



UnitedHealth Group®

**Risk Adjustment Lessons Learned from Early
State Adopters
Presentation to MMIS Conference**

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AmeriChoice: A UnitedHealth Group Company

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Purpose and Topics

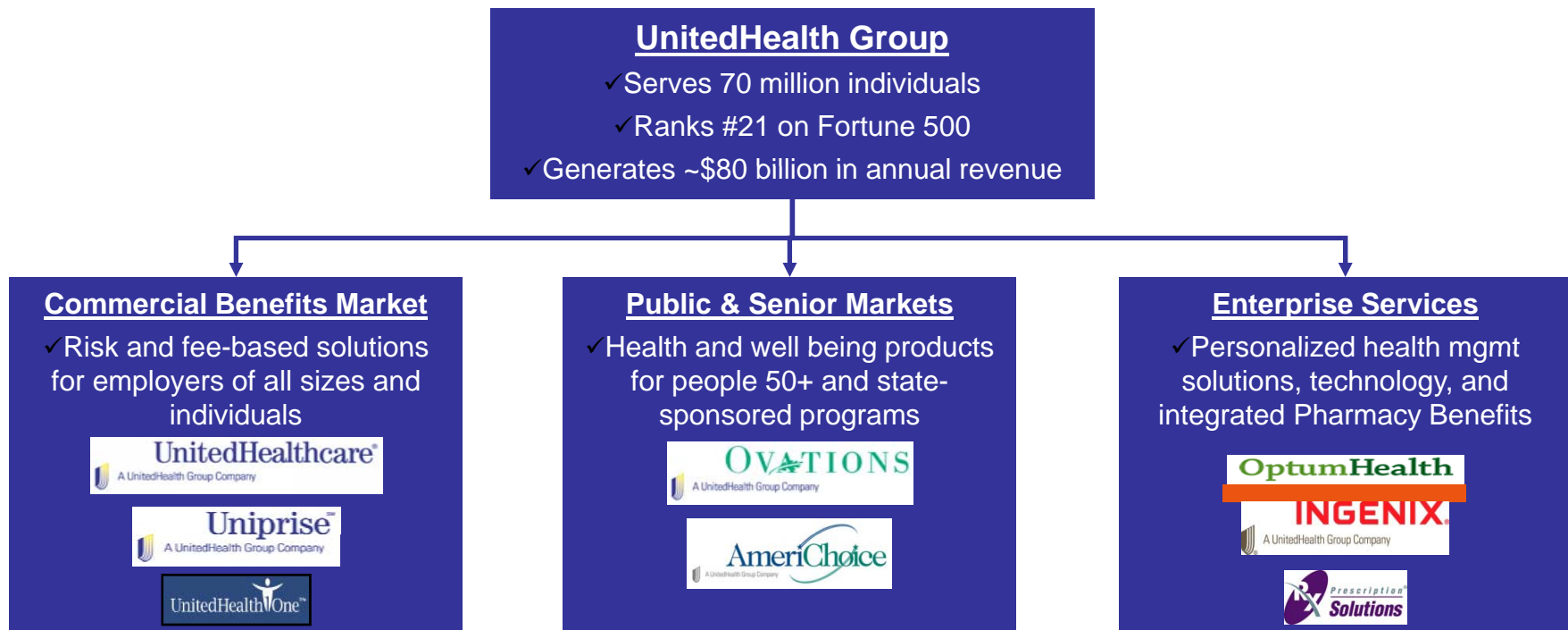


- ❑ Brief overview of UnitedHealth Group and AmeriChoice
- ❑ Summarize United's experiences with state risk adjusted payment programs
- ❑ Describe my work while at the University of Maryland (1998-2003) where the University consulted with states and CMS on risk adjusted payment programs
- ❑ Document the importance of complete and validated data to achieve the policy goals of risk adjustment
- ❑ Describe the tools and analytics our Company uses to support risk adjustment
- ❑ Summarize lessons learned from early adopters that would both achieve state goals and recognize health plan financial realities

UnitedHealth Group Overview



Through its family of businesses, UnitedHealth Group provides a highly diversified and comprehensive array of health and well-being products and services.



Key AmeriChoice Facts



AmeriChoice is UnitedHealth Group's business unit focused on health care benefits and resources for people in state-sponsored health programs.

Key Facts

- Serves 2.1 million members - 70% children, high proportion of disabled adults, pregnant women
- Operates 18 Health Plans; also offers Management Services/Disease Management programs in 5 states and Medicare products in 4 states
- Employs over 3,000 individuals

Noteworthy Recognitions



AmeriChoice/UnitedHealth - Leaders in the Field

- ❑ **US News and World Report** ranks 4 of 13 AmeriChoice Medicaid plans among “Best Medicaid Health Plans of 2007.” One AmeriChoice plan scored in the top 10.
- ❑ **High Performer on Key HEDIS Measures:** AmeriChoice’s plans score ***Above the National Average*** among its competitors in 7 key child and adolescent health measures. In our Michigan plan, 91% of children completed the recommended 6 or more well child visits during their first 15 months of life, compared to a national plan average of 56%.
- ❑ **Provider Strength:** “U.S. physician offices accept UnitedHealth more than any other insurance plan,” reports independent health research firm SK&A Information Services, Inc.. AmeriChoice builds on that vast ongoing network of doctors in serving Medicaid enrollees.
- ❑ **NCQA Award for Multicultural Outreach, 2007:** UHG was awarded for its work in developing innovative solutions to reduce health disparities in the communities with minority populations. This award focused on UHG efforts to make more Asian providers available to the community of Los Angeles.
- ❑ **South Florida Hispanic Chamber of Commerce** named UnitedHealth as it’s “2007 Health Care Provider of the Year.” This was due to “extraordinary local and national health care initiatives” that provide “culturally relevant and linguistically accurate products and services that address Hispanics unique health care needs.”

Products & Footprint



AmeriChoice operates 18 Health Plans that offer Medicaid, SCHIP, ABD, Medicare, and Uninsured products.

AmeriChoice Products

Medicaid

- Temporary Asst. to Needy Families (TANF)
- Primarily mothers / children under 185% of FPL

SCHIP

- State Children Health Insurance Programs
- Children above Medicaid but less than 250% of FPL

ABD

- Aged, Blind & Disabled Persons

Medicare

- Medicare / Medicaid dual eligible members in Special Needs Plans
- **5 current markets**

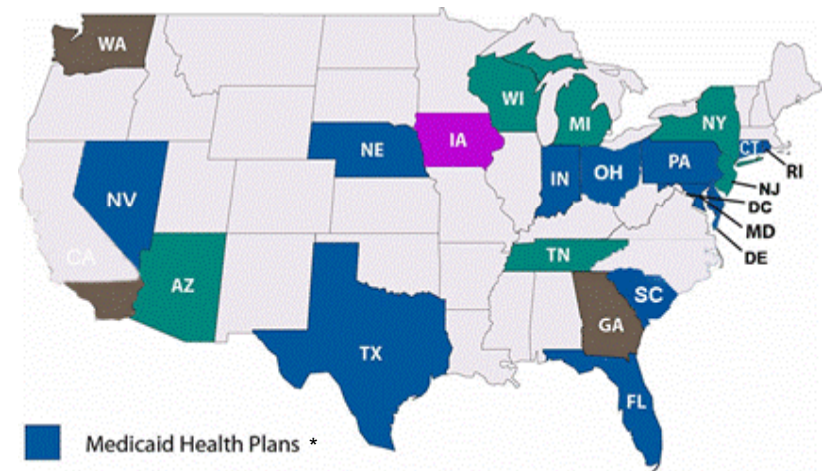
Uninsured

- New product in IN designed to reduce uninsured
- Program being leveraged for other states

Care Management

- Provide Integrated Chronic Care Management (ICCM) in Washington, Georgia, and California (San Diego).

AmeriChoice Footprint (2008)



- Medicaid Health Plans *
- Medicaid/Medicare Health Plans
- Management Service Organizations
- State Children's Health Insurance Program

* Most Medicaid offerings also include an SCHIP benefit

University Of Maryland Work on Risk Adjusted Rates



- While at the University based research center, the Center, in conjunction with Actuarial Research Corporation, was awarded two CMS contracts aimed at providing technical assistance to states on risk adjustment payment systems for state Medicaid programs
- The scope of work began with documenting state experiences with risk adjustment from 1997 to 2003 and culminated in a manual published by CMS which documents the key steps for implementing risk adjusted rates.
 - Key chapters include selecting a system, identifying the necessary data, determining the validity and completeness of the data, readiness for MMIS system and all financial and rate setting components
 - The manual is available on the CMS website at www.cms.gov
- The first deliverable, documenting experiences of all states using risk adjusted rates (over 10 at that time) formed the basis for the lesson learned and keys to success components of the manual.

University Of Maryland Work on Risk Adjusted Rates (Cont.)



□ Key themes and lessons learned include:

- A key to success in risk adjustment is the importance of complete and valid data on both the part of the health plans submissions and the state's subsequent use of the data
- States should work closely with health plans throughout the preparation and implementation phases
- States should simulate results so there are no surprises or business disruptions in the implementation cycle (this also serves as an important validation step where data anomalies can be identified and remedied
- Recognizing that risk adjustment is part of a larger financing and program context to drive better quality care for Medicaid beneficiaries. Indeed as data submission completeness and quality improves under risk adjustment, states are better positioned to drive a data driven quality agenda
- Risk adjustment alone is not a panacea for over rate adequacy

Highlights of Key State Policies on Risk Adjustment



- The majority of states we contract with use some type of diagnostic risk adjuster
 - There has been a growing trend to adopt risk adjustment in state Medicaid managed care programs
 - Risk adjustment has emerged as the predominant model for state payments for Medicaid managed care
 - While certain risk adjustment groupers are common across the states, how states apply risk adjustment varies widely.
 - While CDPS is the dominant model followed by ACGs, recently we have observed new models being adopted by states(Medicaid Rx, CRGs)

- For states that AmeriChoice contracts with, the following slide provides a quick summary on populations, frequency of updates, type of model used and unique state polices such as phase ins and corridors.

- As we go through the slide I'll describe important payment policy and data issues with the states

States Using Risk Adjustment (those contracting with UHG)



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AmeriChoice Risk Adjusted Markets

State	Risk Adjustment Model	Population Risk Adjusted	Update Frequency	Special Policy
Pennsylvania	CDPS	TANF & SSI	Semi-annually	
New Jersey	CDPS	TANF & SSI	Annually	
Wisconsin	CDPS	TANF & SSI	Annually	
Texas	CDPS	TANF & SSI	Annually	
Michigan	CDPS	SSI	Annually	Risk Corridor
Ohio	CDPS	ABD	Semi-annually	
Maryland	ACG	TANF & SSI	Annually	Encounter Completeness Factor for the first four years
Tennessee	ACG	TANF & SSI	Annually	Risk Corridor
New York	CRG	TANF & SSI	Annually	Phase-in
Florida	Medicaid Rx	TANF & SSI	Quarterly	Phase-in, Risk Corridor
Delaware	Medicaid Rx	TANF & SSI	Annually	
Arizona	ERG	TANF & SSI	Annually	Phase-in, 80%
Medicare	HCC & RxHCC	Medicare Eligible	Semi-annually	Phase-in for the first four years

Context



- ❑ From a health plan's perspective, these tools should be viewed within an overall philosophy geared to care coordination and improved health outcomes for members.
- ❑ Sophisticated models to identify at risk enrollees is only the first step to effectively coordinating care and improving health outcomes
- ❑ United's data analytics subsidiary, has developed ImpactPro, a sophisticated predictive modeling tool that we use in many markets and in stand alone Disease Management and Care Coordination programs

Integrated Service Delivery Model



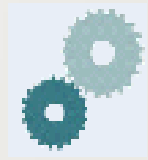
Impact Pro™ Predictive Modeling Engine

Data-Driven Preliminary Risk Stratification

Low Risk Members

Moderate Risk Members

High Risk Members



Call member

Enroll member

Complete HRA

Determine appropriate management based on risk score & HRA responses

Telephonic-based care management

Field-based care management

Continue to monitor, via Impact Pro™

Key to Risk Adjusted Rates



- ❑ Most of the risk adjustment methodologies rely on ICD-9 codes mainly from professional and institutional claims/encounters (with the exception of Florida which uses drug information)
- ❑ Diagnostic information must be received from our providers, processed through our claims system and then sent to the state and be accepted
- ❑ Each step in this process could result in data loss
- ❑ Missing data will result in a “healthier” measure of our members’ acuity

Florida Snapshot



- ❑ One of the key features of Florida's innovative Medicaid Reform program which began in July 2006, was the introduction of a risk adjustment payment program

- ❑ The reform program included traditional MCOs and new Provider Sponsored Organizations

- ❑ At the time of the reform program implementation, the State was not collecting complete encounter data so traditional diagnostic based risk model (CDPS, ACG) was not an option

- ❑ The state studied alternatives that would allow this critical policy goal to move forward and ultimately selected *Medicaid Rx*
 - a system that classifies a subset of the National Drug Codes into categories that can be used for risk-assessment and risk-adjusted payments. (T Gilmer, et al)

Florida Snapshot (Cont.)



- The legislation authorizing the Medicaid Reform program requirement the state to establish a Technical Advisory Panel (TAP)
 - **Risk-Adjusted-Rate Setting:**
 - The Advisory Panel will investigate and guide AHCA on the development of risk adjusted rate methodology to be used. It will make recommendations on mechanisms for determining the risk of Medicaid participants and for the transition to a risk adjustment system, including recommendations for phasing in risk adjustment and risk corridors. The Panel will also examine administrative issues relating to the use of risk-adjusted rates like cost, simplicity, client privacy, data accuracy and data exchange. Implementation of an encounter data system to be used for risk adjusted rates will also be considered by the Advisory Panel.



Lessons learned and Experiences:

- ❑ The use of a Technical Panel has proven to be of great value to both the state and the plans as well as the many stakeholders in the Florida Medicaid program
- ❑ The regular meetings, accompanied by thorough preparation and data simulations allowed important technical issues to be vetted and minimized surprises.
- ❑ For example, the state presented very detailed analyses of Rx drug data to test completeness and timeliness of submissions, allowing health plans to take appropriate actions to assure complete data.

Data Sources of Risk Adjustment



- Risk Identification
 - Demographic
 - Clinical
 - Diagnostic Codes
 - Drug Codes

- Risk Measurements (Weights)
 - Costs
 - Utilization

Data Issues



- Our other panelists have described tools and approaches to make sure all appropriate diagnostic information is provided
- Some of the considerations and factors we believe are important include:
 - Lag/Run Out
 - Up to three months to finalize professional claims
 - Up to six months to finalize institutional claims
 - Inaccurate/Incomplete coding
 - Invalid diagnostic codes
 - Three digits vs. five digits reported in diagnostic codes
 - Disease Persistency
 - Incomplete coding by providers
 - Special efforts for capitated providers

Measure Data Completeness



- ❑ Health Plans need to measure and assess the completeness of their encounter data submitted to the state

- ❑ Quantitative Analysis of Claim Information
 - e.g. Claim Counts

- ❑ Quantitative Analysis of Diagnostic Information
 - e.g. Unique Diagnostic Counts

- ❑ Qualitative Analysis of Diagnostic Information
 - e.g. Illness Burden Measurement

Simulating Results



- ❑ Both the state and the plan should simulate disease burden distributions using the appropriate risk adjustment model.
- ❑ Ideally, all plans results (blinded) could be shared so plans can see and understand the variations among plans. This can serve as an important validation step and whether corridors or phase ins may be appropriate
- ❑ Ideally, the state simulations should be available prior to finalizing scores and use this for both validation, forecasting and estimating the financial impact on the health plans

Lessons Learned



- ❑ My experience with state risk adjustment programs demonstrates that it is common for states to experience implementation challenges in the early years.
- ❑ Many states have chosen to limit payment swings by using corridors or other phase in devices.
- ❑ This allows plans to adjust to the new payment systems and recognizes some of the variation in observed illness burden may be the result of data issues or other implementation realities

Lessons Learned



- ❑ Implementation of risk adjustment necessarily results in payment changes among health plans
- ❑ For states considering the adoption of risk adjustment, they should consider creating a state/health plan work group with a specific agenda to analyze, vet and resolve implementation issues. A critical component of the work should involve analyzing the completeness of the data that will be used in the risk adjustment grouper
- ❑ This will result in a successful program that supports the state's overall policy goals and recognizes the partnership it has with the plans in achieving these goals.

Questions



QUESTIONS

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