Identifying high-risk members under a Medicaid expansion program: Experience in Indiana

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Alternative Benefit Plan (ABP) regulations have created the ability for states to offer benefit plans tailored to the needs of a particular population, such as a Medicaid expansion population. These regulations require exemption for vulnerable populations, including one new exempt population: the "medically frail." This population includes foster care children and those who meet Social Security disability criteria, but also includes anyone with a serious and complex medical condition or a disabling mental or chronic substance use disorder.

States are seeking a methodology to help them identify the medically frail, one that would be both accurate and administratively efficient. This paper describes a methodology that has been used successfully for identifying a similar population in the Healthy Indiana Plan, a Medicaid expansion program initially authorized in 2008 under 1115 waiver authority.

ABP BACKGROUND

Alternative Benefit Plan (ABP) is the new terminology for what used to be known as "1937 Benchmark" or "Benchmark-equivalent" plans. Regulations implementing these plans give states the option to customize the benefit package for a target population, such as a Medicaid expansion population. This has been an appealing option in some states, which had determined that traditional Medicaid expansion was not the best solution.

Final regulations[1] published on July 15, 2013, allow states a broad range of ABP benefit package options, ranging from typical exchange plan benefits to the full array of mandatory and optional state plan benefits.

The benefits in exchange plans (albeit with lower cost sharing, similar to Medicaid program levels) may be appropriate for most healthy individuals in the new adult coverage group. However, to protect new adults with additional medical needs, the Centers for Medicare and Medicaid Services (CMS) has required that “Exempt Individuals” must have the option to receive the full state plan benefit package. State plan benefit packages tend to have more generous long-term care and habilitative service offerings, which may make them more appropriate for disabled individuals than commercial plan benefit packages.

Exempt individuals are defined in 42 CFR 440.315, and include the following:

- Pregnant women
- Blind or disabled
- Medicare-eligible
- Receiving hospice care
- Receiving long-term care
- Medically frail
- Receiving foster care and adoption assistance
- Breast and cervical cancer patients
- Tuberculosis patients
- Emergency services patients
- Medically needy

With the exception of the medically frail, the exempt populations are well-established and concretely

defined. State Medicaid programs already have processes in place for identifying these groups.

MEDICALLY FRAIL

However, it is more challenging to identify the medically frail, as determination of whether or not a member satisfies criteria may be ambiguous.

A state's medically frail definition (42 CFR 440.315(f) must encompass the following:

- Disabling mental disorders
- Chronic substance abuse disorders
- Serious and complex medical conditions
- Physical, intellectual, or developmental disability that impairs one or more activities of daily living (ADLs)
- Disability determination (Social Security or state plan)
- Supplemental Security Income (SSI) program participants, disabled, and foster children

States may add other categories of individuals to the definition. The definition is intentionally flexible, to allow states to include all who would be better served by state plan benefit package.

IDENTIFICATION METHODOLOGY

CMS has not mandated a particular methodology for identification of the medically frail, but has suggested that states may use a combination of the following criteria:

- Eligibility category (for example, those in a disabled or foster child eligibility category may be automatically deemed medically frail)
- Historical medical encounter data (for those currently enrolled)
- Self-identification, as on a questionnaire

Using eligibility category for identification is a good start, but cannot successfully identify all medically frail individuals. Individuals who meet the criteria for medically frail may fall into a variety of different eligibility categories.

Using historical encounter data can be effective for individuals who are already enrolled in Medicaid, but cannot be used for the newly enrolled, because the state will not initially have medical information for them.

Therefore, for those who are newly enrolled in an eligibility category through which they are not automatically deemed medically frail, states are encouraged to develop a process for self-identification with follow-up assessment.

HEALTHY INDIANA PLAN: A CASE STUDY

In 2008, the Healthy Indiana Plan (HIP) faced a similar need to identify high-risk individuals. HIP is a Medicaid expansion program for Indiana residents, aged 19 to 64, with income below 200% of the federal poverty level (FPL). It includes both parents and other adults.

Most HIP members were enrolled in managed care plans with a benefit package similar to those of commercial plans. However, members with healthcare conditions that required additional support were identified and transferred to the HIP Enhanced Services Plan (ESP), where they were managed together with individuals in the state high-risk pool.

Qualifying conditions

Qualifying conditions for the HIP ESP were specified by the state of Indiana, and included high-risk conditions such as cancer, AIDS, transplants, hemophilia, diabetes with complications, and others.

For this methodology to be used to identify the medically frail, the qualifying conditions would need to be expanded to include mental and substance abuse disorders.

IDENTIFICATION OF HIGH-RISK CONDITIONS

Process

For new HIP enrollees, the identification of high-risk individuals began with the Healthy Indiana Plan application.[2] First individuals were given a chance to self-identify as pregnant, blind, or disabled. Pregnant, blind, or disabled applicants were enrolled in regular Medicaid or Medicaid spend-down programs. This was followed by eight health screening questions. The health screening questions focused on identifying applicants with qualifying conditions for the HIP ESP.

Those who answered "Yes" to any of the eight health screening questions were tentatively placed in the ESP. Others were tentatively placed in the regular plan.

Those initially placed in the ESP were assigned a primary care physician (PCP) and received disease and case management. After 12 months, the initial placement in ESP was reevaluated with an automated

process utilizing historical claims data. Where no evidence of a qualifying medical condition was found in the data, the individual was transferred back to the regular HIP program (unless evidence of a qualifying condition was submitted by providers).

Those initially assigned to a managed care plan in the regular HIP program were also assigned a PCP and generally received an assessment soon after enrollment. If the assessment revealed the individual would be better served in the ESP, the PCP could provide documentation of a qualifying condition in order to facilitate transfer.

At any point in the year, if a HIP member (ESP or not) became pregnant or became eligible for Medicaid disability coverage, that member would be transferred to the Medicaid program.

Assessment tool

For a member to benefit from additional services available in the HIP ESP program, the qualifying condition needs to be of sufficient severity. For example, although cancer could be a qualifying condition, a member who was treated for cancer five years ago may require little specialized treatment if the cancer remains in remission.

The state asked Milliman to develop an assessment tool to help *quantify* the seriousness of a member's condition. Milliman developed an assessment tool derived from the Individual Milliman Underwriting Guidelines™ (IMUGs™). The IMUGs were the first "evidence-based" underwriting guidelines, based on nine years of claims data on over 13 million members, in addition to medical literature review.

The IMUGs were developed to assist underwriters with estimating future costs for individuals applying for health insurance. Cost related to a condition is quantified using a debit point system, where debit points reflect the level of projected future claim cost.

Individuals who are transferred to the ESP are required to have substantial additional medical needs. HIP defines this as a minimum of 150 "debit points" in at least one qualifying condition. The tool assists a clinician in calculating debit points. An example of the assignment of these debit points is provided in the next section.

Debit point example: AIDS/HIV[3]

The human immunodeficiency virus (HIV) is a retrovirus that infects cells of the immune system and destroys or impairs their function. In the early stages of infection, no symptoms are usually present. As the infection progresses, the immune system weakens and the person becomes susceptible to serious opportunistic infections and malignancies. The most advanced stage of HIV infection is acquired immunodeficiency syndrome (AIDS). It may take 10 to 15 years until an HIV-infected individual develops AIDS; antiretroviral drugs can slow the progress even further.

AIDS is diagnosed when an individual with an HIV infection has a CD4 cell (T-cell) count below 200. The U.S. Centers for Disease Control and Prevention (CDC) defines AIDS as occurring in a person with:

- Laboratory-documented HIV infection
- CD4 count of less than 200
- An AIDS-defining illness such as candidiasis, cryptosporidiosis, cytomegalovirus, and others in the presence of an HIV infection

Base debit points:

- AIDS 150
- HIV infection (asymptomatic, with CD4 cell count below 200) 90

In addition to the base condition debit points, additional points may be allocated for drugs prescribed for HIV, specified in the tool. A few examples of these drugs include:

- Abacavir 29
- Agenerase 130
- Combivir 100

All members with AIDS meet the debit point cutoff of 150. After adding prescribed drug points to the 90 base points for HIV infection, members with HIV may also qualify for the ESP.

The debit point calculation would be documented in the member's medical records. Similar worksheets have been developed for other qualifying conditions.

INDIANA EXPERIENCE

The methodology described in this paper employs a combination of all three methods suggested by CMS. Applicants with high-risk conditions are initially identified either by eligibility category or by self-identification in the application questionnaire. Self-identification is confirmed by clinicians, using an assessment tool based on Milliman's IMUGs. In addition, the state performs periodic screening of the historical claims data.

These methods have proven effective for Indiana's HIP program. After the health plans received initial training in the use of the assessment tool, they have employed it successfully to identify thousands of high-risk individuals. Annual audits performed by Milliman revealed a high accuracy rate.

The tool provides an objective cutoff that supports consistency of determinations. During the six years of the HIP demonstration, plans and members report general satisfaction with the identification process.

APPLICABILITY TO THE MEDICALLY FRAIL

The process used to identify high-risk members in the HIP program could be modified for identification of the medically frail in ABPs. The self-identification questionnaire, assessment tool, and computer algorithms used to screen historical claims data could all be adjusted to include a broader set of qualifying conditions, and the severity cutoff of 150 debit points could be reevaluated. The process is flexible and could be customized to meet each state's preferences.

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