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Medicaid Unwinding

Rate Adjustment Approaches for Changing Acuity

In October 2024, The Alliance of Community Health Plans (ACHP) and Association for Community Affiliated Plans (ACAP) sent a letter to HHS and CMS expressing concerns with the adequacy of rates in 2024 and concerns about actuarial soundness in the development of 2025 rates,[1] which are in progress or near completion in many states. These comments echoed similar public comments made by leaders of several national Medicaid health plan leaders, and generally centered around capitation rate development not sufficiently addressing emerging experience in 2024 due to acuity, utilization, and unit cost trends exceeding levels anticipated in rate setting.

In a series of issue briefs, Wakely will unpack some of the issues we see in states during this unprecedented time. This initial issue brief will focus on acuity changes during the unwinding, with a second issue brief to focus on the use of emerging experience and risk mitigation in rate setting.

In 2020, In response to the COVID-19 pandemic, Congress passed the Families First Coronavirus Act (FFCRA) to support states and promote health coverage stability during the Public Health Emergency (PHE). The FFCRA allows for a 6.2% increase to a state's Federal Medical Assistance Percentage (FMAP) if certain criteria are met, including providing continuous Medicaid eligibility to members enrolled as of March 18, 2020, or anytime thereafter[2].

Beginning in April 2024, all states began the process of unwinding this continuous eligibility provision, disenrolling members who no longer qualified or did not complete administrative processes to remain enrolled. Over this time, along with the change in level of enrollment, CMS, State and Health Plan actuaries observed changing acuity of members that required additional adjustments to capitation rates and risk mitigation mechanisms to ensure payments to plans remained actuarially sound.

To gain an understanding of the landscape of approaches taken by states and their actuaries during this time, Wakely surveyed 27 markets on issues ranging from the rating approach used to estimate changes in acuity, use of emerging experience, and risk mitigation approaches.

While most states have finished their unwinding process and are returning to normal operations, enrollment change patterns were observable prior to the PHE[3] indicating that lessons learned and techniques developed during this period are likely to find new applications as issues of eligibility

[1] https://achp.org/achp-acap-letter-medicaid-rates/

[2] https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

[3] https://www.kff.org/medicaid/fact-sheet/analysis-of-recent-declines-in-medicaid-and-chip-enrollment/

determination continue to evolve in each state and nationally[4]. In summarizing these approaches, we hope to elevate the discussion of these approaches among actuaries and others interested in how changes in these processes impact the cost to provide Medicaid benefits to a changing enrollee base.

Summary of Findings

This survey of Wakely consultants serving association and Health Plan clients was conducted between October 14 and October 22, 2024, and was supplemented by limited review of rate certifications available in HMA Information Services (HMAIS)[5], including for some non - Wakely clients.

27 states surveyed, most with rates beginning January or July 2024, with five older and six more recent

Table 1 includes high-level findings from the results of the survey.
This includes a summary of States utilizing emerging experience, the methodology used to determine the acuity impact driven by the resumption of redeterminations, changes in methodology, and the use of risk corridors during and after the PHE.

Table 1: Summary of Findings

Topic	Question Asked: How Many States are…	Summary Findings
Model	Using a cohort segmentation approach?	24 of 27 states segmented the population in the base and rating period into stayers/ leavers/ joiners or similar groupings, estimated cost relativities and applied adjustments between base and rating periods for expected changes due to changing mix, with the other three taking three completely different approaches.
Methodology Comparison Basis	Using claims to calculate the impact of acuity changes due to redeterminations?	20 of the States are using a claims-based cost or utilization relativity comparison. Four states use both claims and risk scores. Three states use only risk scores.
Methodology Changes	Fundamentally changing their acuity model as a result of emerging information?	Ten states have incorporated moderate to significant methodology changes as new information has emerged over the course of the unwinding, including changes to the basis of comparison, addition or change of cohorts to the cohort segmentation model, and use of changing lists of expected and actual member disenrollments.

[4] https://www.medicaid.gov/federal-policy-guidance/downloads/cib09202024.pdf

[5] https://hmais.healthmanagement.com/

Contextual Background

Since the beginning of the continuous eligibility period, there have been a range of studies reviewing actual and expected changes in enrollment by state along with their association with state policy and administrative decisions. As a brief overview of these findings:

- Prior to the COVID-19 Pandemic, Medicaid members experience high rates of churning, with nearly 25 percent of Medicaid beneficiaries changing coverage within one year, and most of these beneficiaries (55 percent) also experiencing a gap in coverage[6] that sometimes resulted in greater levels and lower-value catch-up utilization after they re-enrolled in coverage[7].

- While the first few months of the continuous eligibility period coincided with an economic recession with associated new Medicaid enrollment due to job loss, most of the enrollment increase was instead a result of fewer people being disenrolled from Medicaid over the remainder of the period[8].

- While CMS, State Medicaid Agencies and Health Plans worked hard to ensure that members were aware of the need to demonstrate eligibility to retain coverage after the unwinding began, many were not able to complete processes to remain enrolled.[9]

- As a result, of those who were disenrolled from Medicaid, 47% were later re-enrolled in Medicaid, 28% were insured via other coverage, including 16% with employer sponsored insurance, and 23% remained uninsured.[8]

These findings all reinforced observations that state and Health Plan actuaries were making during the PHE and the unwinding[10], that:

- Members remaining enrolled during the continuous eligibility period exhibited lower average costs than the corresponding pre-PHE baseline. Some reasons for this include that some of them had other coverage (with Medicaid as the payer of last resort), others were not frequent utilizers of health care generally, and some of these may not even have known that they were enrolled in Medicaid[11].

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[6] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//199881/medicaid-churning-ib.pdf

[7] https://www.macpac.gov/wp-content/uploads/2022/07/Effects-of-churn-on-hospital-use_issue-brief.pdf

[8] https://www.urban.org/sites/default/files/publication/104785/what-will-happen-to-unprecedented-high-medicaid-enrollment-after-the-public-health-emergency_0.pdf

[9] https://www.kff.org/medicaid/poll-finding/kff-survey-of-medicaid-unwinding/

[10] https://www.soa.org/sections/health/health-newsletter/2024/may/hw-2024-05-schaeffer/

[11] https://doi.org/10.1377/hlthaff.2024.00641

- During the unwinding, members with disproportionately lower costs were the first to be disenrolled, and may have waited longest to re-enroll after losing coverage:
    - Some states implemented prioritized redetermination processes to disenroll members with low utilization early in the process.
    - Members who did not anticipate needing health care services may not have prioritized the completion of paperwork, instead waiting until they needed care.
    - Members who needed healthcare services more frequently may have had more of a reason to complete these administrative processes and may have had more frequent touchpoints with others (such as navigators and providers) who could provide them with support in completing the processes to avoid losing coverage or to have it reinstated immediately when needing care again.
- Different rates of churning in the base or rating periods could result in significantly different average costs between the periods, requiring additional adjustments beyond simply removing members expected to leave as a result of the unwinding from the base period.
- Members losing and re-gaining coverage returned with higher health care needs than they would have had raised average costs and limited the ability of heath plans to consistently manage care for members with higher rates of churning.

The general phenomena above varied considerably over time and by state. For example, net change in enrollment between February 2020 and May 2024 ranged from -10% to +37% for all but four states who implemented Medicaid Expansion during that time frame, who saw even larger increases.[12]

Acuity Adjustment Methodology Comparison

As a result of this state-by-state variation, actuaries working on behalf of each state would be expected to approach the adjustment in each state somewhat differently to reflect the different circumstances. In addition, they needed to apply significant judgment in their development of appropriate adjustments to acuity, both during the PHE and the unwinding, and many changed their approach as new information became available that changed previous understanding of how events would unfold.

[12] https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/

While each state's approach differed in some ways, for comparison purposes, we chose a few important attributes to group them into general categories. The table below summarizes some of these features, why actuaries may choose one approach over another, and how many actuaries used each approach.

Feature	Description	Considerations
Cohort Segmentation	This approach segments the population during the base and rating period into cohorts expected to have differing costs, develops relativities for these expected costs, and applies a membership mix adjustment to reflect movement from base to rating period mix. This is often referred to as a stayer/ leaver/ joiner model because these are some of the most common cohorts used for segmentation	Some states used general information about expected or actual counts of members in each cohort, and others used actual member lists. Many used preliminary assumptions in the initial rate development and trued these up during the rating period. 24 of the 27 states we surveyed used this type of model. The only commonality between the other three approaches was that they each attempted to estimate acuity changes for the total population between periods without segmenting into cohorts.
Comparison Basis	Whether the population is segmented or not, all methodologies relied on a comparison of claims costs, utilization, risk scores, or both claims costs and risk scores between member cohorts or periods	Comparison of claims costs or utilization was the most common approach, with 24 of 27 actuaries using it, four in combination with risk scores. The other three used only risk scores. Comparing claims costs helps mitigate against known risk adjustment model bias that overstates predicted costs for zero or low utilizers and understates costs for high utilizers[113].

[13] https://www.soa.org/resources/research-reports/2016/2016-accuracy-claims-based-risk-scoring-models/

		While these known biases may be unavoidable in budget-neutral risk adjustment, they create significant challenges when used for acuity adjustments. As an example, members with other coverage (as in the case of people with Medicaid and employer coverage during the PHE) or low utilizers of medical services would be more likely to lose Medicaid eligibility during the unwinding. These individuals generally have very low costs that are likely to be over-predicted by their risk scores. By contrast, members at the extreme high end of the cost distribution would be expected to be very motivated to maintain their coverage, and may have considerable support from providers, care coordinators, and others with whom they routinely interact to maintain their coverage. As a result, when acuity differences between stayers and leavers are predicted based on risk scores, costs are likely to be underpredicted for stayers and over-predicted for leavers, resulting in lower reductions to capitation payments during the PHE than appropriate, and lower increases to capitation payments during the unwinding and post-unwinding period than appropriate.
Churn	An adjustment to account for the change in the proportion of members leaving and re-joining after a period of uninsurance	At least seven of the surveyed states explicitly adjusted costs for this phenomenon because it wasn't implicitly reflected in their cohort segmentation. This is particularly likely to be necessary for models based on risk score comparison, since members experiencing churn may have higher costs in the period immediately after re-enrolling that may not be reflected within their risk scores.

Wakely's survey included a sample of 27 states anonymized to protect confidentiality. Certifying actuaries represented include Milliman, Mercer, Optumas and other consulting firms. Differences in approach do not generally indicate outliers between actuarial consulting firms but seem to be more state-specific.

The most recent KFF survey of Medicaid directors suggests that there is an increase in concern related to the overall funding level of Medicaid programs across the country. Over half of responding states at the time of the survey thought the chance of a Medicaid budget shortfall was "50-50", "likely", or "almost certain."[14] Against this backdrop, conversations between states and their managed care partners can be particularly difficult.

In subsequent publications, we will dive deeper into different results produced by different acuity adjustment approaches by state and explore the interactions between the use of emerging experience to inform rate development assumptions and risk mitigation mechanisms in Medicaid Managed Care. This situation is dynamic with many states changing their approach due to emerging information and ongoing negotiations. As a result, later updates to the survey may produce different findings.

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[14] https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2024-2025/

OUR STORY

Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

Wakely is now a subsidiary of Health Management Associates. HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

Broad healthcare knowledge. Wakely is experienced in all facets of the healthcare industry, from carriers to providers to governmental agencies. Our employees excel at providing solutions to parties across the spectrum.

Your advocate. Our actuarial experts and policy analysts continually monitor and analyze potential changes to inform our clients' strategies – and propel their success.

Our Vision: To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

Our Mission: We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.

Learn more about Wakely Consulting Group at www.wakely.com