



Value-Based Payment Reform
Academy:
What to Consider when Designing a
Risk Adjustment Strategy for
Value-based APMs for FQHCs



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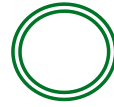
ACCESS CODE: 2383339

MAY 1, 2017

4:00-5:00PM ET

This work is supported through NASHP's Cooperative Agreement with the Health Resources and Services Administration (HRSA), grant #UD3OA22891

LOGISTICS



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AGENDA

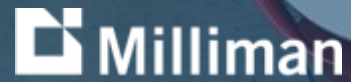


- Introduction
- State role call
- What to Consider when Designing a Risk Adjustment Strategy for Value-based APMs for FQHCs
- Wrap up and evaluation reminder

TODAY'S SPEAKER



John D. Meerschaert
FSA, MAAA
Principal, Consulting Actuary



What to Consider when Designing a Risk Adjustment Strategy for Value-based APMs for FQHCs

John D. Meerschaert, FSA, MAAA
Principal and Consulting Actuary

May 1, 2017

Agenda

- Examples of Alternative Payment Models (APMs)
- Risk adjustment features
- Important issues for FQHCs to consider
- Discussion

Examples of Alternative Payment Models

PCMH / care management fee

- FFS payments
- PMPM payment for care management services

Pay for performance

- FFS payments
- Incentive payments based on quality, utilization, or other measures

Capitation for services delivered by FQHC

- PMPM payment for a specific set of services delivered to attributed population

Shared savings / shared risk arrangement

- FFS or PMPM payment
- Global target for a population's cost of care
- Share savings and/or losses

Global capitation for all services

- PMPM payment for all services delivered to attributed population

Alternative Payment Models

Advantages of APMs for FQHCs

- FQHCs often operate as patient-centered medical homes and engage vulnerable populations
- APMs are designed to reward value and quality
- APMs provide increased flexibility, since revenue is decoupled from the number of services provided
 - Funding can be used to pay for services not typically covered by Medicaid
 - Funding can be used to provide social support coordination that can reduce medical service expenditures
- Increased revenue can be reinvested to support quality improvement and other policy objectives

Alternative Payment Models

Unique criteria for FQHC payment

- The Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 requires the FQHCs be reimbursed through the prospective payment system (PPS), or an APM as long as:
 - Individual FQHCs agree to be reimbursed by the APM; and
 - Each clinic's total payments are equivalent to or higher than the total payments they would have received through PPS
- Provides the stability of a payment floor equal to PPS rates
- Allows for enhanced FQHC reimbursement under APM arrangements
 - In return for higher reimbursement, FQHCs need to provide value to the State and/or MCOs the form of reduced population cost, increased quality, or progress towards other policy goals

Alternative Payment Models and Risk Adjustment

What do risk adjusters do?

- Goal of risk adjustment is to fairly reflect a population's acuity in payment methodologies and quality measurement
- Risk adjusters measure the relative acuity of a population based on various characteristics, such as:
 - Age
 - Gender
 - Geographic location
 - Eligibility category
 - Diagnosis codes
 - Comorbidities
 - Prescription drug usage
 - Social determinants of health (customized models only)
 - Functional status (customized models only)

Alternative Payment Models and Risk Adjustment

Common risk adjusters

- University of California at San Diego
 - Chronic Illness and Disability Payment System (CDPS)
 - Medicaid Rx
 - CDPS+Rx
- Verisk Health DxCG Intelligence
- 3M Clinical Risk Groups (CRGs)
- CMS HHS-HCC model
- CMS Medicare Advantage HCC model
- John Hopkins ACG System
- Milliman Advanced Risk Adjusters (MARA)
- More information in Society of Actuaries risk adjuster study:
 - <https://www.soa.org/research-reports/2016/2016-accuracy-claims-based-risk-scoring-models/>

Alternative Payment Models and Risk Adjustment

Risk weight development

- Risk weights are the relative factors applied for each characteristic according to the risk adjuster logic (e.g., diagnosis, age, etc.)
- Standard risk adjusters come with standard risk weights based on national data
- Many Medicaid programs choose to develop custom risk weights specific to their state's program design:
 - Covered populations
 - Covered services
 - Provider reimbursement rates

Alternative Payment Models and Risk Adjustment

CDPS risk weight example #1

- Risk Score Example: Kate

- Intercept: 0.330
- Demographic: 0.152
- Diagnostic: 0.364
- Total Risk Score: 0.846

<u>CDPS Label</u>	<u>ACUTE</u>
Intercept	0.330
15<=age<25 male	-0.139
15<=age<25 female	0.191
25<=age<45 male	0.000
25<=age<45 female	0.152
45<=age<65 male	0.208
45<=age<65 female	0.292
65<=age	0.250

<u>CDPS Label</u>	<u>ACUTE</u>
CNS, high	2.251
CNS, medium	1.342
CNS, low	0.561
Pulmonary, very high	0.000
Pulmonary, high	1.642
Pulmonary, medium	0.921
Pulmonary, low	0.374
Gastro, high	1.758
Gastro, medium	1.107
Gastro, low	0.364
Diabetes, type 1 high	1.037
Diabetes, type 1 medium	1.037
Diabetes, type 2 medium	0.497
Diabetes, type 2 low	0.497

Alternative Payment Models and Risk Adjustment

CDPS risk weight example #2

- Risk Score Example: Mary

- Intercept: 0.330
- Demographic: 0.152
- Diagnostic: 0.561 + 1.037
- Total Risk Score: 2.080

<u>CDPS Label</u>	<u>ACUTE</u>
Intercept	0.330
15<=age<25 male	-0.139
15<=age<25 female	0.191
25<=age<45 male	0.000
25<=age<45 female	0.152
45<=age<65 male	0.208
45<=age<65 female	0.292
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<u>CDPS Label</u>	<u>ACUTE</u>
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Diabetes, type 2 low	0.497

Alternative Payment Models and Risk Adjustment

Risk adjustment approaches

Prospective Risk Adjustment

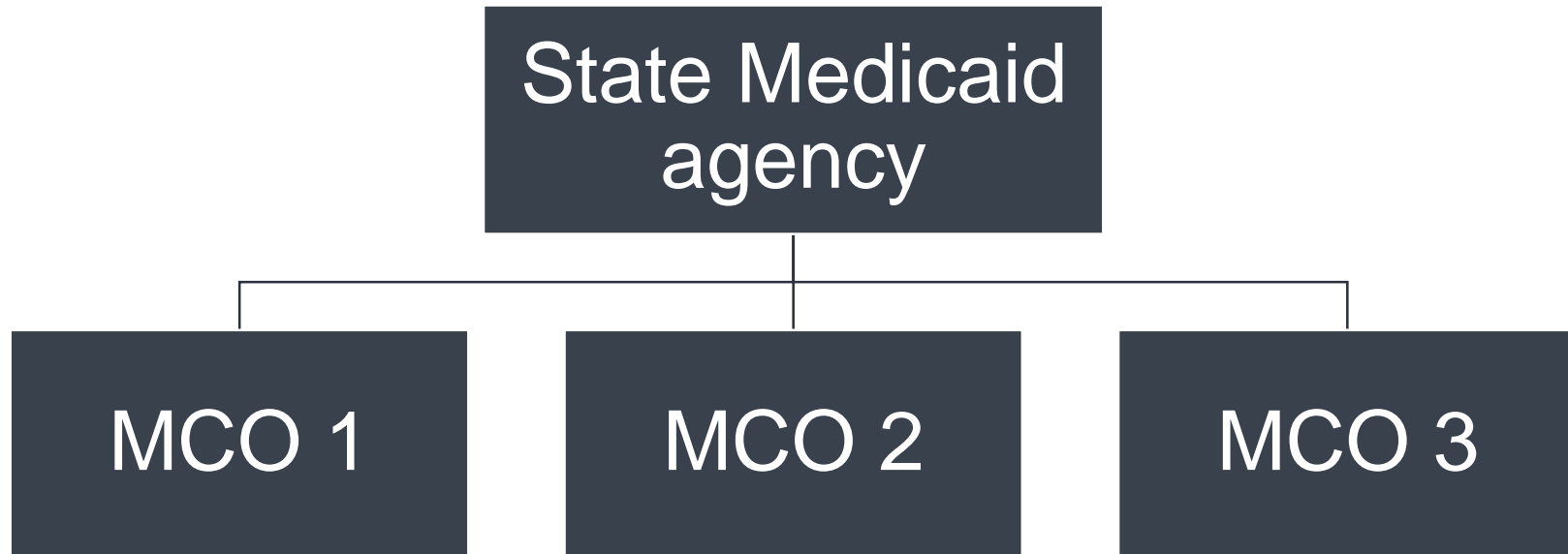
- Data from a given time period used to predict the acuity of the population in a future time period
- Applied prospectively, so impact to revenue known in advance
- Use of older data results in less accurate predictions
- More weight given to chronic conditions that impact costs in future years
- General range of predictive power (R-squared) of 15% to 25%

Concurrent Risk Adjustment

- Data from a given time period used to predict the acuity of the population for the same time period
- Applied retrospectively, so final revenue not known until after the time period is over
- Use of more current data results in more accurate predictions
- More weight given to acute conditions
- General range of predictive power (R-squared) of 40% to 55%

Alternative Payment Models and Risk Adjustment

What payments are typically risk adjusted in Medicaid programs?



Alternative Payment Models and Risk Adjustment

What payments are typically risk adjusted in Medicaid programs?



Alternative Payment Models and Risk Adjustment

When is risk adjustment necessary for an APM?

- Whenever the adequacy of a payment is influenced by the acuity level of the population
 - Complexity of care management activities under a PCMH arrangement
 - Incentive payments that are based on utilization (e.g., ED visits) or other measures that vary with the acuity of the population
 - Fixed PMPM capitation rates, either for a defined set of services or for all covered services
 - Fixed global PMPM target for a population's cost of care
- The optimal risk adjustment methodology for a specific APM will be dictated by the goals and features of that APM

Alternative Payment Models and Risk Adjustment

Important issues for FQHCs to consider

- The first step in risk adjustment is stable APM design (proper rate cells, stable population, etc.)
- The risk adjuster should be specific to the covered services
 - FQHCs typically provide a limited array of services
 - Primary care
 - Women's health and family planning
 - Laboratory and radiology services
 - Behavioral and substance use disorder treatment
 - Dental services
 - Acuity factors can vary dramatically by type of service (hospital inpatient vs. primary care)
 - Most standard risk weights reflect the cost of all acute care services
 - Might be appropriate if the APM is based on a broad array of services
 - APMs that are limited to the services provided by FQHCs should use customized risk weights

Alternative Payment Models and Risk Adjustment

Important issues for FQHCs to consider

- Risk adjusters are not perfect and only explain a portion of a population's acuity level
- Risk adjusters work better on larger, more stable populations
- The choice of risk adjuster will be influenced by the risk adjuster already used by the state Medicaid agency or MCO
 - CDPS+Rx is the most common risk adjuster in Medicaid programs
- Risk adjusters are only beginning to use data on the social determinants of health
 - These social factors may be particularly important for populations served by FQHCs
 - Data on social factors must be tracked over time in order for it to be used in risk adjustment

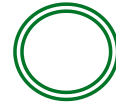


Discussion

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Thank You!



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