



# **Using the ACG Case Mix System to Stratify Health Plan Members for Annual Health Risk Assessment and Care Management Activities**

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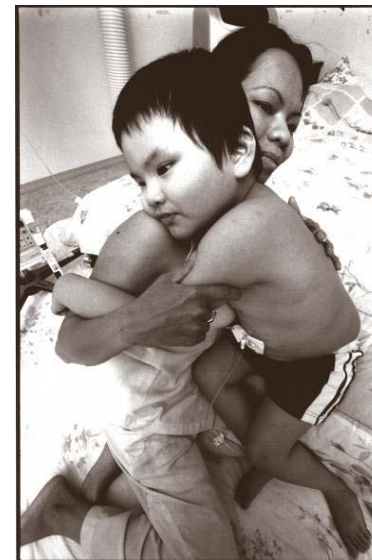
May 11, 2010

ACG International Risk Adjustment Conference



*Our Vision: Healthy Oregonians regardless of their income or social circumstances.*

- **Publically financed health plan for low-income citizens**
  - Medicaid: Mom's and Children, Disabled/ Chronically Ill
  - Medicaid/ Medicare "Special Needs" Plan
- **128,000 Members**
- **Not for Profit**
- **Contracted network**
  - 50% Safety Net PCPs
  - Diverse Private practice PCPs
  - Major metro and rural hospitals
- **Near bankruptcy in last recession...**
- **Participant in IHI Triple Aim Initiative since May 2007**



*Copyright: Bruce Davidson*



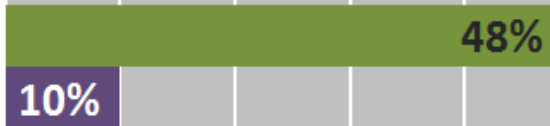
# CareOregon Population "Snapshot"

≈ 128,000 members (Feb 2010)

At or below poverty line



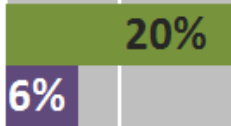
Identify as persons of color



English not first language



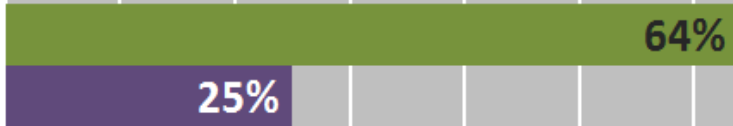
4 yrs old or younger



CareOregon members

Oregon overall

Under 18 yrs old



Female



Live in Portland metro area



# CareSupport Implementation Principles



- **Holistic, person-centered**: members are more than a single disease; biopsychosocial model puts context and social morbidity as important drivers of risk
- **Strength-based**: members' assets are identified as critical to developing a successful intervention; engagement is paramount
- **Proactive**: technology and outreach capabilities designed to identify and outreach to members earlier
- **Population-focused**: we care for individual members but strive to create “best practices” for populations; program development aimed to identify at-risk populations and make broad impacts
- **Team-based**: multidisciplinary teams care for members; comprehensive behavioral-health integration and pharmacy integration

# Population of Impact = Starting with the Costliest Members

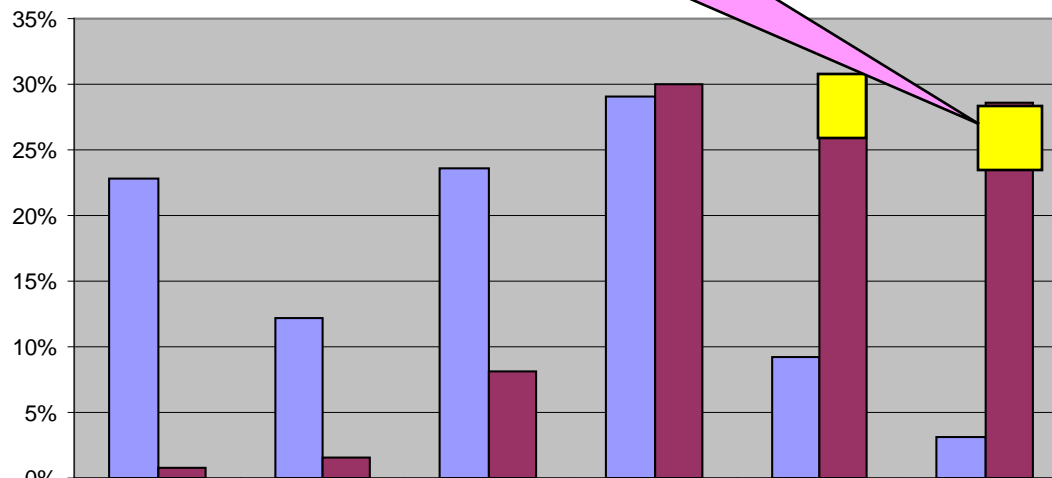


10% Savings  
Has \$12MM  
Annual Impact  
On CareOregon

Includes

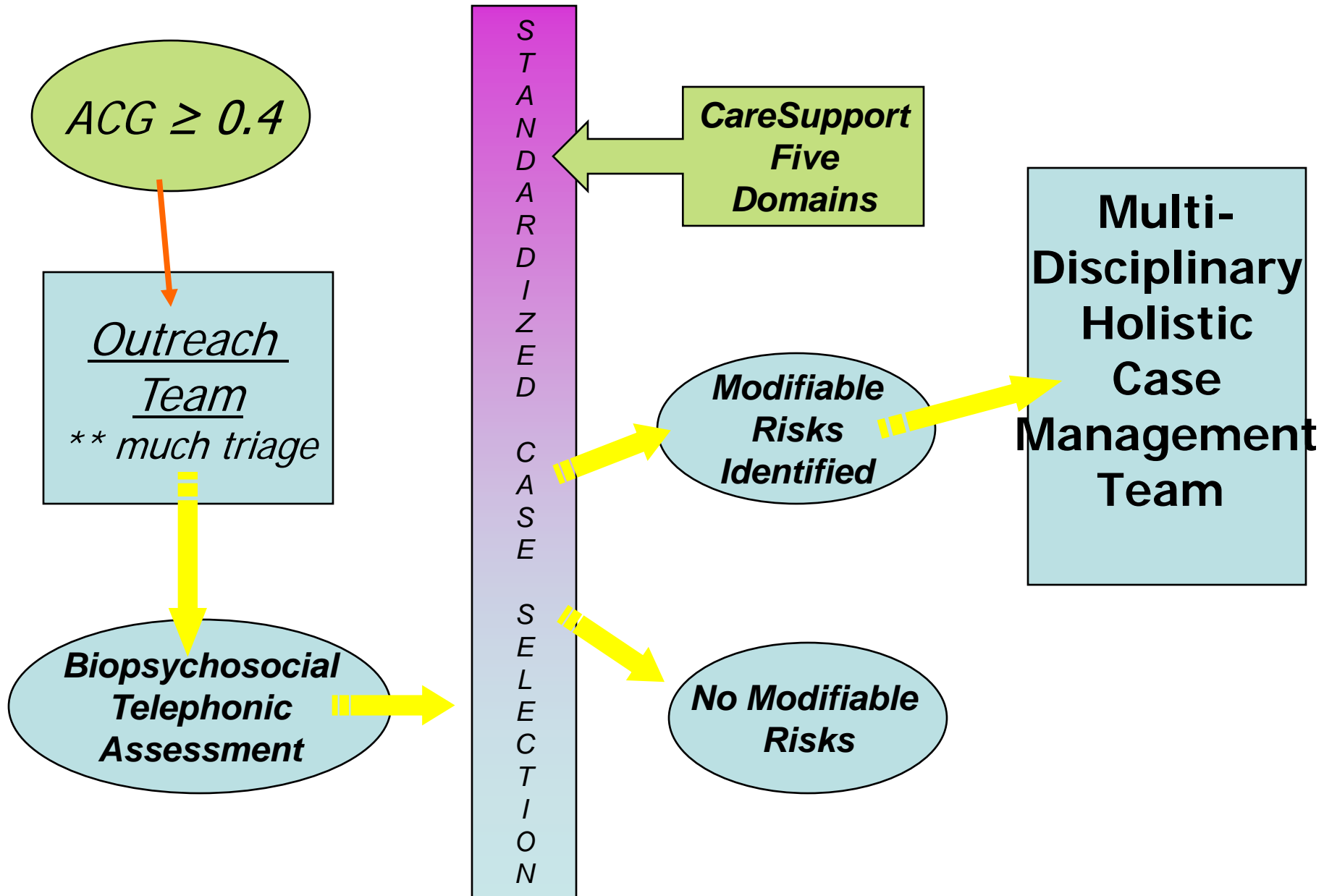
3  
ollment Only

% of Total Dollars

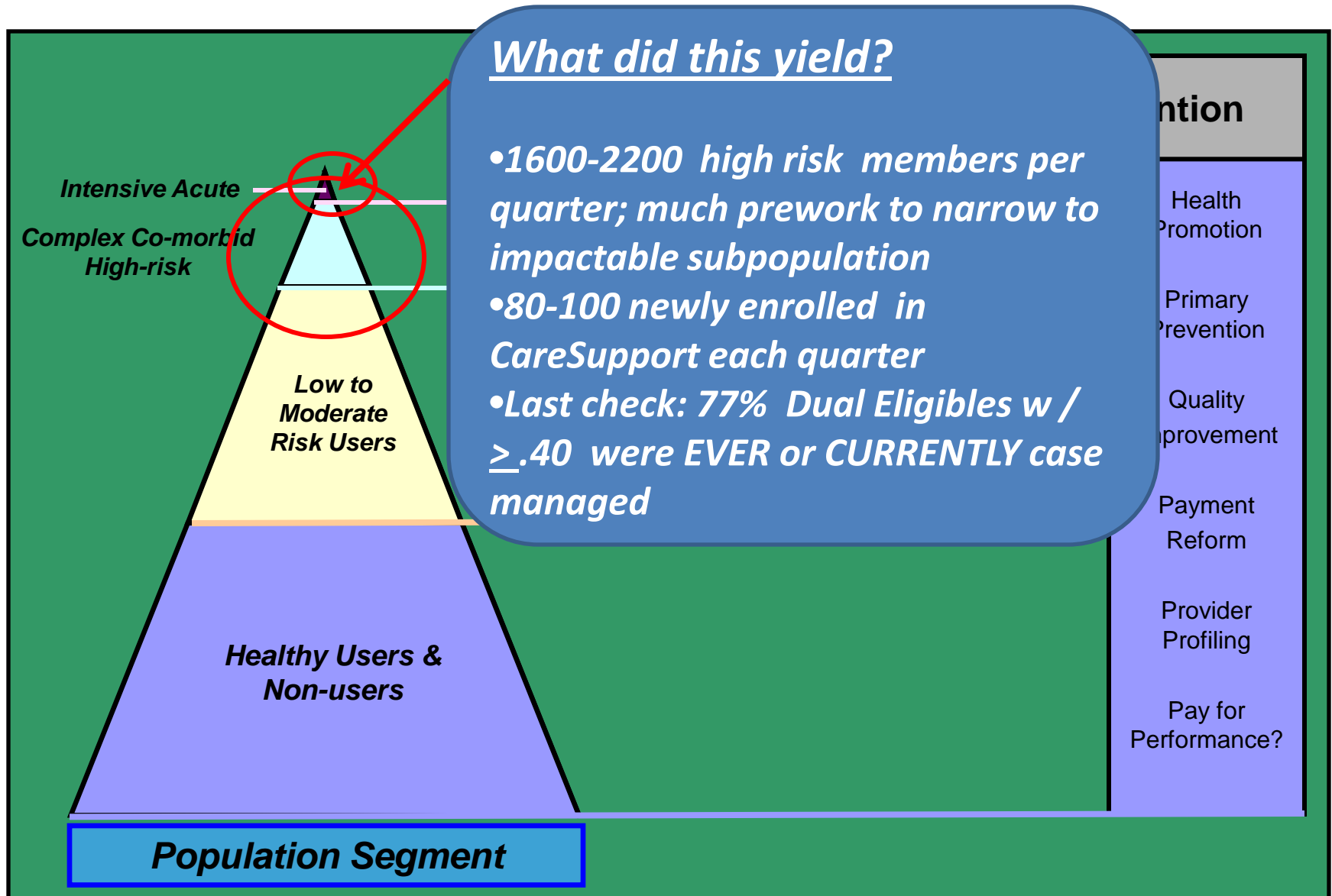


	Non Users	Healthy Users	Low	Mod	High	Very High
<b>% of Members</b>	<b>23%</b>	<b>12%</b>	<b>24%</b>	<b>29%</b>	<b>9%</b>	<b>3%</b>
<b>% of Total Dollars</b>	<b>1%</b>	<b>2%</b>	<b>8%</b>	<b>30%</b>	<b>31%</b>	<b>29%</b>

# Example ACG Workflow

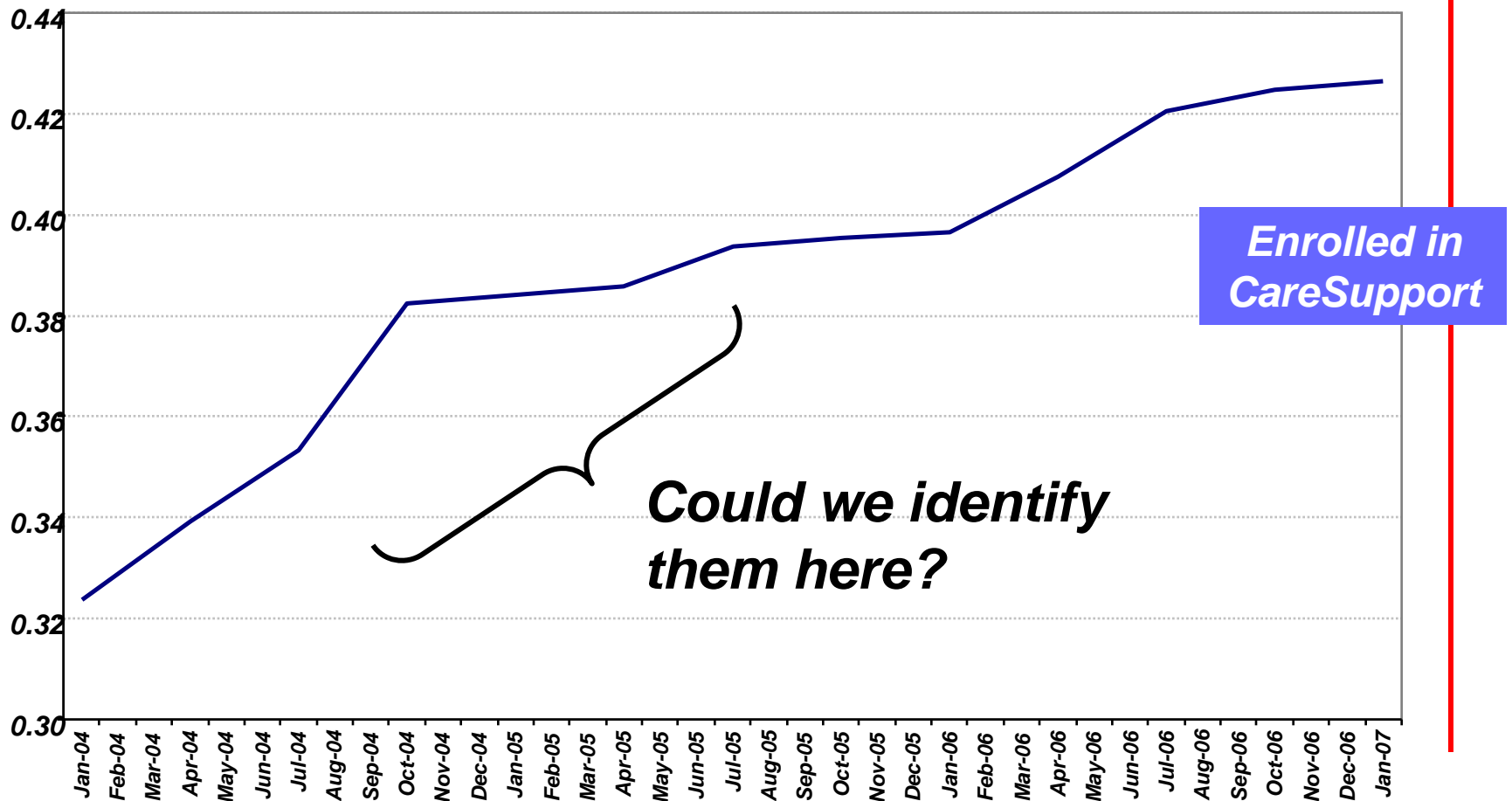


# The Case for a New ACG Approach



# Change in “Hi Risk Group” Average ACG Score Over Time

*Change in rolling year average ACG score (by beginning month of claims period)  
Those enrolled in Case Management after January 2007 n= 952*



# The final straw....



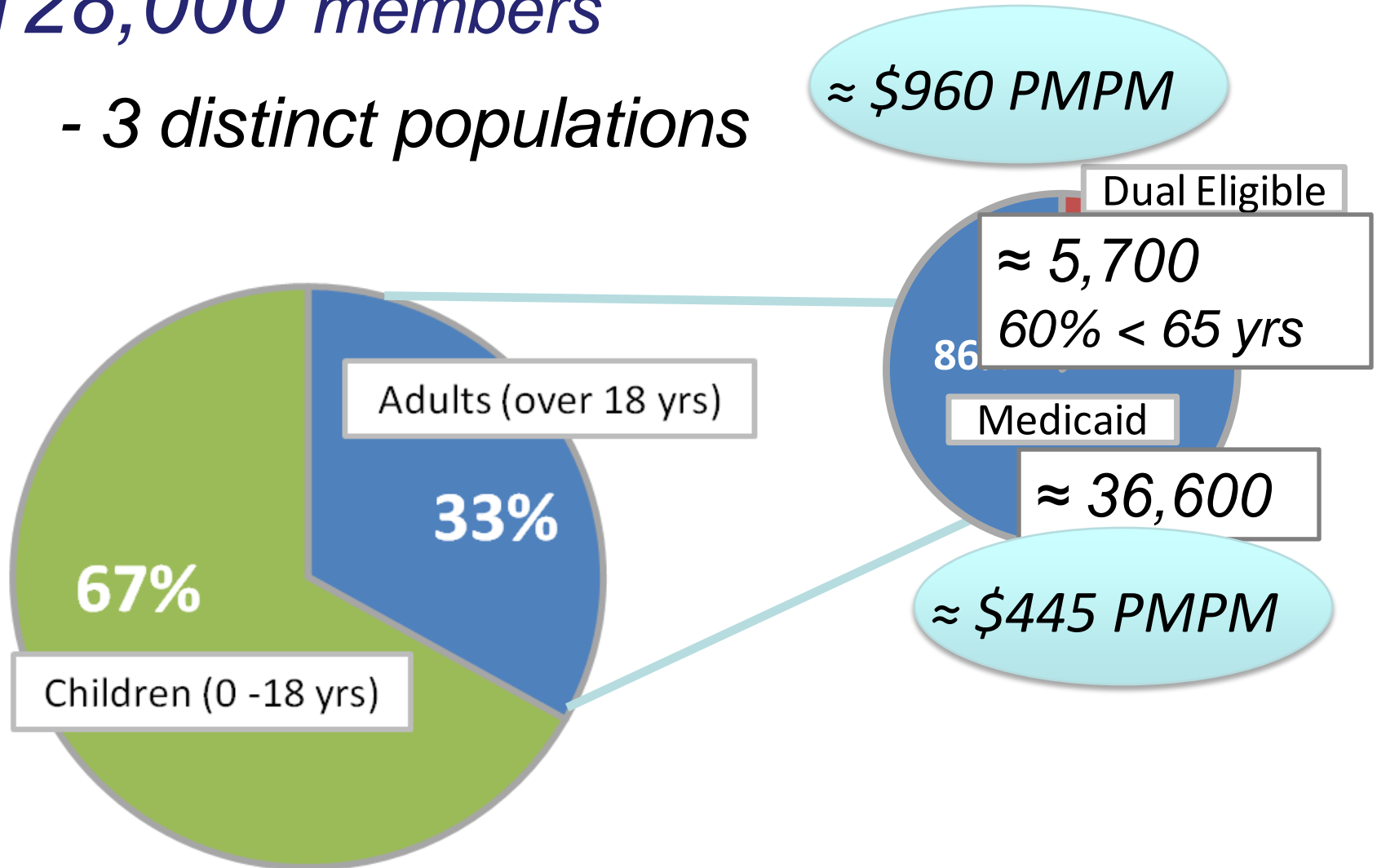
- CMS requirement for SNPs to do annual HRA and document an individualized plan of care for all SNP enrolled members annually = 5700 members!!
- Current reality:
  - HRA not evidence-based and only done once upon enrollment
  - Only stratify population by static cut-point ACG score; cannot realistically write care plans for all 1800 high risk members so we need a new stratification method

# CareOregon Member Population – Feb 2010



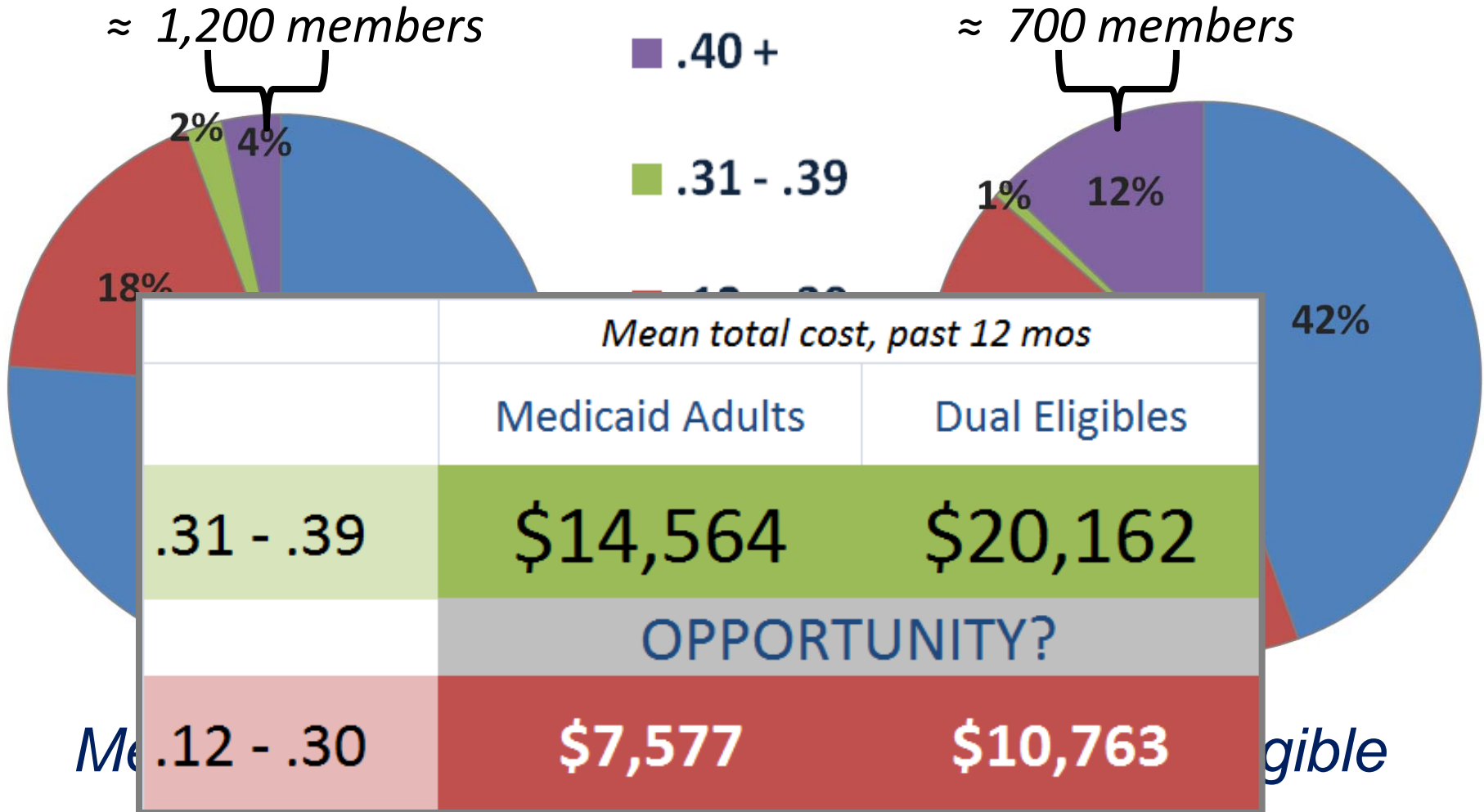
≈ 128,000 members

- 3 distinct populations



# ACG-PM Risk Scores

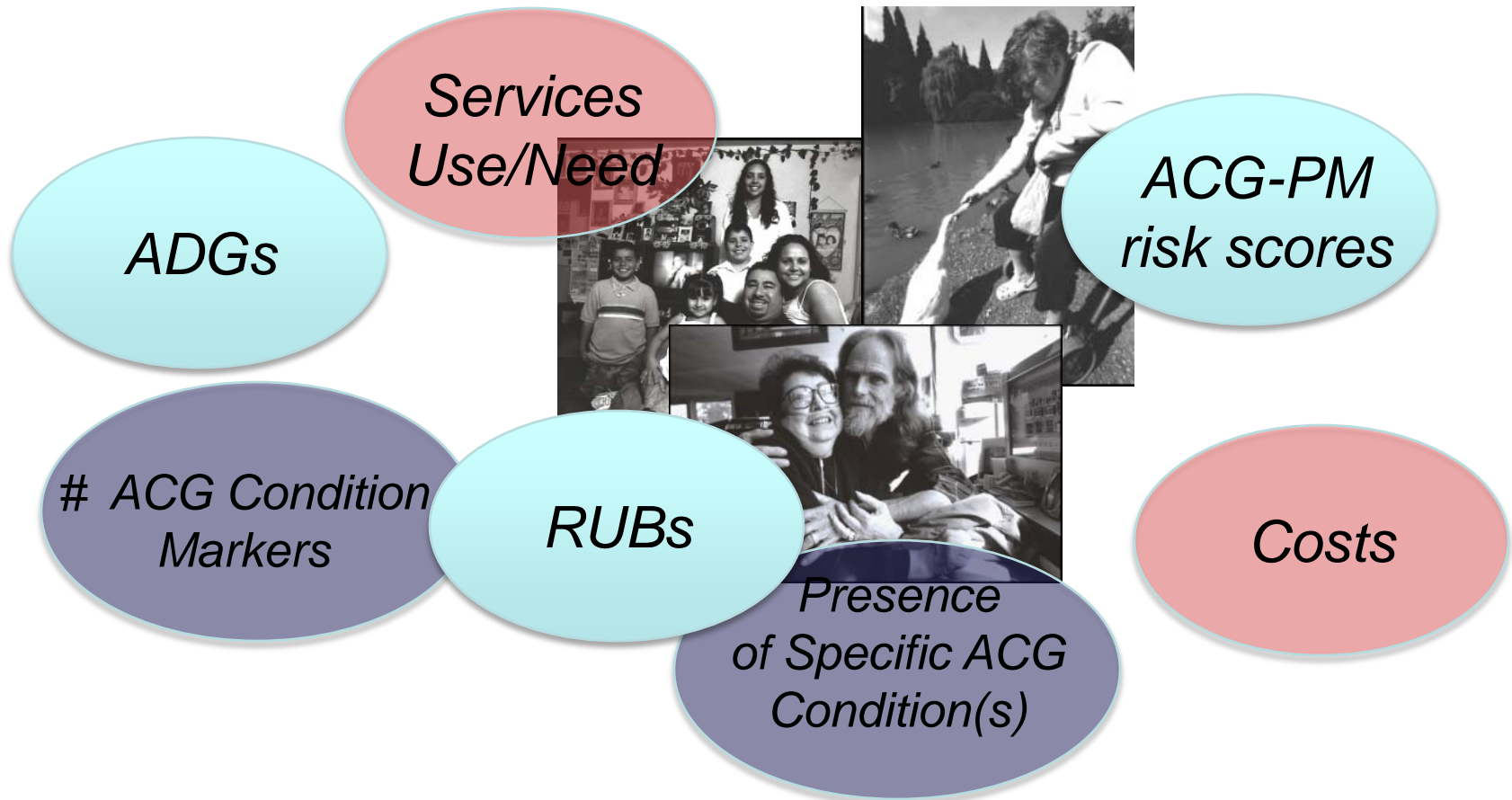
(P) Top 5% cost, next 12 mos



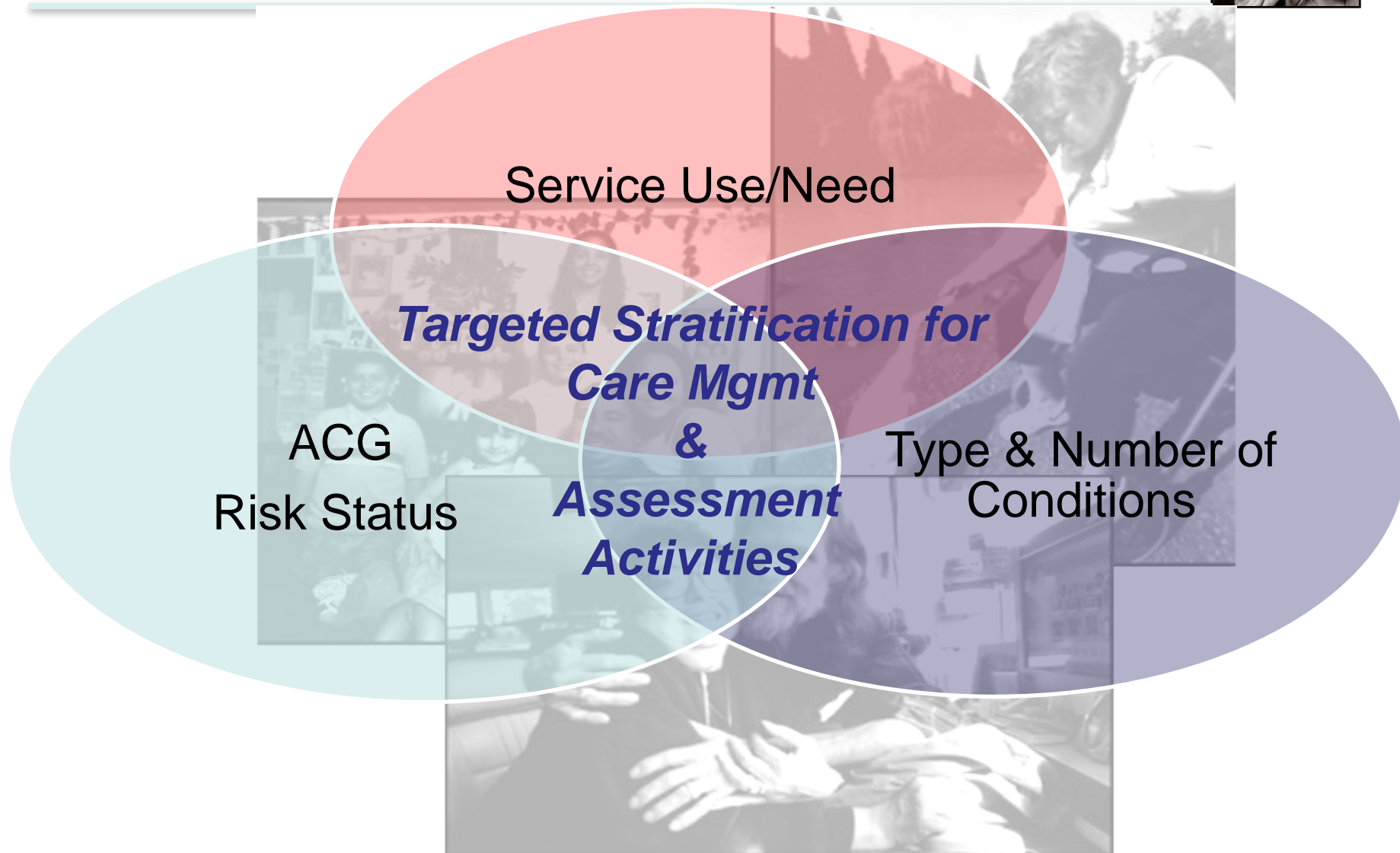
# PREVIOUS State of POPULATION Info



## Discrete “CHUNKS” of information



# Synthesize to create NEW population groupings AND individual level markers



Service Use/Need

***Targeted Stratification for  
Care Mgmt  
&  
Assessment  
Activities***

ACG  
Risk Status

Type & Number of  
Conditions

# APPROACH

## THREE STEPS

### 1. Classified

- Examined
- each gro

### 2. Added se

building k  
strategies

### 3. Combined

results to

- "Level of ca
- Care mgmt

## 12 ACG condition markers

(based on Dx and/or Rx)

*Asthma*

*Arthritis*

*Anxiety*

**CHF**

**COPD**

*Chronic Renal Failure*

**Depression**

**Diabetes**

*High Cholesterol*

*Hypertension*

*Ischemic HD*

*Low Back Pain*



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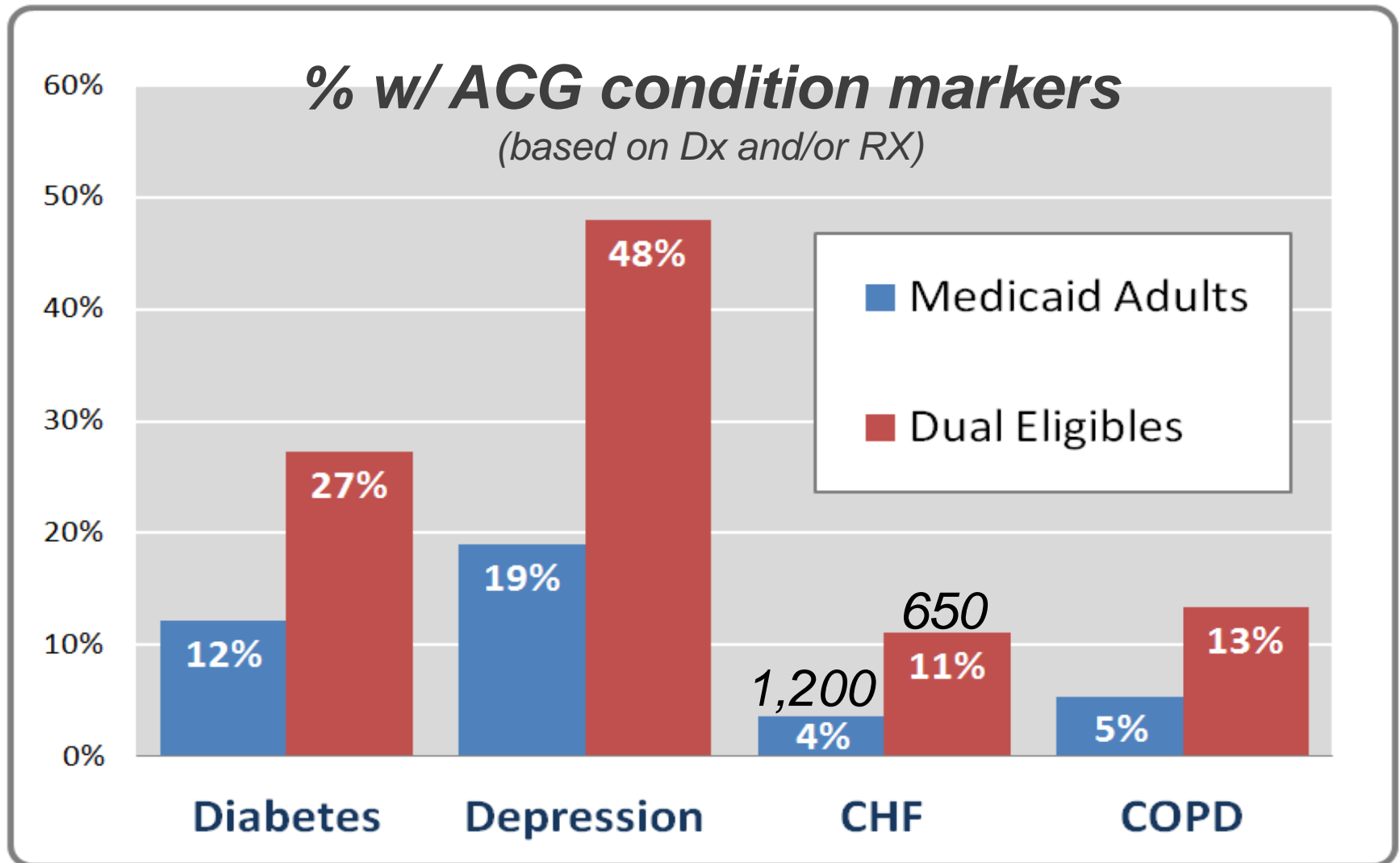
stics for

4 'tiers' –  
of care

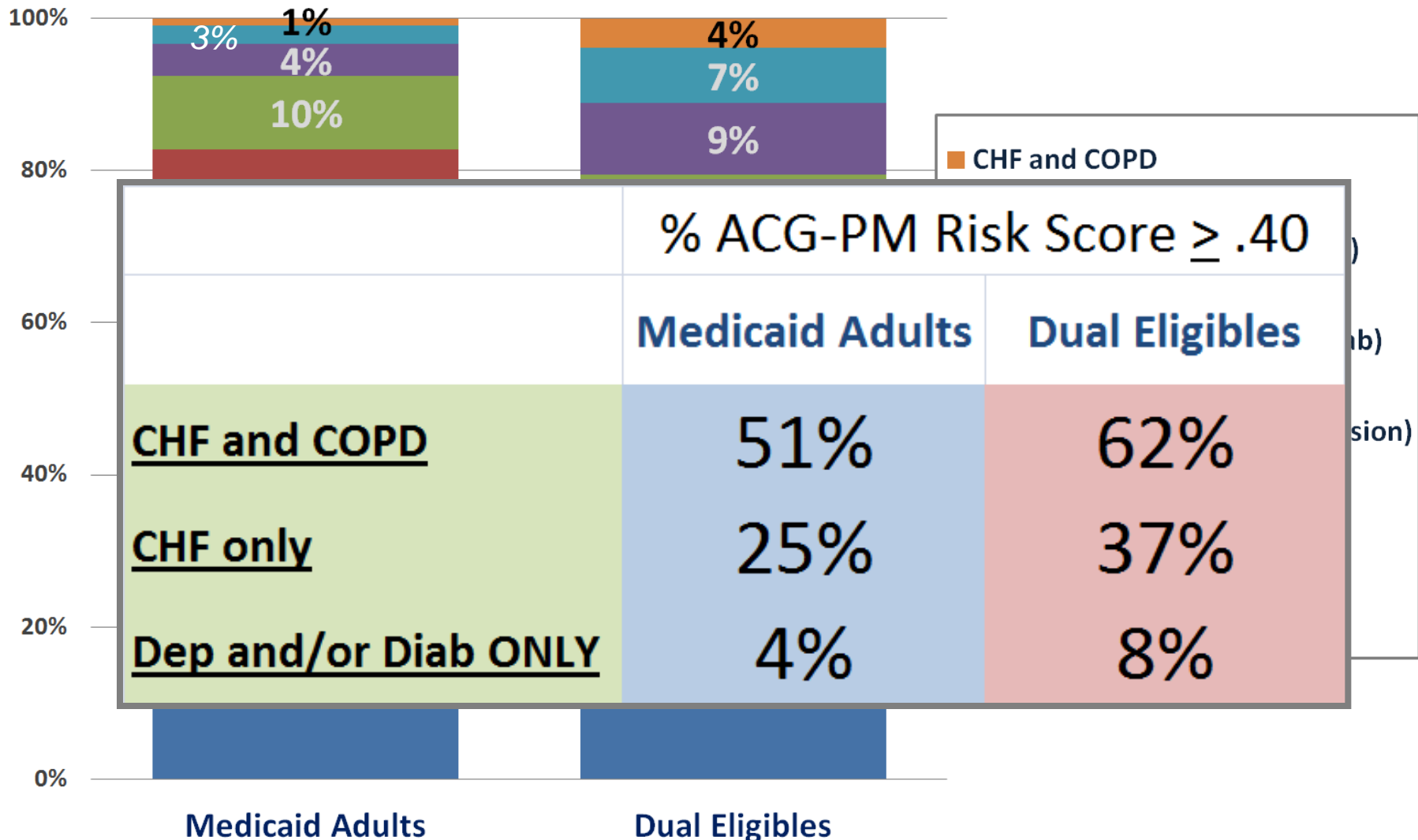
used

gible SNPplan)

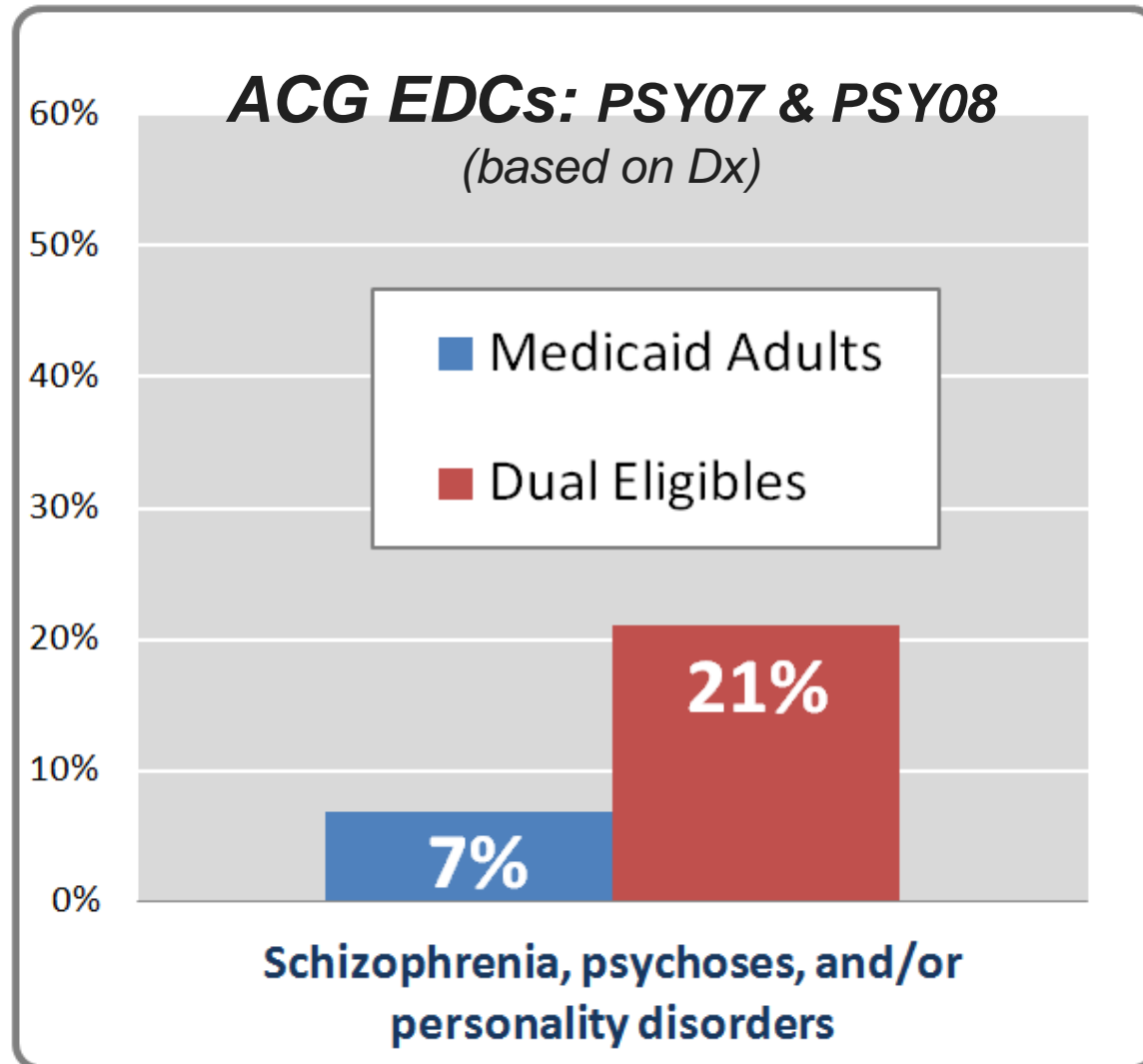
# PREVIOUS "View" of CONDITION PREVALENCE



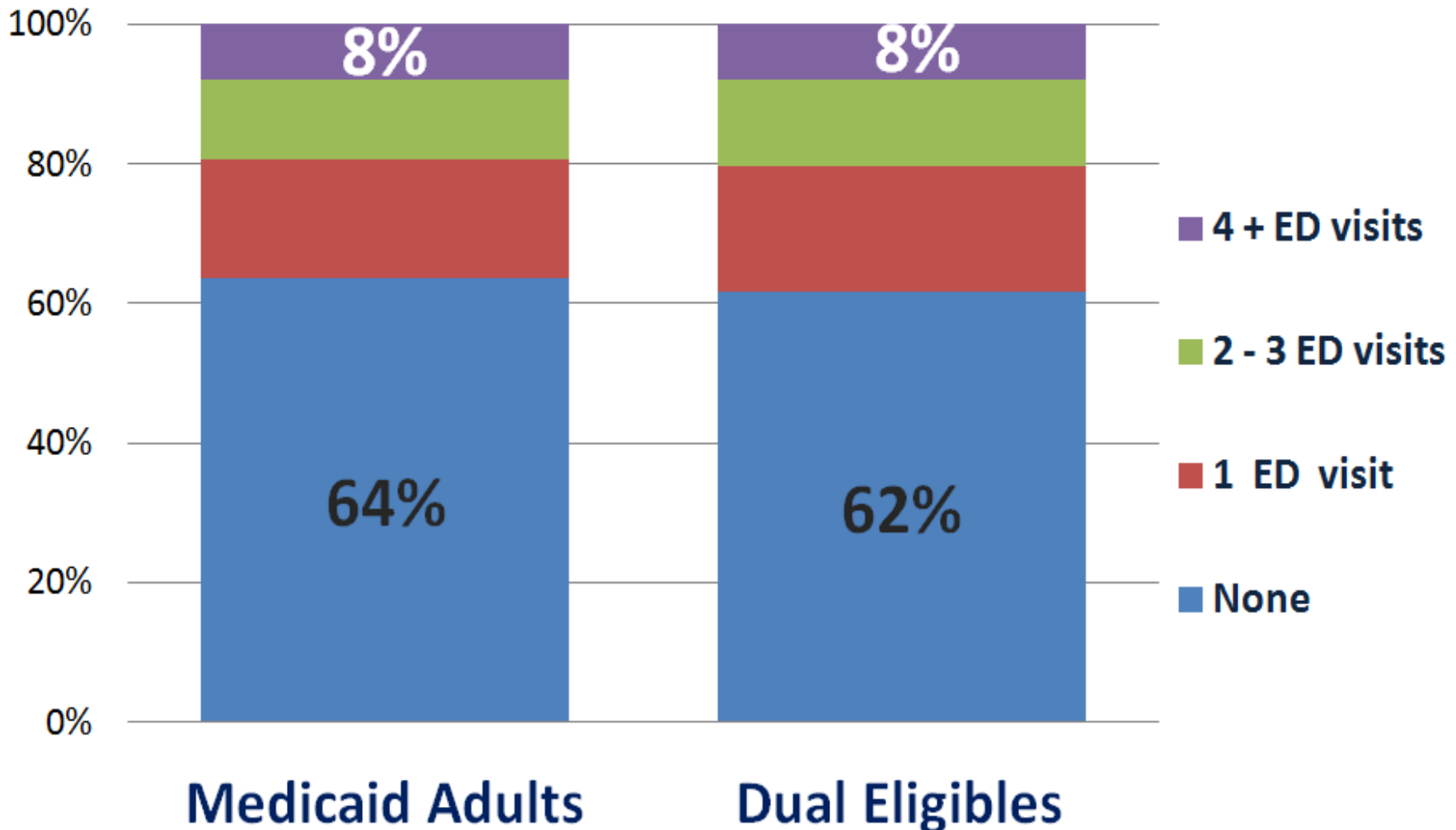
# STEP 1: Grouped members according to key conditions



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## STEP 2: Added SERVICE USE to create “Tiers”



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*Presence  
of Specific ACG  
Condition(s)*

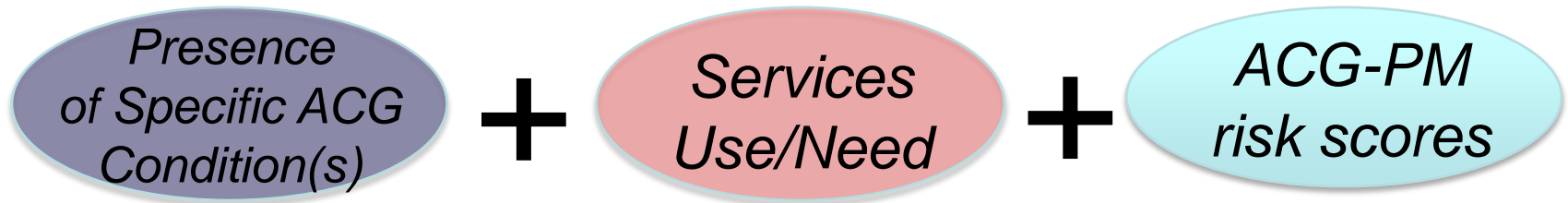
+

*Services  
Use/Need*

	Medicaid Adults n = 34,318*	Dual Eligibles n = 5,712*
<b><u>Tier 1:</u></b> CHF and/or COPD (with or w/o Dep or Diab)	8%	21%
<b><u>Tier 2:</u></b> Diabetes and/or Depression (No CHF or COPD)	24%	44%
<b><u>Tier 3:</u></b> No KEY conditions with 2+ ED and/or Hosp	11%	4%
<b><u>Tier 4:</u></b> No KEY conditions with 0-1 ED and/or Hosp	57%	31%

\* 6% Medicaid adults = no ACG data; <1% Dual Eligible = no ACG data

# STEP 3: Combine “Tiers” with ACG-PM scores to stratify members for Care Plan & Care Mgmt activities



## CURRENT APPLICATIONS:

Medicaid Adults:

Care Mgmt outreach

Dual Eligibles/SNP Plan: “Level of care” HRA & care plan groupings

## STEP 3: Combine “Tiers” with ACG-PM scores to stratify members for Care Plan & Care Mgmt activities



Medicaid Adults: Care Mgmt outreach

**ACG scores = .31 – .39**

Tier 1: CHF and/or COPD (with or w/o Dep or Diab)

Tier 2: Diabetes and/or Depression (No CHF or COPD)

Tier 3: No KEY conditions with 2+ ED and/or Hosp

Tier 4: No KEY conditions with ~~0-1~~ ED and/or Hosp

*≈ 500 members (2%)*

## CareSupport OUTREACH CALL RESULTS\*

CareOregon Medicaid adults (OHP) enrolled as of 2/8/10  
with ACG-PM scores = .31 - .39

Unable to reach mbr	103	21%
CO secondary	75	15%
Language barrier	44	9%
No CAQ - Major mental illness	44	9%



## CareSupport OUTREACH CALL RESULTS:

CareOregon Medicaid adults (OHP) enrolled as of 2/8/10 with ACG-PM scores = .31 - .39

### KEY to OUTREACH TIERS

<b>Tier 4:</b>	No key conditions, 0-1 EDs and/or Hosp stays last 12 mos BUT ACG .31 to .39
<b>Tier 3:</b>	No key conditions BUT 2+ EDs and/or Hosp stays last 12 mos AND ACG .31 to .39
<b>Tier 2:</b>	Depression and/or Diabetes (no CHF or COPD) AND ACG .31 to .39
<b>Tier 1:</b>	CHF and/or COPD (w/ or w/o Dep or Diabs) AND ACG .31 to .39

n = 502 cases*	Tier 4	Tier 3	Tier 2	Tier 1				
CAQ - Enrolled as case	7	10%	8	12%	8	4%	5	3%
CAQ - NOT enrolled as case	5	7%	1	1%	8	4%	2	1%
CO secondary	11	16%	9	13%	21	11%	34	20%
Currently in Case Mgmt	1	1%	4	6%	7	4%	6	4%
Language barrier	12	17%	7	10%	11	6%	14	8%
Lives in care facility	8	11%	5	7%	9	5%	3	2%
Mbr contacted / declined CAQ	2	3%	0	0%	5	3%	5	3%
Mbr unable to complete CAQ	2	3%	0	0%	4	2%	1	1%
No CAQ - 24 hour caregiver	0	0%	1	1%	1	1%	0	0%
No CAQ - Cancer	2	3%	0	0%	6	3%	0	0%
No CAQ - Chronic kidney disease	3	4%	2	3%	3	2%	1	1%

## STEP 3: Combine “Tiers” with ACG-PM scores to stratify members for Care Plan & Care Mgmt activities

### “Level of care” HRA and Care Plan Groupings (Dual Eligibles - SNP plan)

