Hierarchies and Comorbidities

- Weights are additive across major categories

- Within major categories, only the most severe (i.e. expensive) diagnosis counts

- This allows an accounting of comorbidities, but reduces the incentive for upcoding of diagnoses

- For example, if a beneficiary has both diabetes and depression, both count towards the risk score

- However, if a beneficiary has heart failure and hypertension, only heart failure counts towards the CDPS risk score

CDPS Weights

- Cardiovascular, very high   2.037
- Cardiovascular, medium   0.805
- Cardiovascular, low   0.368
- Cardiovascular, extra low   0.130

- Psychiatric, high   0.955
- Psychiatric, medium   0.626
- Psychiatric, medium low   0.325
- Psychiatric, low   0.206

Calculating CDPS Scores

- Multiply the CDPS category vector by the weight vector (and sum the factors)

- Include the intercept and age and gender factors

- A 50 year old female with type 2 diabetes and hypertension has a risk factor of .798
  - 0.225 + 0.121 + .322 + 0.130

- If the same female also had bipolar disorder, her risk factor would be 1.424
  - 0.225 + 0.121 + 0.626 + .322 + 0.130

Calculating Payments for Health Plans

- Average the risk scores of all plan enrollees with eligibility in the 'observation' period

- Calculate weighted average of all plans; normalize to 1.0 to assure budget neutrality

  - If FFS is included as a 'plan' -- HBP is not budget neutral in those states

- Pay each plan it's normalized risk score multiplied by the base rate (eg: $800 PMPM for disabled)

Actuarial Adjustments

- Partial capitation

- Partial risk adjustment

- Risk corridors

- Reinsurance

- Carve-outs (with weight options)
  - Behavioral health carve-outs
  - Pregnancy / delivery carve-outs
  - Pharmacy carve-outs

Medicaid RX Model

- Pharmaceutical based model uses National Drug Codes (NDC) to assign 45 therapeutic categories

- Developed as an alternative to diagnosis based models when the health plan encounter data is low quality

- Pharmacotherapy vs clinical diagnosis

- Combined CDPS + Rx model using 15 MRX categories that were considered to be the least affected by practice patterns

Risk Adjustment and Primary Care

Risk Adjusted Primary Care

- Risk adjustment models have been primarily used to adjust premium payments
  - Acute care (sometimes with carve-outs)
  - Pharmacy coverage (i.e. Part D)

- Risk adjustment models have not been widely used to pay for primary care
  - Primary care is more likely to be integrated (e.g. Kaiser) or paid by fee-for-service

- There is a growing interest in capitated payment for primary care
  - Either fully capitated (and risk adjusted) or partial capitated with FFS component

Risk Adjustment and Scope of Primary Care Services

- It can be a challenge to identify the appropriate scope of services
  - In Medicare, this might be part B
  - In Medicaid, there is wide use of 'other providers' and 'other services'

- Under health care reform, the appropriate scope of services may be changing
  - Medical health care homes, care management, electronic health records, community integration

Data Available to Primary Care Providers

- May be limited to services provided in primary care / primary care clinic

- Missing inpatient diagnoses, diagnoses from other providers and other services, pharmacy data

- Clinical profiles may be incomplete without these data

- Might be possible to obtain these data from the health plan.

Care Coordination and Cost Offsets

- It is often difficult to coordinate care across primary care and other providers such as hospitals and specialists

- Improved care coordination and health promotion activities may result in reduced costs in other sectors

- This might justify a rebalancing of payments to primary care and other providers

Opportunity Frameworks

- Chronic Care Model

- Accountable Care Organizations

- Primary Care Medical Homes

- Integration of Physical and Mental Health and Substance Abuse Services

- Disease Care Management

- Complex Chronic Disease Case Management

Common Elements

- Team based care
  - Reorientation from the physician centric model
  - Collaboration and communication is essential
  - Expanded workforce

- Care management
  - Nurses focused on complex chronic conditions
  - Social workers focused on mental health, care transitions, social issues
  - Pharmacists focused on complex pharmacotherapy
  - Peers focused on education and self management training

- IT needed to support the above efforts

Conclusions

- Risk adjustment does not currently impact primary care directly, although there may be indirect effects operating through the health plans

- Opportunities and risk in capitated primary care

- Multiple avenues for community health centers to demonstrate value through improved care coordination and improved quality of care

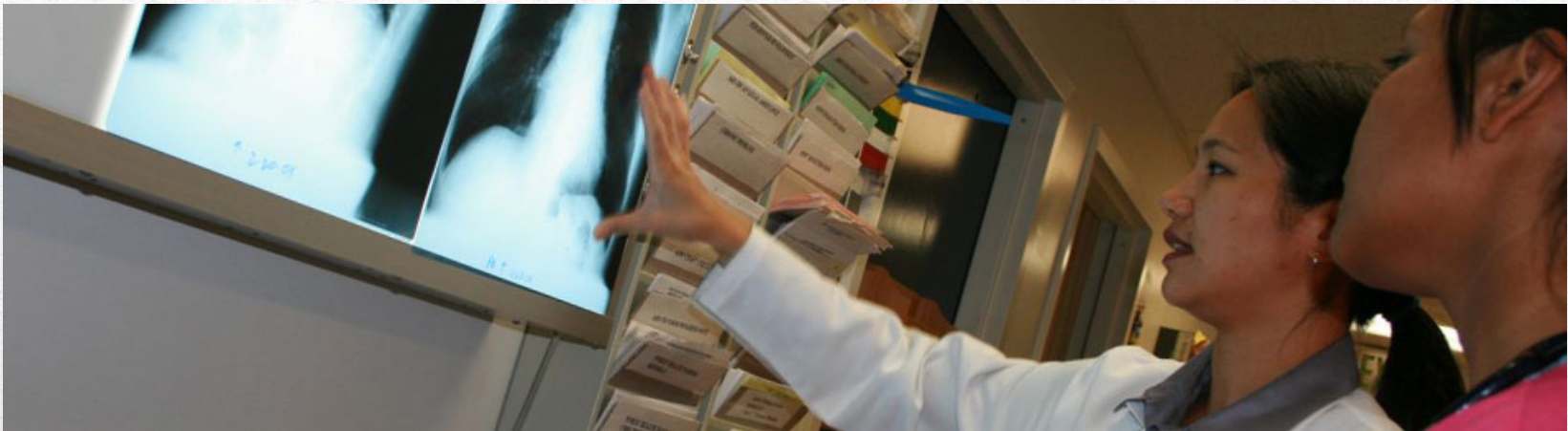- Also an opportunity to expand the scope of primary care / clinic services

Considering Language and Income Barriers in Risk Adjustment: *A Community Health Center Perspective*

Thu Quach, PhD,

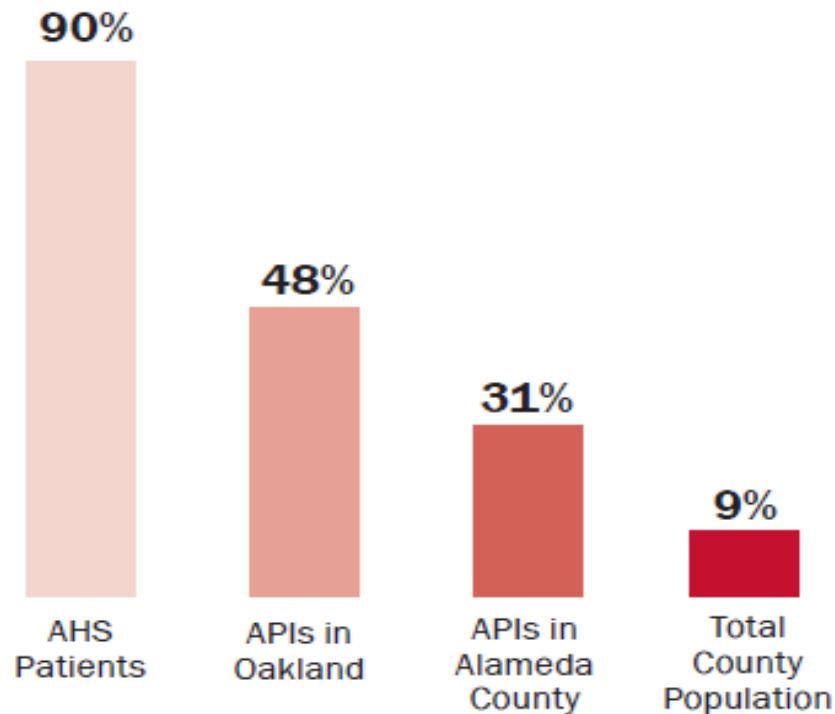Research Director

Asian Health Services

March 8, 2013

Asian Health Services

◆ Asian Health Services (AHS) is a federally qualified community health center located in Oakland, California

◆ Provide medical care, behavioral health services, dental care, health education, insurance counseling, and client advocacy

◆ Our staff is fluent in English and ten Asian languages: *Cantonese, Vietnamese, Mandarin, Korean, Khmer* (Cambodian), *Mien, Mongolian, Tagalog, Lao* and *Burmese*
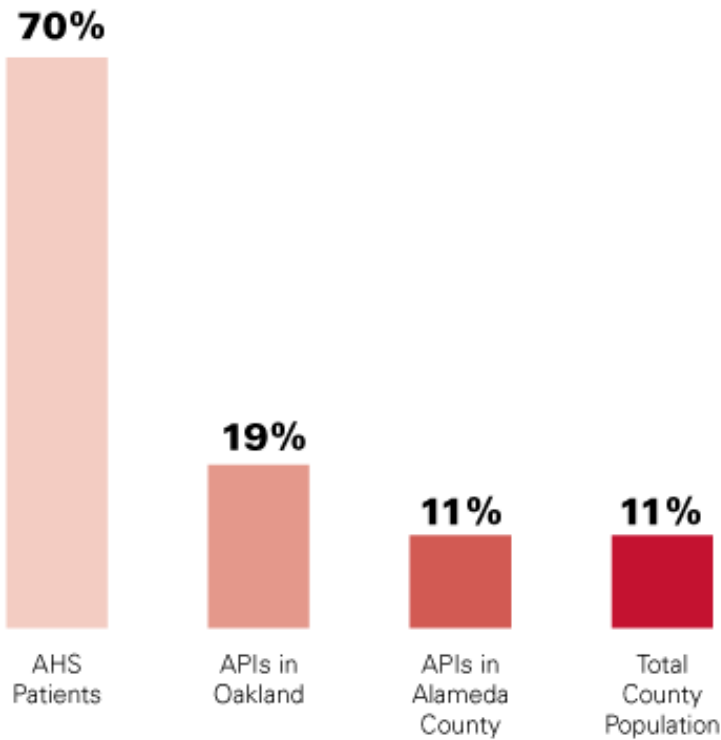
Language barriers

LINGUISTICS ISOLATION***

90% — AHS Patients

48% — APIs in Oakland

31% — APIs in Alameda County
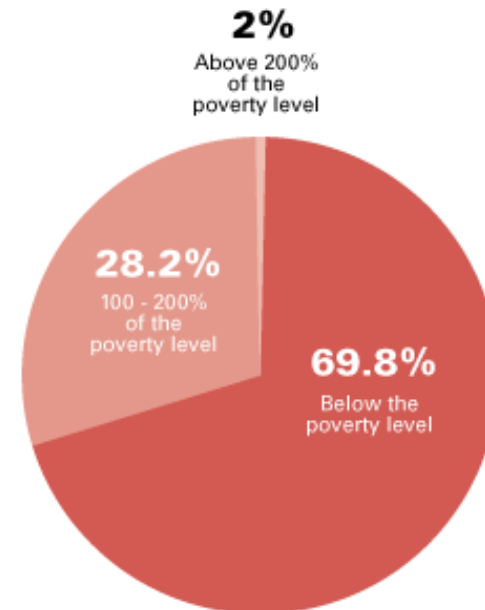
9% — Total County Population

*** Linguistic isolation is defined by the Census Bureau as persons who speak a language other than English at home and do not speak English "well" or "very well."

Low-income

What motivated us to explore risk-sharing modeling?

◆ AHS provides many enabling services (e.g., interpretation, case management, insurance counseling) to improve access and quality care

  ▪ Resources are spent at the front end to keep our patients from getting too sick

◆ Compared to other health centers, it may appear that our patients are not as high-risk based on hospitalization data

  ▪ Not considering how we are addressing some of patient's health risk at the front end

◆ Interested in some way of considering how addressing some of the barriers can be incorporated in risk-sharing modeling

Implementation of Affordable Care Act

◆With ACA, many of our uninsured patients will be moving to the expanded Medicaid programs or the California Exchange

◆Need to ensure **fair payments** that discourage health plans from adverse selection

◆Current risk-sharing modeling does not consider socio-economic factors, only diagnostic risk scores
  ▪ may penalize community health centers that provide enabling services to address socioeconomic barriers at the front end

◆Safety Net Health Plans and Medicaid-focused health plans face greatest risk of adverse selection and churn (enrollees that move between insurance coverage because of eligibility)
 ▪ impacts on community health centers using these plans

Diagnostic Approach Challenges

◆ Conventional risk adjustment includes: **age, gender, disease profile/diagnoses, utilization**

◆ Challenges with using diagnostic approach:

1. Newly insured will have missing or incomplete diagnostic information for use in the modeling.

   ▪ Using diagnostic data from when enrollees first enter the plan may result in many pent-up demand for care – over-predicting of cost

2. Eligibility churn: move between sources of insurance coverage due to eligibility →will have incomplete diagnostic information

Social Determinants of Health

◆ Importance of social determinants of health (SDH):
- Argument for diagnostic premised on SDH linked to health so diagnostic profile would already pick up these differences
- Argument for adding SDH is based on the fact that diagnostic profile alone predicts risk differently depending on the group→ cost of care for two people with identical diagnostic profile will be different for the person who is low-income

◆ Data availability on these variables is a challenge
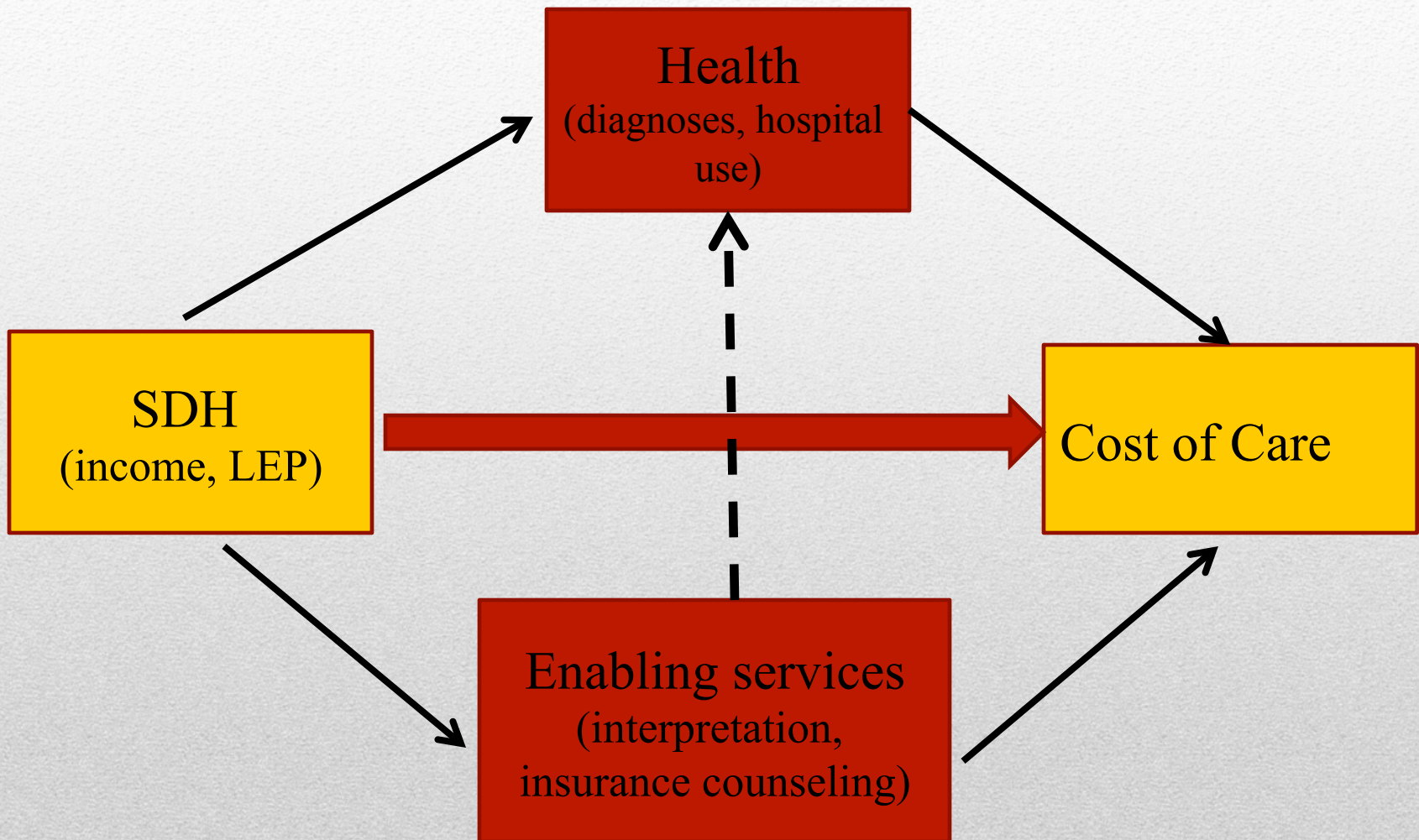
Risk Adjustment Pilot Project

◆ AHS is conducting a pilot project on including social determinants of health in risk adjustment modeling

◆ Exploring inclusion of income and limited English proficiency

◆ Working with academic partners from UC San Diego and UCLA, actuarial consultants, and our community health center network to obtain the necessary data

◆ The purpose is to see how adding in social determinants of health may affect the risk scores and whether that better predicts our patients' risk profile

◆ Only in the early stages of the project; no results yet

Advantages

◆ As a community health center, AHS has some of the data that health plans would not have:

- limited English proficiency

- Income data

- Some additional data to inform enrollees who churn; have data on source of payor at every visit

- Residential address, which may be used for geocoding to help address missing data in some cases

◆ Working with our community health center network to obtain data on hospitalization, time frame for coverage

Challenges

◆ Risk adjustment for hospitalization and less so for primary care
◆ Limited diversity in LEP and income among patients in our health center
- Have a large proportion who are LEP and low-income, making it harder to use an internal comparison
- Would need external comparison groups to compare our patients' risk to
- Would be good to have other community health center data to compare to
◆ Hard to get all the needed data from all health plans to complete the picture
- With different payor source, need to make sure to obtain data from various health plans

Future Steps, Directions and Considerations

◆ Still in early stages of exploring data availability at our health center, health center network, and health plans

◆ Once obtained all the necessary data, will begin to do the modeling using UC San Diego's Chronic Illness and Disability Payment System (CDPS)

- Exploring type of modeling: Prospective risk adjustment uses one year's data to predict the next year, whereas concurrent risk adjustment uses this year's data to inform this year's payments

- We are want to do prospective risk adjustment, similar to what Medicaid is using, and Exchange's bridge program (Exchange normally use concurrent risk adjustment)

- Choice of which risk adjustment to use may depend on who we want to influence – Medicaid or Exchange

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