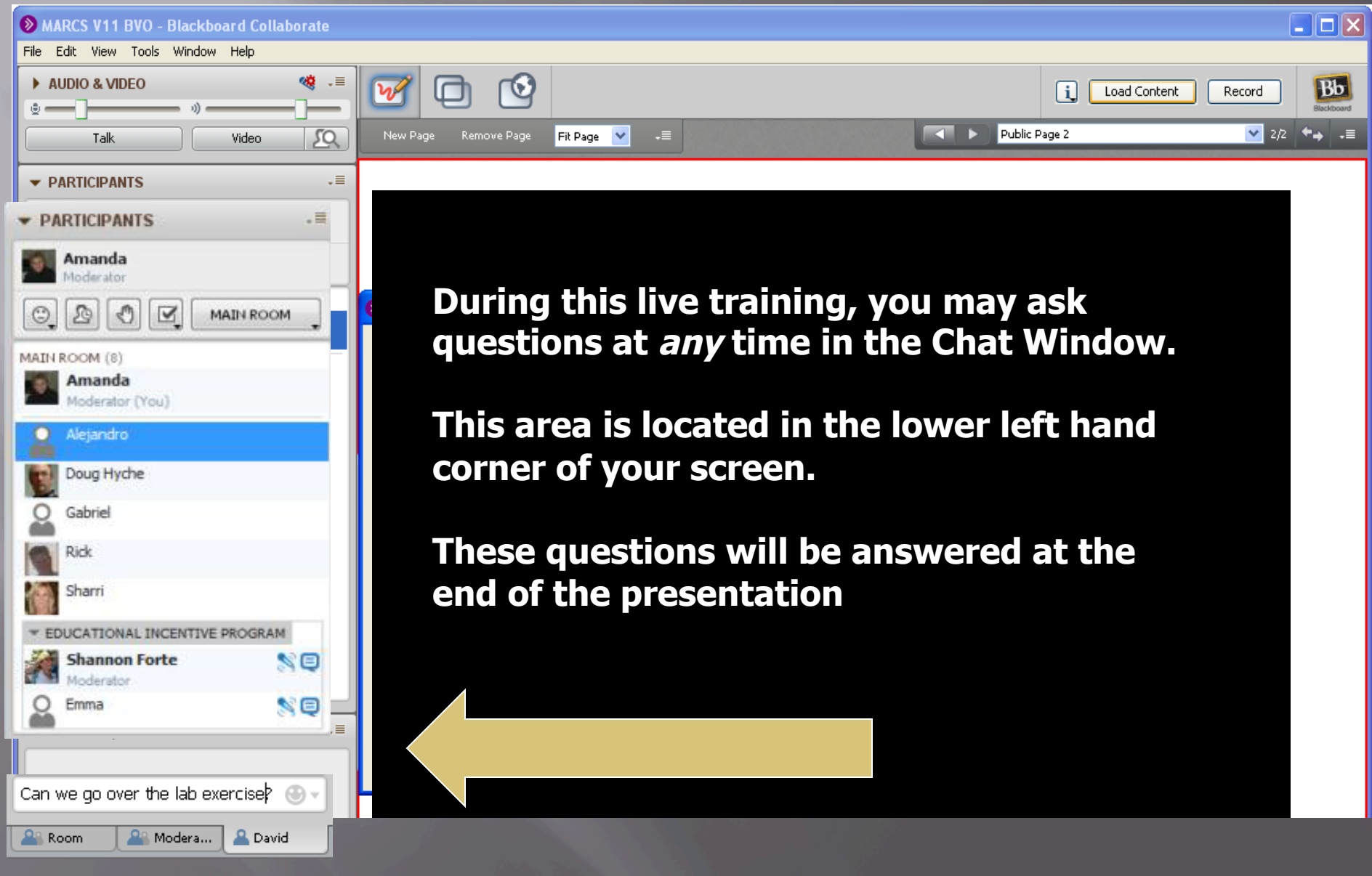
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PARTICIPANTS
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Amanda
Moderator
MAIN ROOM
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Amanda
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Social Determinants of Health: Important Considerations for Medically Underserved Community Health Center Patients

Todd Gilmer, PhD, Professor in the Department of Family and Preventive Medicine, University of California San Diego

Thu Quach, PhD, Director of Research, Asian Health Services

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- Lutheran Family Health Center, Brooklyn NY
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Risk Adjustment: Implications for Community Health Centers

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Division of Health Policy
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University of California, San Diego

Overview

- Program and Policy Goals of Risk Adjustment
- Brief History of Risk Adjustment
- Mechanics of Risk Adjustment using CDPS
- Risk Adjustment and Primary Care
- Opportunities for Community Health Centers to Demonstrate Value Added

Program and Policy Goals of Risk Adjustment

What is Risk Adjustment?

- Health based risk assessment – measuring illness burden at the individual or group level using indicators of health status such as diagnoses, pharmaceuticals, cognitive / functional limitations
- Health based risk adjustment – comparing populations, adjusting outcomes, or adjusting health plan payments using health status

Why is Risk Adjustment Necessary?

% of Population	% of Expenditure
1%	30%
10%	72%
50%	95%

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

Reasons for Risk Variation

- A particular health plan's provider network may predispose it to certain risk selections (e.g., those affiliated with academic medical centers)
- Some geographic regions may include a sicker-than-average mix of enrollees
- Some provider groups may attract specific population subsets (e.g. diabetes, AIDS, children with disabilities)

Benefits of Risk Adjustment

- Allows states to foster competition based on quality and efficiency rather than on risk selection
- Supports health plans that attract clients with specific service needs
- Allows health plans to promote efficiency in care management without the accompanying expenditure risk that results from attracting a sicker population

Medicaid Health-Based Payment Activities

State	Population Covered	Date Implemented	Classification System
Implemented			
Maryland	SSI + TANF	1997	ACGs
Colorado	SSI + TANF	1997	DPS
Oregon	SSI + TANF	1998	DPS
Utah	SSI	1998	Marker Diagnosis
Michigan	SSI	2000	CDPS
Minnesota	TANF	2000	ACGs
Delaware[1]	SSI + TANF	2000	CDPS
Tennessee	SSI + TANF	2000	CDPS
New Jersey	SSI	2000	CDPS
Utah[1]	SSI	2000	CDPS
Pennsylvania	SSI + TANF	2003	CDPS
Washington	TANF	2003	CDPS
Virginia	SSI + TANF	2003	CDPS
Ohio	SSI + TANF	2006	CDPS
Oregon Mental Health	SSI + TANF	2006	CDPS-MH
Florida	SSI + TANF	2006	MedicaidRx

[1] No longer contracting with MCOs on a risk basis.

Risk Adjustment in Health Care Reform

- State health insurance exchanges will use risk adjustment to adjust payments to health plans that are participating in the exchange
- Medicaid programs may use risk adjustment to adjust capitation payment to managed care plans that provide coverage for their expansion populations

Risk Adjustment and Long Term Care

- Dual eligible pilot programs are diving and interest in risk adjustment models that span Medicare and Medicaid, and home and community based and institutional long term care
- These models will need to include additional measures predictive of HCB and LTC services
  - Functional and cognitive limitations, social support
- Additional data from clinician and self assessments
  - WI uses web based assessment

Risk Adjustment and SES

- Substantial literature and growing interest in social determinants of health
  - Income, education, race/ethnicity, language proficiency, epigenetics
- SES may affect risk is complex ways
- Effect of SES on health may be different than the effect of SES on risk (i.e. use of services)
  - Latinos and Asians with LEP are more likely to access outpatient vs. inpatient or emergency MH services
  - LEP is associated with higher medication adherence among Latinos
  - LEP is associated with lower medication adherence among Asians

Mechanics of Risk Adjustment Using CDPS

Chronic Illness and Disability Payment System

- CDPS is a risk adjustment system for Medicaid that maps diagnoses to 58 CDPS categories corresponding to major body systems or chronic diseases
- CDPS is similar to models used for Medicare (ie HCCs), but places a greater emphasis on less common, but costly chronic conditions that are more prevalent among disabled Medicaid beneficiaries
- CDPS models for disabled, TANF Adults, and TANF Children

Major CDPS Categories

- Cardiovascular, Psychiatric, Skeletal, Central Nervous System, Pulmonary, Gastrointestinal, Diabetes, Skin, Renal, Substance Abuse, Cancer, Developmental Disability, Genital, Metabolic, Pregnancy, Eye, Cerebrovascular, AIDS/Infectious Disease, Hematological

CDPS Hierarchies

- CDPS categories are hierarchical within major categories
- For example, in the major category cardiovascular:
  - CARVH includes 7 diagnoses, eg heart transplant
  - CARM includes 53 diagnoses, eg heart failure
  - CARL includes 314 diagnoses, eg AMI
  - CAREL includes 35 diagnoses, eg hypertension