Society of Actuaries®

Health '26 Meeting

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ASOP No. 56—Modeling Meets Medicaid Risk Adjustment in New Academy Practice Note

July 23, 2026

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- **Do** alert SOA staff and/or legal counsel to any concerning discussions
- **Do** consult with legal counsel before raising any matter or making a statement that may involve competitively sensitive information.

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All numbers and charts are mock data and for illustrative purposes only.

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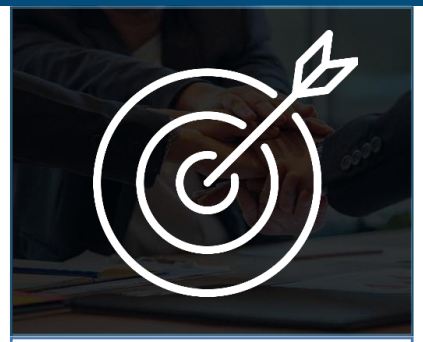

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Housekeeping

- Polling questions
- Q&A at the end of the session, time permitting

What Are Practice Notes?

- Examples of current and emerging approaches
- Non-binding
    - Often overlap with Actuarial Standards of Practice (ASOPs)

Risk Adjustment Practice Note Summary

- Medicaid (excluding long-term services and supports)
- Groupers versus component-weighted regression
- Concurrent versus prospective weights
- Medicaid program design and data interaction
- Data credibility
- Risk weight modeling and diagnostics

Risk Adjustment Primer

- Risk adjustment predicts expected cost from health status
  - Pay for acuity to control for selection bias
- Costs are usually in relative terms (1.0000 is average cost)
- Costs modeled by additive diagnoses or single grouper

Our Panelists

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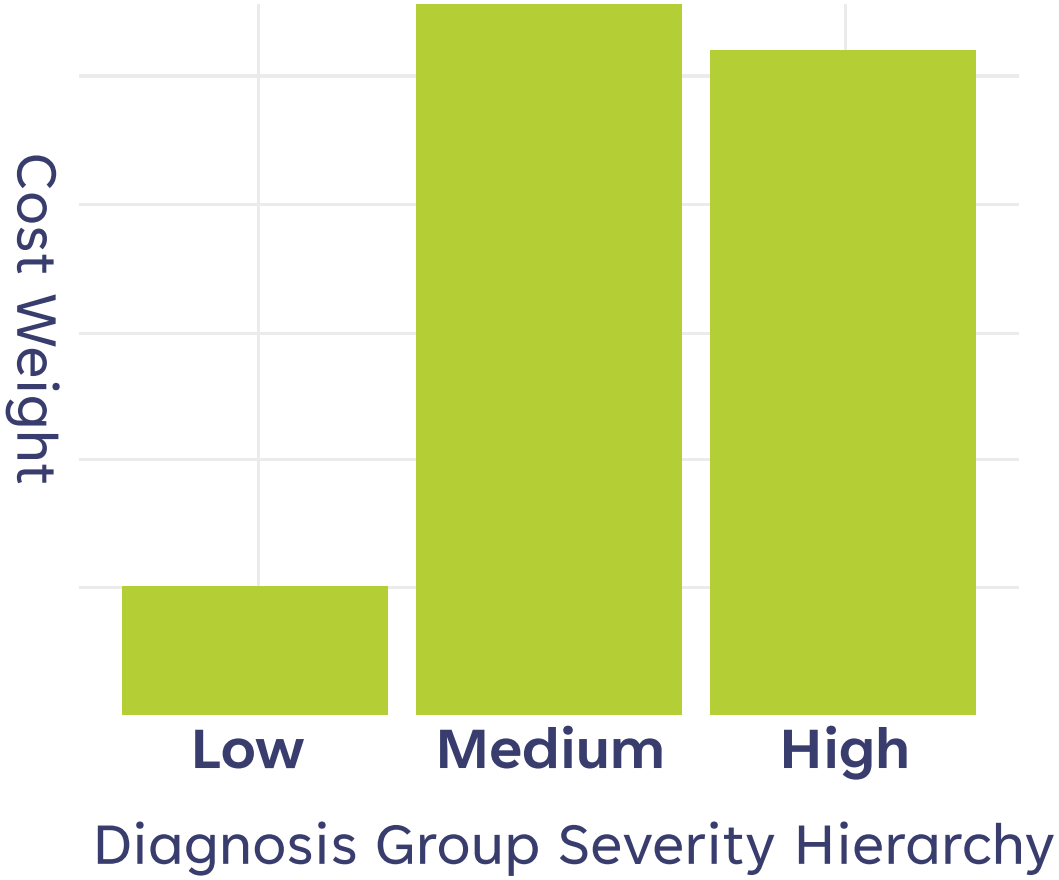
Question No. 1: Monotonically Increasing Cost Weights



For models with disease hierarchy weights, **how do you view a cost weight pattern with non-monotonically increasing weights?**

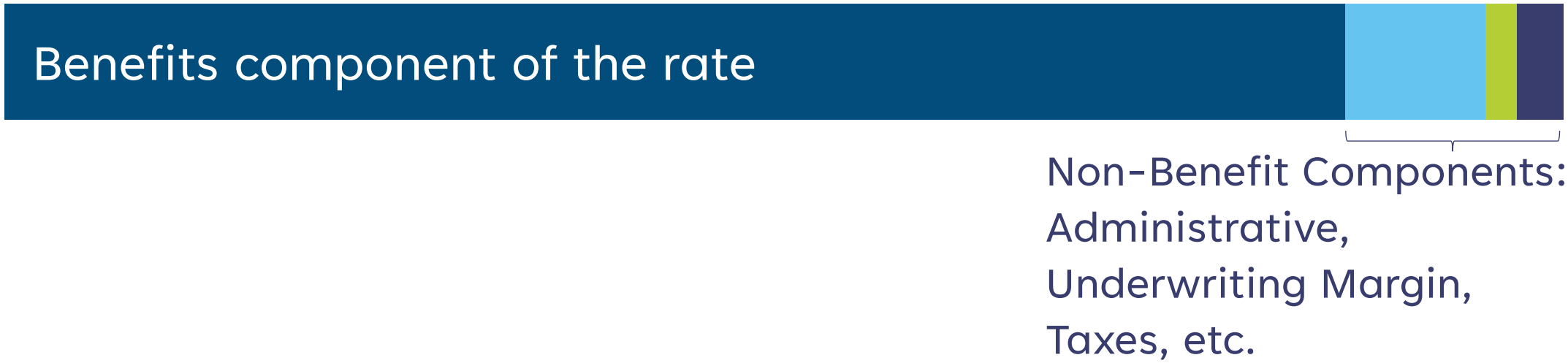
- *For example, Pulmonary regression coefficients:*
  - *Low* 0.5
  - *Medium* 2.9
  - *High* 2.6

Poll No. 1 (Q1): How Would You Handle Non-monotonically Increasing Weights?

A. Use the weights as they are
B. Retrain: Keep both coefficients constrained to equal/increasing weights
C. Retrain: Combine the severities into one coefficient
D. Retrain: Posterior weights with external data (i.e., Bayesian priors)
E. Other

Question No. 2: Non-benefit Components

- **Should any or all of the non-benefit component of a Medicaid capitation rate be risk-adjusted?**



Question No. 3: Rate Cells

- Risk adjustment and rate cell stratification are partial substitutes as both aim to match payments to expected costs. **If the risk-adjustment model is predicting well, how do you decide how many rate cells to maintain?**

Question No. 4: Little Data

- Sometimes a beneficiary has few experience months. **What are ways to handle this issue?**

Poll No. 2 (Q4): How Would You Score a Beneficiary with Little Data?

A. Exclude them
B. Score them the average of all other scored beneficiaries
C. Score them on subtotal average (e.g., geo./demo., managed care plan)
D. Score them with a blend of group average and experience (credibility blending)

Question No. 5: Newer AI Methods

- Generative AI models have been used to review electronic medical records or claims to recommend *diagnosis codes* given doctor notes or procedure codes. **Which stakeholders are financially benefitting from this type of generative AI use?**

Poll No. 3 (Q5): Currently, Which Stakeholder Financially Benefits the Most from Generative AI Use?

A. Beneficiaries
B. Healthcare providers
C. Electronic health record companies
D. Insurers
E. State Medicaid agencies
F. Companies selling AI services
G. All of the above
H. None of the above
I. Feels like an SOA multiple choice exam

Q&A

- Enforcing monotonicity
- Portion of capitation to adjust
- Rate cell level-of-detail
- Credibility and unscored beneficiaries
- Generative AI and diagnosis coding
- Other!

For more information, please contact

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Questions?

Provide Your Feedback

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