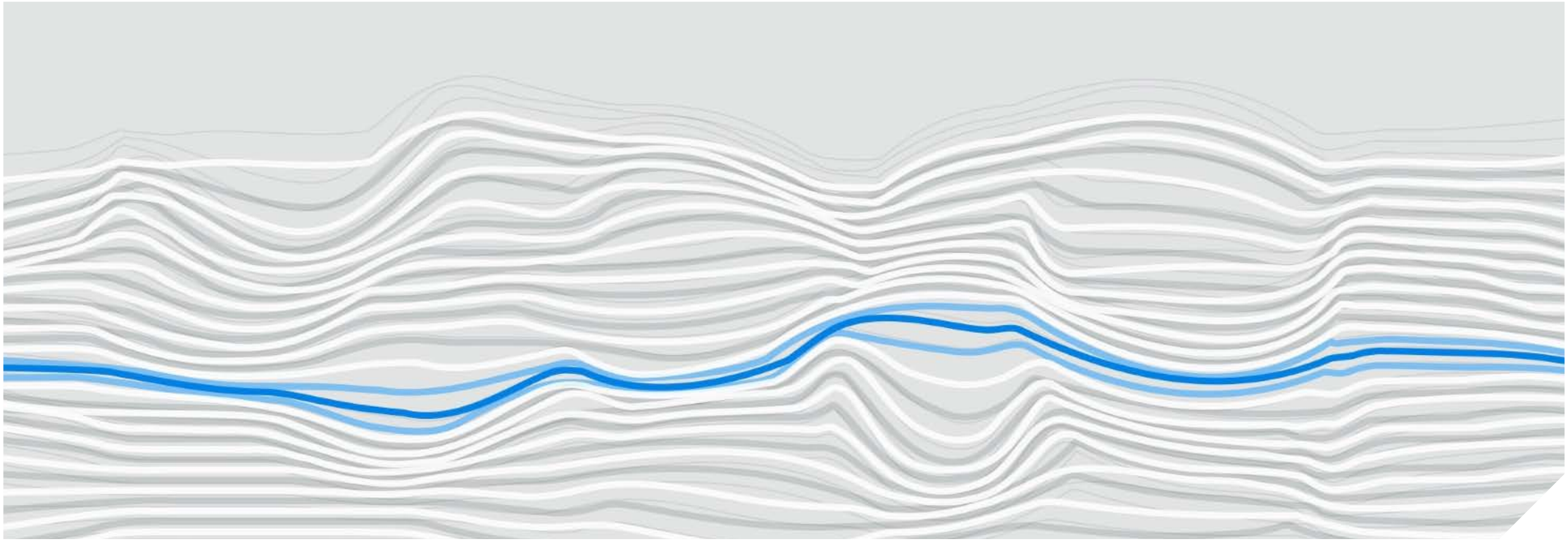
Seven key challenges for Medicaid states considering alternative payment models

February 27, 2019 Milliman Webinar

Milliman

Rebecca Johnson, MBA
Anders Larson, FSA, MAAA
Zach Hunt



Agenda

	Speaker introductions and overview
1	Attribution
2	Claims volatility
3	Risk adjustment
4	Alignment with managed care
5	Quality metrics
6	Service carve-outs
7	Variation in benefits and coordination with other payers
	Questions

Milliman Speakers

Rebecca Johnson, MBA

Senior healthcare management consultant with the New York office of Milliman

Anders Larson, FSA, MAAA

Consulting actuary with the Indianapolis office of Milliman

Zach Hunt

Actuarial student with the Indianapolis office of Milliman

Overview

Overview of alternative payment models

Alternative payment models (APMs) have been gaining popularity over past 10 years

- Pay-for-performance (incentives payments tied to quality metrics)
- Shared savings (one-sided) or shared risk (two-sided)
- Episode-based or bundled payments
- Global budgets or sub-capitation

MACRA has increased the incentives for providers to participate

Medicare FFS has led the way

- MSSP, BPCI, Next Generation ACO, CPC+

Becoming more common in commercial markets

Medicaid markets have been starting to roll out similar programs

Total cost of care (TCOC) models

Holds provider/ACO accountable to total cost (and quality)

Attribute members to provider/ACO	Calculate TCOC target	Compile actual TCOC results	Shared savings / loss
▪ Member Choice ▪ Claims History ▪ Geographic proximity	▪ Historical claim experience trended and adjusted, or ▪ % premium / capitation rate	▪ Actuals above target = loss ▪ Actuals below target = savings	▪ Provider / ACO shares in savings or loss ▪ Quality adjusted

(1) Attribution

Attribution assigns responsibility for outcomes/cost to providers

Many TCOC models base attribution on use of **primary care services**

- For example, attributing a member based on use of evaluation and management (E&M) services for a defined time period

Difficult to appropriately attribute Medicaid members using an E&M approach

- Medicaid members more likely than Medicare and commercial members to access primary care services through the ER, urgent care or not at all

Figure 1: Percentage of Patients With at Least One E&M Visit and/or ER Visit During a Calendar Year

Metric	Market		
	Commercial	Medicare FFS	Non-dual Medicaid
Percentage with E&M visit	72%	87%	69%
Percentage with ER visit and no E&M visit	1%	2%	6%

Note: Values have been rounded. Based on analysis of 2016 markets in the same set of three states. Data sources and methodology for analysis are shown in the white paper.

TAKEAWAY: Leverage analytics to understand the impact of different attribution approaches

Align financial incentives by through appropriate attribution

Including **member choice** in attribution process can help ensure appropriate alignment

Attributing member **without E&M services has risks**

- Expands population covered by APM
- Can result in providers accepting risk for patients without established relationship

(2) Claims volatility

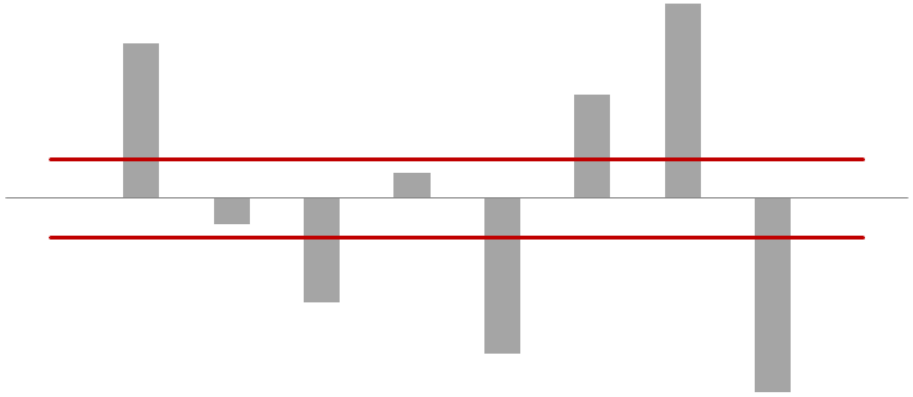
Claims volatility from random variation can disrupt financial incentives

Providers inherently take on some level of **insurance risk** with any TCOC models due to random claims fluctuation

- CMS uses minimum savings rate (MSR) functions (vary by population size) in the Medicare ACO models to address this challenge

Medicaid-specific challenges

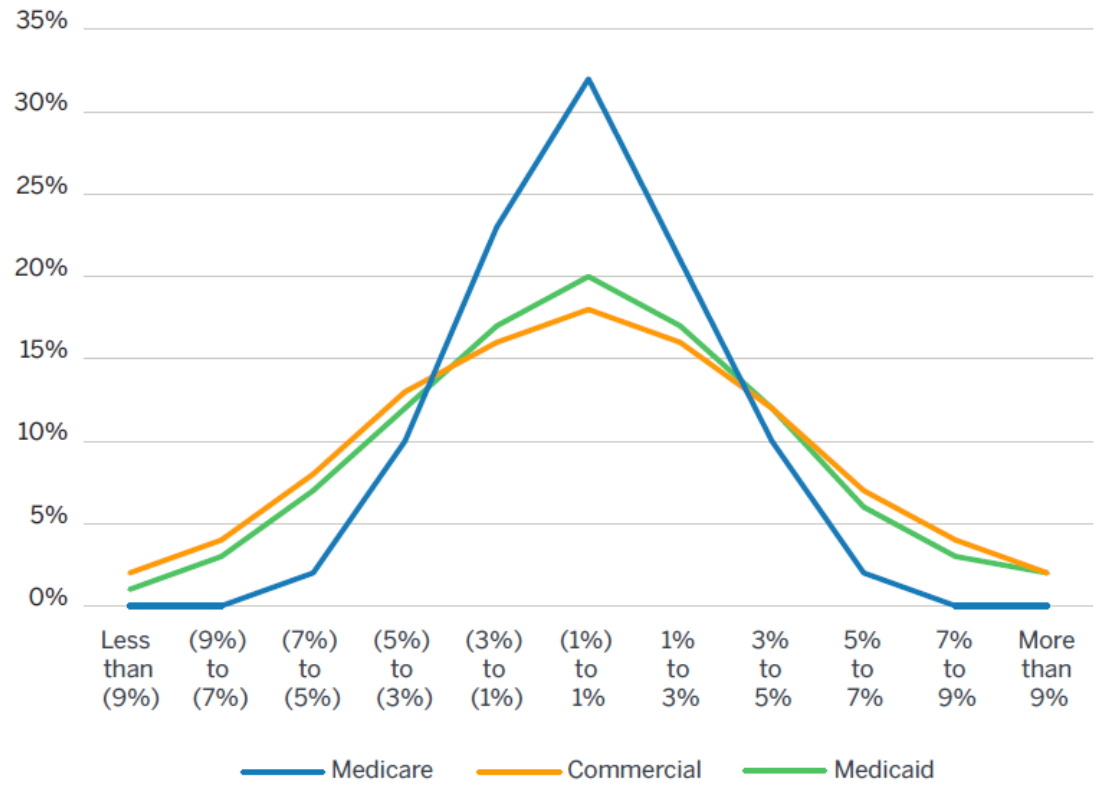
- Difficulty with attribution
- Beneficiaries moving in and out of Medicaid
- A higher prevalence of zero-dollar claimants



Medicaid trends had more volatility than Medicare

- 1,000 simulations of a 10,000-member population
- Standard deviation in risk-adjusted medical (non-Rx) costs
  - 2.5% for Medicare
  - 4.1% for Medicaid
  - 4.5% for Commercial
- Not uncommon in Medicaid for costs to be more than 5% outside expected
- Does not account for increased volatility due to attributing a population to a provider
  - Attributed populations have high turnover rates, which can be exacerbated for Medicaid

FIGURE 2: RANGE OF ONE-YEAR RISK-ADJUSTED PMPM TRENDS, RELATIVE TO MARKET AVERAGE: SIMULATED 10,000-LIFE GROUPS

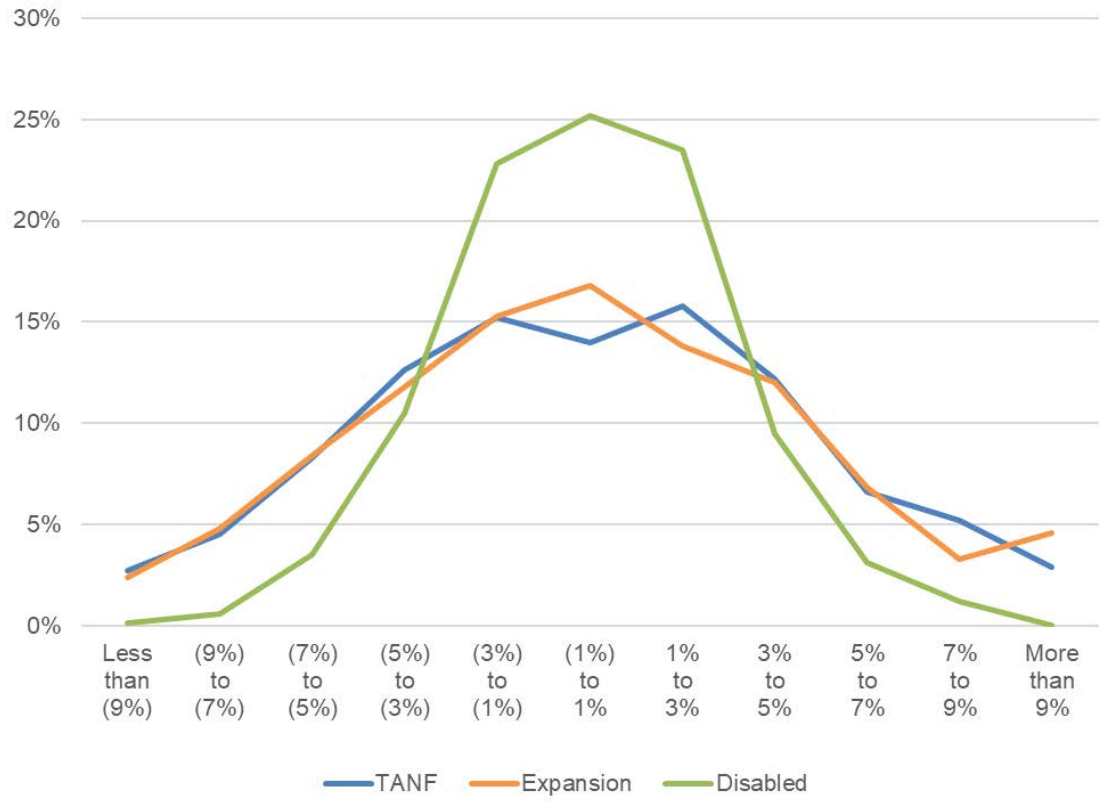


Note: Based on analysis of 2015-2017 markets in the same set of three states. Data sources and methodology for analysis are shown in the white paper.

Trends varied within Medicaid by Aid Category

- 1,000 simulations of a 10,000-member Medicaid population from each aid category
- Standard deviation in risk-adjusted medical (non-Rx) costs
  - 4.9% for TANF
  - 4.9% for Expansion
  - 2.9% for Disabled
- TANF and Expansion populations were comparable the Commercial population
- Disabled population was comparable Medicare

RANGE OF ONE-YEAR RISK-ADJUSTED PMPM TRENDS, RELATIVE TO MARKET AVERAGE: SIMULATED 10,000-LIFE GROUPS



Note: Based on analysis of 2015-2017 markets in the same set of three states. Data sources and methodology consistent with analysis shown in the white paper.

TAKEAWAY: Use established actuarial mechanisms to address claims volatility

Actuarial mechanisms include:

- Stop-loss thresholds
- High-cost claim/claimant carve-outs

Use real-world data to **sensitivity test** impact to APM financial results, varying by stop-loss threshold/cut-point and population size

(3) Risk adjustment

Risk adjustment helps account for changes in relative health acuity over time

Risk adjustment models produce **member-level factors**, based on diagnosis code history, age, gender and other information, to "predict" cost of care

Risk adjusters are commonly used by CMS and Medicaid agencies to **adjust premiums or capitation rates**

- Payers with sicker populations get higher rates than payers with healthier populations

Risk adjusters also used in APM models when **establishing target budgets**

Many different risk adjustment models in the marketplace, such as **CMS-HHC, HHS-HCC, MARA, and CDPS+Rx**

Considerations:

- Segmenting populations for risk-adjustment
- Normalize risk scores
- Recalibrate coefficients (i.e. "prediction" factors)

TAKEAWAY: Risk adjustment an important component if used appropriately

Disease and demographic factors should be reviewed for **reasonability relative to the target population and services covered**

- Customized weights may be an option to ensure alignment with program specifications

Consider impact of **completeness of coding (and changes in coding practices over time)** to ensure real changes in health status are being accurately captured

(4) Alignment with managed care

Importance of coordinating with all stakeholders in an APM world

Some states administer APM models, while others are between the MCOs and the providers

Considerations for **state-administered APM models** where state is already capitating MCOs:

- **Align incentives** to ensure providers are not rewarded for “MCO-generated” savings given capitation incentives at MCO level
- MCOs may sub-capitate for certain services, but if TCOC includes these benefits, **MCO may pay shared savings for services they are not at risk for**
- Savings from APM models **may not accrue to state for a few years** because capitation rates to MCOs are set prospectively

TAKEAWAY: Aligned incentives with providers can drive cost savings beyond what MCOs can achieve alone

States must carefully consider **interactions amongst all stakeholders** when coordinating APM models and MCO capitation payments to avoid unintended consequences

Changes and revisions to APM models and rate structures over time must also be carefully examined

(5) Quality metrics

Value-based payment model = cost + quality

Quality can be difficult to measure, even with “clean data”

Medicaid data **may be less complete or inaccurate** for many reasons, including adjudication potentially by both the MCOs and the state

- CMS introduced stricter rules on encounter data quality in its 2016 Medicaid Final rule

Social determinants can also pose challenges to addressing quality outcomes

- Finding convenient transportation to attend routine physician visits for fill medications
- Unstable housing situations

TAKEAWAY: Establish a quality-measures set that aligns to program goals

Understand **confounding factors** that may influence quality performance outcomes and providers ability to influence them

- Is it a quality issue or a data collection issue?

Approaches could include:

- **Phased-in approach** (increasing financial impact over time)
- **Tiered approach** (pay-for-performance for some measures, pay-for-reporting for others)

(6) Service carve-outs

Ensure benefits included in APM model promote use of high-value services

APM models should **avoid perverse incentives for providers** to reduce utilization for high-value services such as annual physicals, immunizations, and other primary care services

- May want to **carve-out certain services** from TCOC calculations

Long-term care support services (LTSS) significant cost contributor in Medicaid populations but often carved out of APM models because of how the LTSS population uses and accesses care

TAKEAWAY: Consider service carve-outs to ensure stakeholder alignment

Use **data analytics** to model the impact to APM financial results from service carve-outs

Results of modeling can be used to **inform state policy decisions** or provider APM contracting negotiations

(7) Variation in benefits and coordination with other payers

Variation in benefit coverage by entitlement category can add complexity to APM models

Different sets of benefits are offered to individuals depending upon their reason for Medicaid eligibility

These sets of benefits often **change over time**, making it challenging to set a target in a subsequent year based on data from past years

Reimbursement for benefits may vary by population

Coordination with Medicare as a secondary payer for Medicare-covered benefits

- Dual-eligible members comprise a material portion of most Medicaid populations

TAKEAWAY: Carefully weigh advantages and disadvantages of addressing benefit variations

Excluding certain subsets of the population may be the cleanest way to address these challenges

- It may also significantly **reduce the size** of the population included in the APM model

Including these populations may **add administrative complexity**, leading to confusion by providers about the APM model calculations

Milliman

Conclusions

APMs are an important component of improving value of care in Medicaid

Unique challenges presented in APM models for Medicaid must be considered to maximize potential outcomes

Partner with **actuarial and financial experts** to help facilitate understanding how these challenges impact your organization or state

- Experts can also assist with **contracting strategies and APM model designs** that carefully consider these nuances

Limitations and Qualifications

The information in this paper is intended to describe challenges with Medicaid alternative payment models. It may not be appropriate, and should not be used, for other purposes. Commentary in this paper should not be considered recommendations for any specific state Medicaid agency, provider, or managed care organization.

In performing the analysis for this paper, we relied on data made available by CMS, the Milliman Consolidated Health Cost Guidelines™, and various state Medicaid agencies. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications.

Anders Larson is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses presented in this report.

Original Milliman Whitepaper

“Seven key challenges for Medicaid states considering alternative payment models”

http://us.milliman.com/insight/2019/Seven-key-challenges-for-Medicaid-states-considering-alternative-payment-models/

Milliman

Questions?