Risk Adjustment for Dual Eligibles: Breaking New Ground in Massachusetts

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About the Massachusetts Medicaid Policy Institute

The Massachusetts Medicaid Policy Institute (MMPI) is an independent and nonpartisan source for information and analysis about the Massachusetts Medicaid program (often referred to as "MassHealth"). MMPI seeks broader understanding of MassHealth and a rigorous and thoughtful public discussion of the program's successes and challenges ahead.

About BD Group

BD Group provides analysis of health care and human services to public agencies, providers, and consumer groups. Its principals are Ellen Breslin Davidson and Tony Dreyfus. Breslin Davidson was a principal analyst at the Congressional Budget Office, and served at MassHealth as director of managed care reimbursement and analysis, and as deputy assistant commissioner. Dreyfus was the lead analyst for the original development of the Chronic Illness and Disability Payment System (CDPS), a diagnosis-based risk adjustment system used by many state Medicaid programs.

Executive Summary

Massachusetts is developing a system of integrated care for about 115,000 residents ages 21 to 64 who are "dually eligible" for both Medicare and Medicaid. The state's Medicaid program, MassHealth, aims to integrate the care and financing for this population in order to improve quality, outcomes and cost-effectiveness. Achieving these goals will require the state and Federal governments to develop a new financing model with risk adjustment as a key component.

Effective risk adjustment is essential to the success of an integrated care program. Risk adjustment will help to ensure that integrated care organizations are appropriately compensated for the risk of their enrollees and will encourage innovative care for dual eligibles with high levels of need.

The Need for Risk Adjustment

Risk adjustment is particularly important for dual eligibles because their health care costs are both varied and predictable. Dual eligibles experience diverse physical, mental and developmental conditions. Some have very low costs, some have intermediate costs, and a few have very high costs. Among people with disabilities, costs are more predictable because much of their care is related to their chronic conditions.

Risk adjustment is a system for adjusting payments to health plans to reflect the differing health needs of enrollees, with higher payments made to health plans with members needing more care and lower payments to health plans with members needing less care. Without risk adjustment, providers of integrated care would face strong incentives to enroll the less needy among the duals. By contrast, providers that attract more than their fair share of enrollees with high needs would be underpaid, and could face large financial losses or have to reduce expenditures.

Risk adjustment for programs serving the dual eligibles should take advantage of diagnostic data complemented by information on functional status.

Using Diagnoses to Adjust Payments

Most efforts to develop risk adjustment systems have focused on diagnoses, because they are good predictors of cost and readily available from claims data. Adjusting rates by diagnoses is already common practice by Medicare and many state Medicaid programs.

Medicare shifted decisively toward diagnosis-based risk adjustment in its capitated Medicare Advantage program starting in 2000. Risk adjusted Medicare payments now surpass $100 billion annually. In addition, many state Medicaid programs implemented diagnostic risk adjustment even before Medicare. Twenty-two states report that they adjust Medicaid payments using diagnoses.

Massachusetts can choose from a number of diagnosis-based risk adjustment systems to help set rates for its program for dual eligibles. A likely choice is either the CMS-HCC system or the closely related DxCG system.[1] Medicare and MassHealth have years of experience with these models, and either system could be refined to better predict variations in the costs of dual eligibles.

The Importance of Functional Status

Diagnoses alone, however, will not predict the full service needs for persons with disabilities. The inclusion of functional status measures in risk adjustment would improve the accuracy of predictions. Functional status can be defined by a range of measures, including ability to perform basic activities of daily living and cognitive status. Limitations in these areas create the demand for long term support services. Long term support services account for a large share of expenditures but are used by only some dual eligibles, so that good predictions about the need for these services will substantially improve payment accuracy.

Using functional status as a risk adjuster, however, is much less established than using diagnoses. Massachusetts can learn from the experience of New York and Wisconsin in their use of functional status data to risk adjust payments for long term support services. Since functional status data are not readily available, the state must first establish a mechanism to collect functional status data and then in later years incorporate the data into the risk adjustment system.

Since 2005, New York has required that managed long term care plans submit functional status data on almost 30,000 members. Using this data, New York created risk adjusted rates for a wide range of support services, including home health, personal and nursing home care.

Wisconsin has enrolled almost 35,000 people in its Family Care program, which provides institutional and home and community-based services for frail elders and people with disabilities. Each beneficiary's functional status is measured using a standardized state administered screening tool. This information is then used to adjust capitation rates.

The state should consider carefully the best way to collect and use functional data for risk adjustment. The state could delegate assessment of functional status to integrated care organizations or the state might prefer to retain this responsibility. In either case, functional assessment would add to the overall program cost, but increased attention to functional status would be useful not only for risk adjustment but also for care management and program monitoring.

1 CMS-HCC is the Federal Centers for Medicare and Medicaid Services' Hierarchical Condition Category model; DxCG is the name of a model offered by the company Verisk.

MassHealth Experience with Risk Adjustment

Massachusetts can also build on practices that MassHealth has developed and refined over time. Current practices used by MassHealth include the use of rating categories and a diagnosis-based risk adjustment system for the managed care organization program. Rating categories are a way to group individuals, often based upon eligibility criteria, and have long served as the first step in MassHealth's rate setting process. MassHealth has also used risk sharing arrangements and stoploss to limit risk to health plans.

Implementing Risk Adjustment in the Demonstration Program

The demonstration period represents an excellent opportunity for CMS and MassHealth to lay the foundation for the future in a collaborative and transparent manner. We would encourage CMS and MassHealth to aim for a unified payment system under which Medicare and Medicaid adopt the same rating category structure, risk adjustment system, data collection requirements and risk sharing arrangements. A unified payment system of this kind would reinforce the goals and benefits of integration, simplifying administrative requirements for all parties and focusing attention on a single set of requirements and incentives.

Recommendations

We offer the following recommendations as a stimulus for discussion. We recommend that CMS and MassHealth:

1. Establish rating categories based on the type and severity of diagnoses among dual eligibles to capture some of the variation in risk among enrollees.
2. Select a single risk adjustment system on the basis of several criteria, including accuracy, transparency, and the experience of payers; this risk adjustment system should be refined to better predict the risk of dual eligibles.
3. Develop a method to predict long term support service needs. Initially CMS and MassHealth can use individual data on prior expenditures for these services, but should move to using functional data by the third year of the demonstration.
4. Establish standards for the collection of data on functional status and begin collection as soon as the program starts. Uniform standards will allow the use of this data for risk adjustment in future years and for consistent program management and monitoring from the start.
5. Put integrated care organizations at limited financial risk during the demonstration period to minimize losses and gains.

6. Update capitation rates frequently for changes in the risk of enrollees during the initial years of the demonstration program in order to maintain payment accuracy.

Time to Break New Ground

CMS and MassHealth are about to break new ground in Massachusetts. CMS and MassHealth annually spend $2.5 billion on care for duals ages 21 to 64. Integrating the care and financing for this population holds much promise to improve the quality of care that dual eligibles receive from the Medicare and Medicaid programs. CMS and MassHealth should invest the time needed to create a strong payment model that will promote an improved system of patient-centered care for this expensive and vulnerable group.

Beyond Massachusetts: A National Payment Model

Massachusetts and other states would benefit from a national effort to create a single model for adjusting payment in integrated programs. This approach could reduce each state's burden of constructing its own model and reduce the complexity of CMS's work with states in the demonstration. States would likely need to tailor the national model to reflect covered benefits and local service patterns. A national model could include an available diagnosis-based risk adjustment system refined to better predict costs for dual eligibles ages 21–64, and a set of functional variables for risk adjustment in the demonstration programs.