COLORADO
Department of Health Care Policy & Financing

*Federally Qualified Health Centers effective on or after October 1, 2022
Non-Federall Qualified Health Centers effective on or after January 1, 2022

APM 2 Chronic Condition Risk Adjustment

Each provider receives an initial risk adjusted threshold, based on the statewide baseline and risk adjusted to align with the demographic profile and level of acuity/comorbidities for their most recently attributed membership prior to the start of the performance period.

The Department's actuary, Optumas, developed risk adjustment factors specific for this program, based on the statewide data for the 12 chronic conditions. The risk adjustment factors are based on actual observed variation in episode cost due to category of aid, gender, number of comorbidities (chronic conditions), and the number of any behavioral health conditions. These factors were based on actual Colorado data. Multiple years of data were used to develop the factors to provide a higher level of episode volume to address credibility concerns, and to provide more stable factors. Optumas was able to use multiple years of data since the calculations were on a statewide-basis and were not impacted by changes in attribution for prior years.

Each of the risk factor categories, and the methodology used to calculate those risk scores, are noted below:

- *COA*: the category of aid (COA) risk adjustment factors are based on the observed variation in cost by episode type based on the four main population categories of AA (adults), AC (children), DA (disabled adult), and DC (disabled children). This calculation was only for members with no comorbidities or behavioral health conditions, to ensure those factors did not influence the COA risk factor.

- *Gender*: the gender risk adjustment factors are based on the observed variation in cost by episode type based on Gender within each COA. This ensures that variation observed by gender is normalized for, and not impacted by, variation in COA. This calculation was only for members with no comorbidities or behavioral health conditions, to ensure those factors also did not influence the Gender risk factor.

- *Comorbidities*: the comorbidity risk adjustment factors are based on the observed variation in cost by episode type based on the number of additional chronic conditions identified for a member. Chronic conditions in this context are the same 12 chronic conditions under the gainsharing model. The comparison of variation of cost was normalized for variation in COA and Gender to ensure those factors did not influence

the comorbidity factors. The risk factors are specific to each incremental increase in the number of additional chronic conditions/comorbidities from 1-7, and for 8+ comorbidities. The 8+ group was selected due to small sample size at that level. This calculation was only for members with no behavioral health conditions, to ensure those factors also did not influence the comorbidity risk factor.

- *Behavioral Health*: the behavioral health risk adjustment factors are based on the observed variation in cost by episode type based on the number of other chronic conditions identified for a member. The comparison of variation of cost was normalized for variation in COA, Gender, and comorbidity level to ensure those factors did not influence the behavioral health factors. The risk factors are specific to each incremental increase in the number of behavioral health conditions from 1-3 and for 4+ conditions. The 4+ group was selected due to small sample size at that level. The behavioral health conditions used for this adjustment are:
    - Bipolar Disorder, Schizophrenia, Depression & Anxiety, Trauma & Stressors Disorders, and Substance Use Disorder.

The risk adjustment factors were tested for their predictive value, by comparing the actual episode cost in the statewide data to the predicted episode cost based on each member's demographic and comorbidity information. The results in the predictive value of the risk adjustment were consistent with levels found in other well established and widely used risk adjustment tools (Medicaid Rx, CDPS + Rx).

To establish the initial risk adjusted threshold for each provider, each of their most recently attributed members are given a risk score based on the criteria they meet for the above risk score factors. That score is aggregated for each member, and applied to the statewide baseline threshold for each chronic condition that member is identified as having. This risk adjusted threshold for each of the provider's attributed members is then aggregated across the 12 chronic conditions based on the mix of conditions for their members.

A final aggregate risk adjusted threshold will be calculated at the end of the performance year to account for the final attributed membership that the provider is eligible to receive shared savings for the performance period. This will include mix adjustment across the of chronic conditions and application of risk adjustment to align with their final attributed membership.

This final aggregated threshold is known as the Acceptable Threshold and will be the basis for calculating shared savings when compared to the actual performance period expenses. The provider will only be eligible to receive shared savings if they meet a Minimum Savings Rate (MSR) of 2%. The MSR adjusted threshold is known as the Commendable Threshold. The MSR is applied to ensure that savings achieved are due to measurable interventions and not

random fluctuation in costs from year to year. Appendix III outlines a sample calculation of a provider specific thresholds, including risk adjustment.