

Implementation Sites: Key Facts

**Maryland Medicaid**

**PURCHASER:** The State of Maryland, Department of Health and Mental Hygiene.

**PRODUCT:** HealthChoice, a program established in 1997 through a 1115 waiver to provide mandatory capitated managed care services to 90% of beneficiaries in the Maryland Medicaid program.

**DATE that health-based risk adjustment first implemented (payment adjusted):**  
July 1997

**PREVIOUS METHOD OF PAYMENT:** Fee-for-service payment for the majority of recipients. There was also a voluntary HMO program with about 110,000 members, paid with a capitation rate.

**SIMULATION:** A simulation tested the model's predictive accuracy, but not plan payments.

|  | <b>Year One</b>  | <b>Current Year</b>  | <b>Projected for Next Year</b>   |
|--|--|--|--|
| Groups Covered:<br>SSI, Disabled<br>TANF<br>Dually Eligible, 65 and older<br>Employees, dependents<br>Retirees<br>Other (describe)       | ✓<br>✓<br><br><br><br><br>(separate payment rate for HIV/AIDS. Newborn and maternity kick payment. New members excluded) | ✓<br>✓<br><br><br><br><br>MCHP<br>(separate payment rate for HIV/AIDS. Newborn and maternity kick payment. New members excluded) | ✓<br>✓<br><br><br><br><br>MCHP<br>(separate payment rate for HIV/AIDS. Newborn and maternity kick payment. New members excluded) |
| Number of participating plans  | 9  | 7  | 6  |
| Number of covered lives  | 310,000  | 410,000  | Increase   |
| Phase-in of Payment Adjustment   |  |  |  |
| a. Percent of payment based on health-based risk adjustment  | 100%   | 100%   | 100%   |
| b. Transitional risk corridors   | No   | No   | No   |
| c. Reporting adjuster for encounter data completeness  | N/A  | Yes<br>Constant Cohort Analysis  | Yes<br>Constant Cohort Analysis  |
| Risk assessment method:  |  |  |  |
| a. Diagnosis Grouper (name)  | ACG  | ACG  | ACG  |
| b. Type of prediction model  | Prospective  | Prospective  | Prospective  |
| Basis of future payment to the plans: plan level risk score or based on the specific individuals who are enrolled at the time of payment | Individual   | Individual   | Individual   |

|  |   |  |   |
|--|---|--|---|
| Relative value weights   |   |  |   |
| a. Source of weights (local or imported)   | Local   | Local  | Local   |
| b. Type of data used for weights   | FFS   | FFS  | FFS   |
| c. Time frame of the data used for weights   | 1995<br>State Fiscal Year   | 1997<br>State Fiscal Year  | 1997<br>State Fiscal Year   |
| d. Size of population used to establish weights  | 350,000   | 360,000  | 360,000   |
| e. Truncating outlier costs  | Yes   | No   | No  |
| Risk adjustment time frames:   |   |  |   |
| a. minimum enrollment before being included in the risk adjustment calculation                                       | 6 months  | 6 months   | 6 months  |
| b. minimum lag between the date the diagnosis was assigned and the date payment was adjusted based on that diagnosis | 14  | 14   | 14  |
| c. Frequency for updating risk scores  | Annually  | Annually   | Annually  |
| Risk sharing after any phase-in period   |   |  |   |
| a. Risk corridors  | No  | No   | No  |
| b. Stop loss   | Yes<br>(state provided)   | Yes<br>(plans purchase;<br>except two plans that<br>have state-provided)   | Yes<br>(plans purchase)   |
| Carve-outs from risk adjustment model:   |   |  |   |
| a. Service categories, e.g., mental health, prenatal care  | Used all inpatient, outpatient and physician claims, no other categories of service | Used all inpatient, outpatient and physician claims, no other categories of service  | Used all inpatient, outpatient and physician claims, no other categories of service |
| b. Populations with defined conditions, e.g., beneficiaries with HIV/AIDS  | SOBRA, Under 1  | SOBRA, Under 1<br><br>HIV/AIDS have a separate rate cell<br><br>Also carves out rare high cost diagnoses from managed care | SOBRA, Under 1<br><br>HIV/AIDS have a separate rate cell                            |
| Encounter data collected from the MCOs for health-based risk adjustment  |   |  |   |
| a. Diagnosis codes   | Yes   | Yes  | Yes   |
| b. Procedure codes   | Yes   | Yes  | Yes   |
| c. Charges   | No  | No   | No  |
| d. Identification of the treating provider   | Yes   | Yes  | Yes   |

|  |    |     |     |
|--|----|-----|-----|
| Number of plan's risk scores that were affected by missing data from their providers                                     | 0  | 8   | 2   |
| Number of plan's risk scores that were affected by the plan's data system limiting the number of diagnoses per encounter | 0  | 1   | 0   |
| Data audits:   |    |     |     |
| a. Audits using encounter data   | No | Yes | Yes |
| b. Audits using medical records  | No | Yes | Yes |

ADDITIONAL INFORMATION:

Weiner, Jonathan P. et al. "The Development of a Risk-Adjusted Capitation Payment System: The Maryland Medicaid Model." *Journal of Ambulatory Care Management* 21(4) (1997): 29-52.