Aetna Inc - Vice President, Healthcare Economics at UnitedHealth Group

Interview conducted on September 15, 2023

Topics

Medicaid Market, Provider engagement, Risk Adjustment, Revenue Levers, Cost Savings, Premium Calculations, Value Creation Strategies

Summary

The Tegus Client and the Vice President of Healthcare Economics at UnitedHealth Group discuss various aspects of value creation and MLR in the Medicaid space, including state regulations, provider engagement, RAF, member retention, and Medex management. The Tegus Client seeks to understand how different levers can impact premiums and MLR, while the Vice President emphasizes the importance of Medex management and member engagement. They also discuss managing high-cost members and closing the gap between high MLRs and target levels. The Tegus Client seeks clarification on how rate cell and RAF scores impact premium rates and how to calculate the end premium. The Vice President suggests using historical data to project premiums and discusses points of contention between NCOs and providers. They also explore reasons behind unexpected value capture by an ACO and suggest restructuring the deal or reevaluating cost components. The conversation further discusses the most reliable driver of premium increases and the most attractive economic opportunity, with the Vice President highlighting the importance of driving RAF and the impact of population category. They also discuss the importance of provider relationships and state attractiveness in driving premium increases.

Expert Details

Vice President, Healthcare Economics at UnitedHealth Group. The expert’s analytics focus on Risk Adjustment impacts, unit yields, member identification and prioritization, HCC recapture and prevalence, and revenue projection inputs/guidance for the Medicare Advantage and Medicaid membership.

Vice President, Healthcare Economics at UnitedHealth Group. The expert is responsible for leading a team focused on Risk Adjustment Analytics – specifically for prospective HouseCalls, retrospective Chart Reviews, Physician Claim Reviews, and In Office Assessments. The expert’s analytics focus on Risk Adjustment impacts, unit yields, member identification and prioritization, HCC recapture and prevalence, and revenue projection inputs/guidance for the Medicare Advantage and Medicaid membership. The expert is skilled in Financial analysis, clinical analysis, strategy, product development, network & pricing, P&L analytics, Operations Management, and relationship management.

Q: Do you have expert in Medicaid?
A: Yes, expertise in Medicaid. It's actually been my focus for the past 2 years.

Q: Please describe your familiarity with risk adjustment.
A: Risk Adjustment - very familiar. I lead our risk adjustment analytics team. Focus was in the MA space and now is in the Caid space across ~20+ markets and we run programs focused on driving accuracy and completeness. Prospective and retrospective programs. Very familiar with the states that allow supplemental data vs needs to come through the claim.

Tegus Client

Thank you for taking the time to speak with me today about the economic creation opportunity for Medicaid, and who would get credit essentially with an NCO for the value creation. To start off, can you please share us

your point of view?

Vice President, Healthcare Economics at UnitedHealth Group
Yes. It's a really interesting time, at least, I'll say from my experience and the things that my business is going through right now of how states interpret regulations. And so you guys can probably appreciate that every state put out their letters and their requirements and how things are supposed to play out. And then multiple NCOs get those letters, and they interpret them differently.

In the MA space, everyone's pretty clear, like, "Here's how you engage with CMS. Here's your sweep. Here's your EOL. Here's when you're actually going to submit stuff," and everything is due on February first, over the past three years and they extend the extension into August. It's not like that in Medicaid.

So for example if we speak about Florida. The first thing that comes to mind is it's a more challenging market from a provider engagement standpoint. So that's a tougher market to operate in.

I don't know the specifics of why, but I can just tell you that when we look at our program and we work with the providers, we just don't get response and agreement from them as strong as we do in other markets. Now New York is a great market because it's a notification-only market, at least from everything that we know. And basically, what that means is when we find a condition as the health plan through a prospective or retrospective program, when we find that condition, we can then send it to the provider.

The provider has four to six weeks, whatever the time period is we think is appropriate to respond. If they don't respond and say I disagree, we have met that obligation, and I can then submit to the state. And so those conditions found will count towards risk adjustment.

In the State of Virginia, they allow supplemental data. So Virginia actually operates very similar in that regard to the MA space. So in the MA space, you retrieve the chart from the provider that codes it. They find it an HCC. You submit it to CMS. It drives revenue and increases the RAF for the member. Virginia operates the same way. So you can find things as a health plan, and you can submit those supplemental data to state supplemental to the claim and then that will drive value. So Virginia is one of the best markets to operate in because you have less hurdles and less kind of challenges there.

Now what I say about it being a very interesting time is we are actually going through with clients and helping additional states get comfortable with removing that physician engagement process, and so that they will allow supplemental data to be submitted.

The way it works right now in some of our programs is, if we find additional conditions, we actually have to go back to the provider, get them to respond, get them to approve what was found as extra conditions and then can modify the claim and submit that claim to the state. So the more you can remove that provider process, the better you can do at driving and retaining value for the health plan.

Tegus Client
Got it. And realizing this is kind of a fool's errand given how different states are, I'm going to think of like a macro or national-type generalities and then I would love this commentary as we go along here, what are pieces that are typically highly variable across different states?

Maybe I'll start at the most basic level here. The types of levers that we have identified as potential areas to drive MLR shifts. So on the revenue side, the things that come to mind. So rate cell setting of moving people either to SSI/SSDI, certain states have SMI designations, which will apply for our population here. So that's one.

Two is RAF and risk adjustment, so a patient who was undercoded, getting them coded appropriately with all the kind of conditions they have that might be missed, if they're just going to the ER to solve one specific problem.

And then the last piece is quality score bonuses and/or release of withhold, so like release of penalties as the last bucket on the revenue side. And then the cost side is not more straightforward, but it is essentially, can you drive Medex savings to get to the other part of MLR? So am I missing any other buckets of value

creation? What else comes to mind here?

Vice President, Healthcare Economics at UnitedHealth Group
Maybe the only thing I would add, and maybe you're including it in some of the RAF health, because I'd say member retention where you can do all the right work, but if you can't keep a month or on 12 months, then the value really drops, which is harder in the Medicaid space. We all know the reason for that population, but yes.

Tegus Client
Yes. What I'm trying to understand, somewhat both practically but also theoretically, is how these different levers then interplay? And I'll give you an example, let's say there is a patient who is $50,000 total cost of care. They are basically unengaged from the system.

So let's say they are not coded appropriately at all. Let's say, they're TANF, 14 to 54 years old, female. Based on the spreadsheet and the Florida rate cells, that would tell me that their premiums are closer to $200 a month or so.

Vice President, Healthcare Economics at UnitedHealth Group
$200, yes.

Tegus Client
Yes, $200 or so. And so they get to premiums of, let's say, $2,300 a year over $50,000 total costs of care, which means their MLRs are completely out of whack. Is that the way to think about it?

And then two, what happens to the translation, let's say, we had an intervention, we coded them appropriately, so their RAF goes from basically one to like 1.5. We got them SSI/SSDI benefits. Obviously, these are all difficult things to do. But assume we've got them SSI/SSDI benefits and move rate cells. How does that actually change the way we should think about premiums?

Vice President, Healthcare Economics at UnitedHealth Group
Yes. I think your idea and your math, that makes sense. Obviously, in the zero-sum game, you got the flip side of like, what is everybody else doing in the market? And very often it's the same thing that you're all chasing the same tail. But yes, I think that makes sense.

Tegus Client
So is it right to say then that in a world where a patient is completely uncoded or undercoded that you would take this like $23,000 over $50,000 total cost of care, and that's like your MLR? Well, I guess you would do it the other way, but like your MLR is like extremely high.

Vice President, Healthcare Economics at UnitedHealth Group
Yes.

Tegus Client
Like somewhere like the 2,000%-ish range?

Vice President, Healthcare Economics at UnitedHealth Group
Yes. If it's $50,000 over $24,000, yes.

Tegus Client
Got it. So how should we think about the way RAF should move for this population? And maybe we can talk about those different levers. But on the RAF side, for patients that sit in this pool, what would you expect their MLR to be if they're managed properly? Or what would you expect their RAF to be if they're managed properly?

Vice President, Healthcare Economics at UnitedHealth Group
I'm not sure what I would expect their RAF to be, but their MLR, I think with someone like this, ideally you get them in like the 90%, 95%. There's not a whole lot of margins there, but you're going to hopefully offset it by some other healthier members.

I mean, that's how insurance works, that you're going to be able to subsidize and get yourself down to an MLR culture to 85%. On the MA side, you got to stay within the 85-ish range. If you get too much lower than that, after a couple of years then you're just giving it all right back.

So you got to watch that. Obviously, it depends on how administratively strong are you in the program you administer? Are you able to do it at a 5% margin? Can you operate at a 90% business? I mean, if so, then great. If you got programs that really work, you want to take on those risks your members, you've got more to work with.

Every health plan is different. Some health plans are like, "We're going to just really take the really sick," and so they'd want these members because they're like, "Hey, if I can just reduce the Medex by 10%, I've got my business case." So I think if you can get yourself in that 90%, 95%, hoping you can have some others to offset it, you're in an okay spot. But if you're going to focus on just these really high Medex driving members, it's going to be a challenge without some strong administration to the programs.

Tegus Client
Right. What needs to happen to get someone from an MLR of like 2,000-some to 90%? And obviously, some of this will come from the Medex side, but I'm mostly thinking on the premium side. So maybe the first part is you move them to a different rate cell, right? That's one opportunity.

At least in Florida, it looks like if you move someone from TANF, typical, it's like $200 a month to an SMI rate, so you get to like $1,300 a month. That obviously gets you to yearly premiums of $15,000, $16,000 a year. That still won't rightsize your MLRs near what you want it to. So I guess the question to me then is, what's closing the gap here? Is it risk adjustment? Or what else is happening that would get an MLR to the 90%?

Vice President, Healthcare Economics at UnitedHealth Group
Yes. I think you hit it on the head. It comes down to Medex management because the revenue only gets you so far. It maybe gets you half the way there like your math suggests here. So then you do need to drive engagement. And then you're probably thinking about, okay, well, what kind of member incentives can I offer for certain engagement levels?

So we've got a product that if a member hasn't seen a provider in the first nine months of the year, then we call them up when we try to get them and we do a three-way call. They get them in to see a provider. That's one way that you're going to help. So the good news is that they haven't gone to see a provider in nine months, your Medex is at zero.

But my guess is you're not seeing those people because you're talking about Medex of 50, so they're getting in. So on those admissions, you're going to need to figure out how to get those providers on the admission side to tap into a PCP or somebody who can get on that on the preventative side. So maybe the first admission happens and then you guys could like say, "Okay, who can be kind of the watchdog to make sure that doesn't happen again?"

Tegus Client
Right. Can you help me then understand how I should think about the way premium when you both have this rate cell impact and this RAF impact? So let's say someone is TANF, RAF of one baseline because they haven't seen it. They haven't seen a provider properly. You then get them on SSI/SSDI benefits, and your RAF is now 1.5.

To me, the premium should move because they're now in a different rate cell so that it should also move because they have a different RAF score. And I'm trying to understand how you would basically quantify the impact of what the premium should be after you take into account both of these elements.

Vice President, Healthcare Economics at UnitedHealth Group
I think you'd probably want to look at what you see for premiums in those different age categories on average for different RAFs and then you can start to say, "Okay, here's what I got for somebody that's a 1.3. Here's what I got for somebody that's a 1.5," see what that difference is.

I'm not sure if that's answering your question, but I would use your actual data to support. When I do these movements, here is the value of it, what I've seen historically. It doesn't mean it's going to play that way in the future, but I've historically seen that when I moved from this to this aid category or RAF score, what my increment is and revenue for them.

Tegus Client
If we don't have historical data, how would you triangulate really roughly the end premium? How we should think about value creation that comes from revenue levers for this population? And it might be that you need to calculate rate cell and RAF separately. It might be that you just need to calculate the end premium, and that's how you get to the value creation. I'm struggling to understand what the right methodology is or how typically people think about it on the NCO side?

Vice President, Healthcare Economics at UnitedHealth Group
Yes. We do use historical data. So maybe I'm not going to be able to answer your question from if you don't have it, how would you project it because we do look at our different programs, and we can see what yields we get on them, and that helps to drive our future expectations. So absent of that, I think you've got a lot of variables. It's hard to say what you're going to project that.

And maybe somebody who's deeper in the rate cell and the tables and the calcs, they might give you a better answer than I can. I don't deal in that deep math. I deal more within the strategy and how we actually drive the value and retain the members and the product we deploy.

Tegus Client
Got it. Can you tell me a little bit more about what happens when you look at this historical data? I'm imagining like a two-dimensional matrix. You have the rate cells on one side, you have RAF scores on the other, and you basically map to see what premiums ended up for that population within a RAF 1.0 TANF, like RAP 1.2 TANF, and that's how you figure out the different premiums.

Vice President, Healthcare Economics at UnitedHealth Group
Yes.

Tegus Client
Okay. And then you can understand if someone does both the RAF and the rate cell shift, like this is what the new premium will look like. That's how you drive it. So when people are undergoing either initial contracting or settlement processes, how you think about the parts where there's the greatest points of contention essentially between the NCO and the provider or whoever holds the value-based contract on the other side?

Vice President, Healthcare Economics at UnitedHealth Group
The first thing that comes to mind is when you asked about the greatest point of contention, I'd say, there is a difference of opinion in what should be documented at the point of care or within that visit.

And so let's say, I'm a diabetes patient, but I go in to see the provider for a broken arm. They're going to document that I have a broken arm. They may not document that I have diabetes. And then the health plan will say, "Well, last year, they had diabetes. How do they have diabetes this year?" And the provider will say, "Well, my visit, it's the MEAT". But basically, if they don't do one of those four things for that condition, they don't document it.

And so the health plan is like, "Yes, but they have diabetes." They're like, "I agree, they have diabetes, but it was not addressed in this visit. Therefore, I'm not going to document it in this claim, and therefore, we don't get to submit it for risk adjustment."

And so that's where everyone agrees, but they don't want to put on the page because it didn't have an impact on how they treated that member. They fixed a broken arm. Diabetes had nothing to do with the arm.

So if you can give providers to say, "Hey, I agree. They have it. And yes, I will document even though I didn't meet or assess or treat it," then you're going to have a much stronger alignment. And that's going to drive your RAF.

Tegus Client
Makes sense. Is there anything else that comes to mind? If provider group actuary and NCO actuary are sitting in a room at the end of the year, trying to hash out settlement, what are other things that will come up that tend to be a point of contention?

Vice President, Healthcare Economics at UnitedHealth Group
Do they have an actuary? I mean, obviously, a lot of providers, they don't have a whole lot of sophistication, no offense to them in their analytics. I worked on the provider side years ago so I appreciate them. They're phenomenal in medicine, but running a business is not their strength and that's okay. I'm a horrible doctor, so credit given to them.

I don't think they sit at the tables and have contention between the health plan and the provider as far as the value. I think it really comes down to the documentation. That's where you're going to have any contention because really the providers, they care about coding things like at a CPT level.

They get paid based on the CPTs and the physicians specifically on their RVUs. Most providers are on an RVU basis, so the more patients they see, the more they assess, the more complex, the more they get paid.

Their compensation has nothing to do with risk adjustment. And so that's where you got this weird tension in the system. It's like, "Well, I don't care what you guys get paid a health plan, other than I want you to be solvent to make sure you pay my claim, but that's on you guys to figure it out."

So we do have to figure out like, how do we get those providers to align incentives? And so you can look at, how do you actually deploy a program that's going to compensate them for accuracy and completeness and documentation? Now be very careful about how you incent in that it's not an incentive for an outcome, but it's an incentive for a behavior. And what I mean by that is just have them doing the work versus them giving you the answer that you want.

But we know from our experience that if you can at least drive the behavior, the outcomes will move with it. You're going to get more better documentation, more agreement, if you actually have better engagement response rates.

Tegus Client
Okay. What if there were a provider group like an ACO is under a capitation type construct. And at the end of the year, you do settlement and the NCO realized this ACO is capturing way more value than they expected.

What would be your hunch as to the core reasons why? And what would be pretty accepted if like they're just, "That's just like the way it goes," versus like, "We should push back or negotiate to get back some of the value that we're losing on the table."?

Vice President, Healthcare Economics at UnitedHealth Group
So you would say that their membership pool has higher risk score than you expected?

Tegus Client
Yes. Or yes, there's something about the economic structure, the way it's been laid out where the ACO is coming out a lot more favorable in terms of what economics they're getting versus the NCO.

Vice President, Healthcare Economics at UnitedHealth Group

Interesting. The NCO is not losing money. They're just not capturing as much as they would like is what I think I'm hearing you say.

Tegus Client
Yes. Or maybe the NCO is losing money. We can talk about that situation, too.

Vice President, Healthcare Economics at UnitedHealth Group
Okay. Well, if the NCO is losing money, then completely restructure the deal, so that it works. Because otherwise, you're like it's not a good deal for them to do more business that's losing.

Tegus Client
Right. But why would they be losing money? What are the big reasons this would happen? It clearly means that something didn’t go correctly during the initial papering, and I'm trying to figure out how you get ahead those kinds of situations.

Vice President, Healthcare Economics at UnitedHealth Group
Probably they mis-weighted things, or they mis-appreciated what's going on or they need to think about how to structure it to be more focused on the preventative side versus perhaps the hospital side, try to obviously reduce the admissions so that they can drive that Medex down. Yes, if the NCO got themselves under water, I have to look at the data to be able to say, "Hey, what are you guys missing here?"

But they're clearly paying for more value than they're getting. And the simple thing is, okay, I'll look at your Medex trend and what you think you can do for Medex, and then expect you're going to have a 15% administrative margin on there. And you're going to run it for 10, you're going to walk away with 5% at the end of the day. I mean, that's ideally where they get themselves to, and so they probably have underappreciated the cost components.

So the other thing they could then think about is like, well, okay, how do we maybe grow ourselves out of this? Do you create an incentive structure for providers to have perhaps drive RAF more?

But again, just because you increase the RAF, if you're giving away too much of it, it's like selling more units when you're losing money every time. It's like you can't do it ourselves out of it when you're losing $5 every time you sell a widget. You got to fix your structure.

So you could try to have that say, "Hey, the NCO is not driving up revenue, so we need to figure, how do we drive more RAF and create incentive structure for the providers?" But if you're giving them $0.95 on every dollar and you as the MCA to administer your program, you got to spend $0.10, $0.15, you're losing money every time, so selling more is not going to get you on a trouble. So it's like you're in ACO arrangement and I think because your ACO arrangement like in theory, you should work for both of you. But if it's not working for one, then you've underappreciated your cost to deploy your programs.

Tegus Client
Right. I guess then when you think about abstracting back to these revenue levers like rate cell, RAF and bonus, let's leave it by number of retention because that's harder to think about here. But I guess when you think about these three buckets, what in your mind is most reliable as a driver of premiums increase? What is most attractive to you as an economic opportunity?

Vice President, Healthcare Economics at UnitedHealth Group
I'd say probably going after driving RAF because rate cell is probably set by the state, and that's not going to be super volatile or movable each year, but you could impact your RAF more.

Tegus Client
Can you maybe say more?

Vice President, Healthcare Economics at UnitedHealth Group
Well, my understanding of your question is like if I think about rate cell versus around, where do I invest my time? Where might I see the biggest opportunity? And the rate cell, those are set. The state says, "Here's what we're going to pay for the premium," and it's based on your membership allocation or distribution.

But if you think about, how do I drive more like? Like you said, it's getting them from a TANF to an SSI. If you can have them, classify them, then their RAF is going to improve and they're going to get to the better rate cell, but the rate cell doesn't change much within those buckets.

Now if you're staying within the bucket, then it's like, well, you got to make sure you get accuracy and completeness in all your conditions. So RAF feels like it's a bigger opportunity. And we all know it like if you go for the members that are sicker, you have higher Medex, but you have more revenue to work with. And that's where I think about going after those numbers that at least give you revenue to work with.

Tegus Client
Got it. So what I'm hearing from you is that there is less variance within TANF or SSI, SMI and so the opportunity is in moving down to those different risk flows?

Vice President, Healthcare Economics at UnitedHealth Group
Yes. Let's say like if I think about what we see for yields on programs, they can be 30% higher to 50% higher in an SSI versus a TANF, same program, same conditions or comparable as much as they can be. And so the aid category really drives a difference there.

Tegus Client
Yes. It sounds like the population is always difficult, but on a like-for-like case basis, you're getting higher yields on SSI versus TANF.

Vice President, Healthcare Economics at UnitedHealth Group
Yes.

Tegus Client
Because I have to imagine that getting people on SSI benefits is not something a provider is going to ask. I just can't imagine it's part of their core services. And so is the NCO trying to deploy resources to get people on those benefits? Or is it something they're outsourcing to another vendor? How does that work?

Vice President, Healthcare Economics at UnitedHealth Group
I would say that they're deploying vendors to try to get those classifications. SSI can also be ABD, aged, blind and disabled. So I don't know how subjective that really can be.

Tegus Client
Any other commentary or how you would think about relative state attractiveness for a revenue lever opportunity? What's the framework? Or what are the factors that you'd want to know if you're thinking about entering X, Y, Z state as it relates to revenue?

Vice President, Healthcare Economics at UnitedHealth Group
I think you'd want to look at NCO and provider relations. So if the health plan has a strong partnership with the providers, you're going to get stronger results. Maybe even what I'd say is in the cases where you have the health plan owns the provider group, so in the Twin Cities, you've got like, HealthPartners and Park Nicollet. I think HealthPartners are the insurance side, and then Park Nicollet is the provider side.

A Kaiser, right, where they do their own insurance, but then they have their own providers, that model where you've got the provider beholden and in theory, aligned incentives, I think is going to help you move the needle better.

So if you're looking at prospective health plans, if they've got any installed provider base, that's going to be a leg up to start. But outside of that, it's like, okay, well, let's talk about the relationships you have. Let's talk about how well they partner with you in different programs or initiatives you deploy.

And if that's strong, then you're going to be able to help them move the needle with you and drive the accuracy and completeness. Even so far as maybe some provider or some health plans, they could be working with providers that don't have their resources.

And so how receptive is the provider to the health plan stepping in to help them? So if you have coders, you've got coders on the provider, you get coders on the health plan side, they've got different personalities and guidelines to how they operate.

But if you can have a provider group that's like, "Gosh, we really need help on the coding just in general to keep up," or, "We're open to you sending one of your coders in to help us," that's going to help them. The coder criteria, they're going to be the same. So if the health plan can put one of their coders into the provider's office, then the incentives are going to be aligned. The coding rigor will be consistent.

And the provider is like, “Great, you just helped me solve getting this documentation done. My rejects, my going back and forth with health plans on claims, that's reduced. You've taken off this burden of an expense ahead operationally. My revenue is up”. All these things can help to align to them. But again, they got to be a provider comfortable with letting somebody come in and do that for them.

Tegus Client
Okay. Are there other specific states that you would call out as ones that you would think are particularly friendly, particularly nonfriendly and any reasoning?

Vice President, Healthcare Economics at UnitedHealth Group
Yes. I mentioned Virginia and New York. Florida, not so friendly from the provider engagement side, but again, that could be overcome if you've got the right relationships. Wisconsin is proving itself to be a little bit more progressive and perhaps moving in the ways of Virginia, so it might be one to consider pursuit in. It's not a huge market, but opportunity nonetheless. Louisiana, Rhode Island have also been healthy markets. Dakota is really small and Minnesota is really small.

Tegus Client
Yes. And you mean there is like a revenue coding opportunity and you're seeing yield on being able to do that on the Medicaid side given some of the regulatory dynamics as well as like provider relationships and stuff like that.?

Vice President, Healthcare Economics at UnitedHealth Group
Yes. Provider relationships for sure being the key. That's where at some point, you're going to say coding is a bit of a commodity, and so how do you just get everybody to be on the same page? So I wouldn't say that any one of those markets is more poorly coded than the other, but I would say that when we do find things that the providers are willing to engage and they'd be like, "Yes, I agree. That makes sense."

I hate to say that the provider is bad at coding, and that's why, things get missed. I would often tell them like, "Man, I could never be a medical coder, like looking through hundreds of pages and documenting." I would not be good at it, so I have complete respect for that job and how things can get messy.

Tegus Client
Cool. Thank you again for taking the time to speak with me today. Enjoy the rest of your day.