

# Impact of 2013 to 2014 HCC Risk Model Changes on SNPs

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# Agenda

- What are we doing for the SNP Alliance?
  - Overall goals
  - Populations we are analyzing
  - Opportunities and limitations of our approach
- What have we seen in our initial results?
  - General observations
  - Individual HCC changes
  - Populations with most favorable / least favorable MLRs
  - Populations with most favorable / least favorable impacts of risk model change from 2013 to 2014
- What are our next steps?

# Overall Goals

- Identify special needs populations that are most positively and negatively impacted by the changes in risk factors
- Identify special needs populations with the most and least favorable MLRs
- Determine how changes in institutional risk factors differ from changes in community risk factors
- Identify HCCs and comorbidity interaction terms with most significant increases and decreases in risk weights
- Determine how changes in interaction terms positively or negatively affect the various high-risk populations
- Determine fact-based recommendations to improve payment accuracy for SNPs and other specialized managed care plans serving high-risk / high-need populations

# Populations We Are Analyzing

- Gathered data on many combinations of
  - Community versus institutional
  - Age ranges
    - 65+ versus under 65
    - Over 80 / 85 (used a definition of “frail elderly”)
  - Risk score cohorts
  - Those with specific chronic conditions
  - Those with specific multiple chronic conditions
- All combinations analyzed for total, dual, and non-dual populations
- Report will not be able to specifically comment on all combinations, but data will be included to review

# Opportunities and Limitations of Our Approach

- Using Medicare 5% sample data
- Opportunities using this data
  - Largest (and only) data set available
  - Ease of use
- Limitations of using this data
  - Still only 5% of total FFS population
  - Utilization reflective of an unmanaged, FFS population
  - Only includes costs for traditional Medicare benefits
  - Diagnoses reporting not reflective of increased MA plan efforts
  - FFS population mixes will be different than MA mixes overall and individual MA plans' mixes

# General Observations

- As is the case with regression models, there are winners and losers among subpopulations of the overall population when risk model changes are made
- Impact of change in risk models from 2013 to 2014
  - Favorable to the overall institutional population
    - Increase in risk scores driven by increase in demographic risk weights
    - Little impact due to change in HCC risk weights
  - Unfavorable to the overall dual eligible population
    - Certain segments of dual population still saw increases (e.g., institutional duals)
- Most population combinations we analyzed with interaction terms saw increased risk scores
  - Diabetes / CHF only exception (1.6% decrease)

## General Observations *(continued)*

- Some populations with historically high MLRs saw risk score increases
  - Institutional population MLR decreased from 125% to 119%
  - CLF population MLR decreased from 101% to 97%
- Some populations with historically low MLRs saw risk score decreases
  - CKD population MLR increased from 89% to 107%
  - Adults with Developmental/Intellectual Disabilities population MLR increased from 96% to 104%

# Examples of Individual HCC Changes

- HCCs were dropped
  - 2013 HCC 132 (Nephritis)
- HCCs were added
  - 2014 HCC 48 (Coagulation Defects and Other Specified Hematological Disorders)
  - 2014 HCC 112 (Fibrosis of Lung and Other Chronic Lung Disorders)
- HCCs were combined
  - 2013 HCCs 15 (Diabetes with Renal or Peripheral Circulatory Manifestation)
  - 2013 HCC 16 (Diabetes with Neurologic or Other Specified Manifestation)
  - 2013 HCC 18 (Diabetes with Ophthalmologic or Unspecified Manifestation)
  - Now is 2014 HCC 18 (Diabetes with Chronic Complications)
- HCCs were split
  - 2013 HCC 10 (Breast, Prostate, Colorectal and Other Cancers and Tumors)
  - Now is
    - 2014 HCC 11 (Colorectal, Bladder, and Other Cancers)
    - 2014 HCC 12 (Breast, Prostate, and Other Cancers and Tumors)



# Examples of Individual HCC Changes (continued)

- HCCs with largest increase in their risk weights
  - 2014 HCC 157 - Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
    - 1.323 increase in Community risk weight
    - 0.533 increase in Institutional risk weight
- HCCs with largest decrease in their risk weights
  - 2014 HCC 134 – Dialysis Status
    - 0.872 decrease in Community risk weight
    - 1.719 decrease in Institutional risk weight
- Interaction terms were added
  - Were added to Community only, Institutional only, and both
  - Comorbidities with disabled, schizophrenia, sepsis, cardiorespiratory failure
- **Important to keep in mind relevance of risk weight change for an individual HCC in terms of overall model**

# MLR Observations

- Full population MLR slightly better than 100% reflects that benchmarks are nearing FFS cost levels
  - Full population has 96.7% MLR
- Some subpopulations have MLRs that are more favorable ...
  - Ages 80+ / 85+, non-dual, non-institutional (91.5% / 89.1% MLR)
  - Non-dual (94.8% MLR)
  - Non-institutional (95.2% MLR)
  - Ages 65+ (96.5% MLR)
  - HIV / AIDS (95.5% MLR)
  - COPD (96.2% MLR)
  - CLF (96.5% MLR)
  - CHF / COPD comorbid population (96.3% MLR)

# MLR Observations *(continued)*

- ... others have MLRs that are less favorable
  - Ages 80+ / 85+, non-dual, institutional (128.1% / 124.4% MLR)
  - Institutional (119.0% MLR)
  - Dual (102.1% MLR)
  - Under age 65 (97.6% MLR)
  - CKD (106.9% MLR)
  - Adults with Developmental/Intellectual Disabilities (103.5% MLR)
  - Adults with Physical Disabilities (101.2% MLR)
  - Schizophrenia / COPD comorbid population (105.7% MLR)

# Impact of Risk Model Change Observations

- Essentially no change in overall aggregate nationwide risk score
- Some subpopulations had risk scores that were positively impacted ...
  - Institutional (5.1% increase)
  - Non-Dual (1.0% increase)
  - Ages 65+ (0.6% increase)
  - Ages 80+ / 85+, non-dual, institutional (5.5% / 5.3% increases)
  - Ages 80+ / 85+, non-dual, non-institutional (1.2% / 1.7% increases)
  - CLF (4.4% increase)
  - Schizophrenia comorbid populations with CHF, COPD, and Seizure Disorder (4% to 5% increases)
  - Disabled and chronic pancreatitis comorbid population (18.3% increase)
  - Disabled and pressure ulcer comorbid population (22.7% increase)

## Impact of Risk Model Change Observations *(continued)*

- ... and some subpopulations had risk scores that were negatively impacted
  - Dual (1.7% decrease)
  - Under age 65 (1.2% decrease)
  - **CKD (16.8% decrease)**
  - HIV/AIDS (1.7% decrease)
  - Adults with Developmental/Intellectual Disabilities (6.9% decrease)
  - Adults with Physical Disabilities (4.8% decrease)
  - Diabetes / CHF comorbid population (1.6% decrease)

# Next Steps

- Finalize investigation of population subsets
- Finalize report
- SNP Alliance will work with members to evaluate potential implications and develop recommendations to Congress and CMS
- Follow up with the SNP Alliance and individual member plans
  - Other analyses using FFS data
  - Comparisons to results using plan specific data
  - HCC prevalence rate benchmarking and auditing

# Thank You!

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