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Risk Stratification to Inform Care Management for Medicare-Medicaid Enrollees: State Strategies

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IN BRIEF

Individuals dually eligible for Medicare and Medicaid are among the highest-need populations in either program. States integrating care for this high-need population must ensure that individuals' health and social service support needs are addressed promptly. Stratifying Medicare-Medicaid enrollees by their level of need may help states and health plans in better prioritizing and promptly addressing care management needs to ensure high-quality, timely care.

This brief describes how three states – **California**, **Ohio**, and **Virginia** – are requiring integrated health plans to stratify Medicare-Medicaid enrollees by their level of need within new capitated financial alignment demonstrations. It details each state's stratification process, including the data used, risk groups, and assessment time frames. This information can help guide states implementing financial alignment demonstrations, as well as states and health plans integrating care through Dual Eligible Special Needs Plans or managed long-term services and supports programs.

States across the country are seeking to improve care for individuals dually eligible for Medicare and Medicaid through integrated models supported under the Affordable Care Act. While many Medicare-Medicaid enrollees have significant health care and social support needs, other individuals who are dually eligible are in relatively good health, requiring fewer services.

Prioritizing new enrollees who are most in need of immediate care management and services is of high importance for both states and integrated health plans. States' risk stratification requirements seek to ensure that health plans contact new enrollees promptly and that enrollee needs are assessed at appropriate intervals. The timing of initial health plan contacts varies across states, and the type of assessment required also differs, with some states requiring brief health risk assessments and others using more comprehensive clinical and social assessments.

Through support from The SCAN Foundation and The Commonwealth Fund, the Center for Health Care Strategies (CHCS) interviewed representatives from three early implementer states – **California**, **Ohio**, and **Virginia** – about their approaches to stratifying Medicare-Medicaid enrollee needs within capitated financial alignment demonstrations.[1] The brief also shares unique elements of Illinois, Michigan, and South Carolina's current and proposed risk stratification requirements. Lessons from these states can inform other state and health plan efforts to implement integrated care programs serving Medicare-Medicaid beneficiaries with a range of needs.

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California: Providing Beneficiary Service and Utilization Data Prior to Health Plan Enrollment

California's prior experience enrolling seniors and persons with disabilities into managed care highlighted the importance of sharing utilization data with health plans prior to enrollment to support continuity of care and timely assessment. While transitioning seniors and persons with disabilities into managed care, California provided enrollee data to health plans after the date of enrollment. This led to delays in health plans' ability to promptly contact beneficiaries, making it difficult for plans to meet health risk assessment (HRA) and care plan timeline requirements. For Cal MediConnect, California's financial alignment demonstration for dually eligible individuals, the state is working collaboratively with the Centers for Medicare & Medicaid Services (CMS) to share Medicare and Medicaid claims data with Medicare-Medicaid Plans (MMPs) prior to the start of an individual's coverage.

For Cal MediConnect, which began enrollment in April 2014, California requires MMPs to stratify enrollees into two categories – higher and lower risk. Individuals are determined to be higher risk if they meet one of the predetermined conditions or qualifications listed in Exhibit 1. The time frames within which MMPs must complete initial HRAs are tied to risk level (Exhibit 1). Higher risk enrollees must receive an HRA within 45 days of coverage and lower risk enrollees must receive an HRA within 90 days.[3] Reassessments must be completed at least annually for both risk levels.

For beneficiaries enrolled in Cal MediConnect, the state is providing MMPs with: (1) the most current and available 12 months of Medicare Parts A, B, and D fee-for-service (FFS) claims data; (2) Medi-Cal[4] FFS claims data; (3) Medi-Cal Treatment Authorization Request data; and (4) In-Home Supportive Services (IHSS) payment and assessment data. For those individuals who are passively enrolled, data is shared through a secure portal 45 days prior to each enrollee's coverage date and refreshed 15 days prior to, and 15 days after, the coverage date. For individuals who voluntarily enroll, data are shared 15 days after the coverage date. Data on scheduled surgeries, diagnoses, prescriptions, and other service use help MMPs to ensure continuity of care and establish communication with enrollees' providers. California Medicaid officials noted that this enhanced communication through data sharing has strengthened the state's ability to build strong provider networks and mitigate provider concerns about managed care.

Illinois: Setting Thresholds for Percentages of Expected Enrollees in Risk Categories

Illinois' contract with Medicare-Medicaid Plans for its capitated financial alignment demonstration requires plans to stratify enrollees into three levels: low- or no-risk; moderate-risk; and high-risk.[2] Under the three-way contract, no less than 20 percent of enrollees can be assigned to the moderate- and high-risk categories, combined; while no less than five percent of enrollees can be assigned to the high-risk level. Thus far, Illinois is the only demonstration state that prescribes the percentage of enrollees that health plans must have in specific risk categories.

Exhibit 1: California's Risk Stratification Requirements[5]

Stratification Levels: Two

Higher-Risk: An individual at increased risk of an adverse health outcome or worsening health status if initial contact does not occur within 45 calendar days of coverage, including, but not limited to, those who:

- Have been on oxygen within the past 90 days;
- Have been hospitalized within the last 90 days, or have had three or more voluntary and/or involuntary hospitalizations within the past year related to behavioral health illnesses;
- Have had three or more emergency department visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the diagnoses of chronic diseases);
- Have In-Home Supportive Services (IHSS) greater than or equal to 195 hours/month;
- Are enrolled in the Multipurpose Senior Service Program (MSSP);
- Are receiving Community Based Adult Services (CBAS);
- Have end stage renal disease, AIDS, and/or a recent organ transplant;
- Have cancer, currently being treated;
- Have been prescribed antipsychotic medication within the past 90 days;
- Have been prescribed 15 or more medications in the past 90 days; and/or
- Have other conditions as determined by the MMP, based on local resources.

Lower-Risk: An individual who does not meet the requirements of a higher-risk enrollee.

Stratification Process: MMPs each developed a health-risk stratification mechanism or algorithm[6] approved by the state to identify new enrollees with higher and more complex health care needs. Following are data sources used to identify risk level:

- Medicare utilization data, including Medicare Parts A, B, and D;
- Medi-Cal utilization data, including IHSS, MSSP, skilled nursing facility, and behavioral health pharmacy data;
- Results of previously administered assessments; and
- Other population- and individual- based tools.

Assessment Time Frames: Initial HRAs must be conducted in-person, at an agreed upon location, for all enrollees. Enrollees always have the option to request in-person meetings for reassessments. HRAs must be completed within the following time frames from the date of coverage, based on individuals' stratification levels:

- Higher-Risk Enrollees: 45 days
- Lower-Risk Enrollees: 90 days

Reassessments must be conducted at least annually, within 12 months of the last assessment, or as often as the health and/or functional status of the individual requires.

Staffing Ratios: Not defined at state level.

Ohio: Promoting Care Management through Defined Risk Stratification

Ohio's risk stratification approach in its financial alignment demonstration program, MyCare Ohio, builds on its experience working with health plans in its Medicaid managed care program. The state learned that it needed to provide more specific guidance to ensure desired health plan performance. For MyCare Ohio, the state designed a risk stratification approach that promotes person-centered interventions and follow up driven by individuals' needs.

For MyCare Ohio, which began enrollment in May 2014, MMPs are required to stratify enrollees into one of five[8] risk levels, with individuals moving between levels as their needs change (Exhibit 2). This flexibility fosters independence, allowing individuals to graduate to lower risk levels as the delivery of appropriate services and supports helps them to do so. Conversely, the system also triggers a timely reassessment that places individuals in higher risk levels when there is a change in condition necessitating additional supports. MMPs have the flexibility to define threshold criteria for each risk level and identify the most appropriate interventions for individuals within each risk level.

Each MMP developed a risk stratification approach within MyCare Ohio's contract requirements.[9] Risk levels are identified using: (1) claims data provided by the state; (2) predictive modeling software; (3) HRA tools; (4) functional assessments; and (5) referrals from individuals, family members, and providers. The MMPs generate a preliminary risk level for each new enrollee that determines the corresponding specified time frame for completing initial comprehensive assessments.

Michigan: Informing Risk Stratification upon Beneficiary Enrollment

Michigan has created a brief, easy-to-deliver verbal survey to be used by enrollment brokers in their soon-to-be implemented demonstration to inform initial risk stratification determinations.[7] During enrollment, individuals will be asked a series of nine yes or no questions (e.g., "Have you used the emergency room more than once in the last 90 days?" and "Have you spent a night in the hospital within the last 90 days?"). Answers to these questions will be provided to health plans when individuals are enrolled, and subsequently, used to help determine their appropriate risk stratification level.

Each month MyCare Ohio MMPs submit care management data to the state that identify enrollees by stratification level. External quality review organizations (EQROs) will use these data to evaluate MMP performance in addressing the needs of MyCare Ohio enrollees. The state will use the EQROs' evaluations for MMP oversight. The state also plans to share best practices and lessons from data collection and evaluations among all MyCare Ohio MMPs.

By instituting a risk stratification framework with multiple levels, Ohio is supporting its MMPs to deliver the appropriate level of care in the most suitable and desired setting for all Medicare-Medicaid enrollees. The flexibility provided to MyCare Ohio MMPs to define the five risk levels allows them to tailor their processes to meet the needs of their enrollees and organizations. The requirements outlined by the state ensure that a consistent level of care and services are provided to MyCare Ohio enrollees regardless of which MMP manages their care.

Exhibit 2: Ohio's Risk Stratification Requirements[10]

Stratification Levels: Five

- Intensive
- High
- Medium
- Low
- Monitoring[11]

MMPs may adopt three stratifications levels if they meet specific requirements outlined in the contract corresponding to intensive, medium, and monitoring levels. To date, all MyCare Ohio MMPs have used five stratification levels.

Stratification Process: MMPs use a combination of predictive modeling software; health risk assessment tools; functional assessments; referrals from individuals, family members and providers; and administrative claims data to determine risk level. Additional information used to determine risk level includes medical, behavioral health (i.e., mental health and substance use), long-term services and supports, and social needs. MMPs must consider the following factors when determining an individual's risk level:

- Duration of 1915(c) home- and community-based services waiver enrollment;
- Current waiver acuity level;
- Change in existing care manager relationship;
- Change in caregiver status/support;
- Presence and severity of chronic conditions;
- Poly-pharmacy;
- Nursing facility or assisted living facility placement;
- Functional and/or cognitive deficits;
- Displayed risk factors for being institutionalized;
- Inpatient or emergency department utilization;
- Residential housing status;
- Gaps in care; and
- Stability of support system.

Assessment Time Frames: Used to determine the time frame and mode by which enrollees receive an initial comprehensive assessment and reassessment, as well as the ongoing contact schedule. Initial comprehensive assessments must be completed within the following time frames from the health plan enrollment effective date:

- Intensive: 15 days
- High: 30 days
- Medium: 60 days
- Low and Monitoring: 75 days

Reassessments must be completed within 365 days after initial or prior reassessment. Reassessments must be conducted more frequently upon changes in individual's health status or needs, diagnosis, caregiver status, functional status, upon a significant health care event, or as requested by the individual, his/her caregiver, or provider. Location and mode for assessment is determined by risk level. Individuals in Intensive and High levels, and any individuals receiving home- and community- based waiver services receive assessments in-person. Individuals in other risk categories may receive assessments telephonically unless an in-person visit is requested by the enrollee, caregiver, or provider.

Staffing Ratios: MMPs must maintain the following staffing ratios (defined as one full-time equivalent per the number of enrollees specified) for each risk stratification level:

- Intensive: 1:25 – 1:50
- High: 1:51 – 1:75
- Medium: 1:76 – 1:100
- Low: 1:101 – 1:250
- Monitoring: 1:251 – 1:350

Virginia: Identifying Priority Populations through a Stakeholder-Driven Process

Virginia's earlier efforts to enroll individuals receiving long-term services and supports (LTSS) into managed care, while ultimately suspended, reinforced the state's desire to meaningfully engage beneficiaries, providers, and advocates in the design and implementation of its financial alignment demonstration, Commonwealth Coordinated Care (CCC), which began enrollment in April 2014.

Through a robust stakeholder engagement process, Virginia established a risk stratification approach for CCC based on key vulnerable subpopulations. The state identified four risk stratification levels: (1) Community Well; (2) Vulnerable Subpopulation (excluding Elderly or Disabled with Consumer Direction and Nursing Facility): Individuals with intellectual/developmental disabilities, cognitive or memory problems (e.g., dementia and traumatic brain injury), physical or sensory disabilities, serious and persistent mental illnesses, end stage renal disease, and complex or multiple chronic conditions; (3) Elderly or Disabled with Consumer Direction waiver Vulnerable Subpopulation; and (4) Nursing Facility Vulernable Subpopulation. Individuals in the Community Well stratification level must receive an initial HRA within 90 days of enrollment with an MMP, while those in the other levels must have an HRA completed within 60 days. After the first calendar year of the demonstration, these time frames will shorten as outlined in Exhibit 3. Nursing Facility residents and Elderly or Disabled with Consumer Direction waiver enrollees must receive HRAs face-to-face.

Virginia's Enrollee Vignette Exercise Confirms Subpopulation-Specific Care Management Approaches

As part of the MMP readiness review process, Virginia created a series of enrollee vignettes depicting individuals with a range of health care and social services needs. MMPs were asked to describe their processes for completing HRAs and providing care management for these enrollees while demonstrating a person-centered approach. The state and external experts, including Community Service Boards, which serve as the single point of entry for individuals with serious mental illness and intellectual/developmental disabilities, were invited to MMPs' vignette presentations to ensure that approaches to care management addressed population-specific needs and would work in daily practice.

To ensure continuity of care, Virginia provides weekly CCC Medical Transitions Reports to each MMP. For passive enrollments, these reports are sent to MMPs up to 60 days prior to an individual's coverage date; however, reports are sent to MMPs within a week after an individual opts-in and prior to coverage. Data provided in advance help MMPs prepare to serve the individual quickly upon his or her enrollment. The Medical Transitions Reports provide Medicaid FFS data about service providers, service authorizations, and paid claims (primary and acute medical care, behavioral health care, LTSS, pharmacy, and dental services).[12]

Exhibit 3: Virginia's Risk Stratification Requirements[13]

Stratification Levels: Four

- Community Well: Individuals who do not fit into the vulnerable subpopulation categories.
- Vulnerable Subpopulation (excluding Elderly or Disabled with Consumer Direction and Nursing Facility): Individuals with intellectual/developmental disabilities, cognitive or memory problems (e.g., dementia and traumatic brain injury), physical or sensory disabilities, serious and persistent mental illnesses, end stage renal disease, and complex or multiple chronic conditions.
- Elderly or Disabled with Consumer Direction Vulnerable Subpopulation: Individuals enrolled in the 1915(c) Elderly or Disabled with Consumer Direction waiver who are elderly or who have a disability who would otherwise require a nursing facility level of care.
- Nursing Facility Vulnerable Subpopulation: Individuals residing in nursing facilities.

Stratification Process: MMPs developed and implemented an identification strategy using a combination of predictive-modeling software, assessment tools, referrals, administrative claims data, and other available resources to inform medical, behavioral health, substance use, and long-term services and supports needs. MMPs establish criteria and thresholds.

Assessment Time Frames: During year one of the demonstration, stratification levels determine time frame requirements for initial HRA completion from the health plan enrollment date:

- Community Well: 90 days.
- Vulnerable Subpopulation (excluding Elderly or Disabled with Consumer Direction and Nursing Facility): 60 days.
- Elderly or Disabled with Consumer Direction Vulnerable Subpopulation: 60 days (must be face-to-face).
- Nursing Facility Vulnerable Subpopulation: 60 days (must be face-to-face and incorporate Minimum Data Set elements).

During subsequent years of the demonstration, time frames for HRAs will shorten to 60 days for initial assessments for all enrollees except Elderly or Disabled with Consumer Direction waiver enrollees whose assessments will need to be completed within 30 days of enrollment.

Reassessments must be completed by the anniversary date of the plan of care for both the Community Well and Vulnerable Subpopulation (excluding Elderly or Disabled with Consumer Direction and Nursing Facility) group. Those in the Elderly or Disabled with Consumer Direction Vulnerable Subpopulation category must be reassessed by the plan of care anniversary date, not to exceed 365 days. For individuals in the Nursing Facility Vulnerable Subpopulation group, reassessments must be conducted in accordance with Minimum Data Set guidelines/time frames for quarterly and annual plan of care development.

Staffing Ratios: Not defined at state level. Staff ratios are monitored weekly through contract monitoring team calls with each MMP.

As part of the contract management process, Virginia is monitoring caseload ratios; claims and service authorizations; HRAs; and plan of care development on a weekly basis to continually evaluate how well MMPs are addressing enrollees' needs. The state adopted specific quality measures to hold MMPs accountable and ensure that vulnerable subpopulations receive appropriate care and services.[14]

South Carolina: Using Initial Health Screens to Inform Risk Stratification

MMPs in South Carolina's demonstration, set to launch in February 2015, will have the option of administering an initial health screen to triage new enrollees most in need of medical and social supports.[15] The screen, which will take about 10 minutes to complete, can be done telephonically or in-person within 30 days of enrollement. In addition, all enrollees will receive a comprehensive assessment to determine the full scope of their needs and develop a thorough, person-centered plan of care. Risk scores calculated from the initial screen will factor into the enrollee's ultimate risk stratification level, supplemented by historical claims data, demographic information, medical conditions and functional status, care patterns, and resource utilization data.

Conclusion

States seeking to develop risk stratification approaches for individuals dually eligible for Medicare and Medicaid can look to the experiences of California, Ohio, and Virginia. In these three states, a combination of prior managed care program experience and stakeholder input shaped the definition of risk groups and the process of risk stratification. Providing health plans with individual enrollee data before enrollment, including service utilization and prior approvals, is critical to timely risk stratification and subsequent assessment, care management, and continuity of care. Employing a larger number of indicators in the determination of risk level may be more beneficial to identification of individuals at highest risk. Including both clinical (e.g., prior utilization of services and gaps in care) and non-clinical factors (e.g., housing status and support system stability) may also be useful to the accurate determination of risk status.

States' prior experiences with managed care may influence the level of autonomy given to health plans in developing risk stratification approaches. California, Ohio, and Virginia differed in the degree to which they let health plans define plan-specific risk categories and risk stratification algorithms. Past experience with implementing managed care programs and experience serving individuals dually eligible for Medicare and Medicaid in an integrated setting also demonstrate the value of stakeholder engagement. Input from beneficiaries and their families, providers, and organizations serving Medicare-Medicaid enrollees is essential to identifying subpopulations and their unique risk factors.

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ENDNOTES

[1] CHCS also interviewed representatives from Massachusetts, but decided not to include that material in this brief because the interview with Massachusetts' Medicaid staff confirmed the state uses stratification solely for rates, not care management purposes.

[2] Centers for Medicare and Medicaid Services and Illinois Department of Healthcare and Family Services. Contract Between United States Department of Health and Human Services, Centers for Medicare and Medicaid Services in Partnership with the State of Illinois Department of Healthcare and Family Services. Available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/IllinoisContract.pdf.

[3] In California the enrollment date is not the same as the date of coverage. The state enrolls individuals 30 days prior to the date of coverage, allowing it to send data to MMPs before individuals are "activated."

[4] MediCal is California's Medicaid program.

[5] Centers for Medicare and Medicaid Services and California Department of Health Care Services. *Contract Between United States Department of Health and Human Services, Centers for Medicare and Medicaid Services in Partnership with the California Department of Health Care Services and Medicare-Medicaid Plans*. Available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContractwithoutSub.pdf.

[6] Plan-specific health risk stratification mechanisms or algorithms were approved by California state officials prior to implementation.

[7] Susan Yontz, Division Director, Integrated Care Programs, Michigan Department of Community Health. Personal communication, October 1, 2014.

[8] Ohio's three-way contract allows MMPs to build their stratification approach around either three or five risk levels. All current MMPs use five risk levels.

[9] Centers for Medicare and Medicaid Services and Ohio Department of Health Care Services. *Contract Between United States Department of Health and Human Services, Centers for Medicare and Medicaid Services in Partnership with The State of Ohio Department of Medicaid and Medicare-Medicaid Plans*. Available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OhioContract.pdf.

[10] Ibid.

[11] MyCare Ohio MMPs define the criteria for each of the stratification levels.

[12] Virginia Department of Medical Assistance Services. *Companion Guide: Commonwealth Coordinated Care Medical Transitions Report*, Version 1.6, July 2014.

[13] Centers for Medicare and Medicaid Services and The Commonwealth of Virginia Department of Medical Assistance Services. *Contract Between United States Department of Health and Human Services, Centers for Medicare & Medicaid Services in Partnership with The Commonwealth of Virginia Department of Medical Assistance Services and Medicare-Medicaid Plans*. Available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/VirginiaContract.pdf.

[14] Ibid.

[15] Teeshla Curtis, Program Manager, South Carolina Department of Health and Human Services. Personal communication, October 1, 2014.