

HEALTH WEALTH CAREER

# MERCER GOVERNMENT HUMAN SERVICES CONSULTING

## ACTUARIAL/FINANCIAL



# MERCER GOVERNMENT HUMAN SERVICES CONSULTING

## ACTUARIAL CONSULTING

Since 1985, Mercer has consulted with more than 30 states and the federal government on a wide variety of health care and human services issues, including actuarial, data/systems analysis, clinical, policy, pharmacy, operations, and procurement.

State, county, and local governments face numerous challenges as they work to continue providing quality health care to more people while dealing with tightly constrained budgets. Budget crises, increasing enrollment, escalating health care expenditures, challenges with splintered and less-than-optimal health care delivery systems, and escalating demands for health plan oversight and accountability are some issues that present unique obstacles to each state and require innovative solutions.

In addition, the landscape of government-sponsored health care programs is changing. This is evidenced by the release of initiatives that came about primarily as a result of provisions under the Patient Protection and Affordable Care Act (PPACA). These initiatives are changing the delivery and financing of health care in the United States and include such topics as health home models, accountable care organizations, health insurance

exchanges, and increased focus on duals integration and managed long-term care programs by the Centers for Medicare and Medicaid Services (CMS).

Mercer's Government Human Services Consulting team provides consulting assistance built on actuarial knowledge, consulting experience, and creativity to develop comprehensive solutions for its clients. With the increased emphasis CMS is placing on actuarial expertise, Mercer is well-positioned to assist clients on a variety of topics ranging from traditional capitated rate setting to program development and compliance with these new health care delivery models.

Mercer's actuarial consultants have assisted with a variety of issues, including:

- Actuarially sound capitation rates and rate ranges, with CMS rate approval.
- Risk adjustment for capitation rates.



- Creative alternatives for full-risk and partial-risk contracting, including stop loss, reinsurance, and risk corridors.
- Cost effectiveness and budget neutrality analysis for 1915(b), 1915(c), and 1115 waivers.
- Managed long-term care capitated rate setting.
- Health home reimbursement analysis.
- Accountable Care Organization shared-savings target development.
- Financial analysis related to duals integration projects involving Medicaid and Medicare funding.
- Actuarial analysis to support the development of state exchange programs as well as the basic health plan option.
- Cost evaluation of expansion populations, including the expansion of Medicaid coverage under PPACA.
- Focused data-driven efficiency studies related to health plan management of emergency room utilization and potentially preventative inpatient admissions, as well as management of pharmacy.
- Health plan reviews for compliance and efficiency benchmarking.
- Financial impact of legislative changes and legislative testimony.
- Policy and program strategy, design, and development.
- Technical assistance sessions, including contract/rate negotiations with health plans.
- Primary Care Case Management (PCCM) program enhancement strategy.
- Identification of efficient provider networks.

## A CASE STUDY

### Situation

As state-managed care programs have become reliant on managed care financial and encounter data as sources for rate-setting calculations, questions have been raised as to how the resulting rates reflect the concept of value-based purchasing, which is a key tenet of many states' purchasing strategies. To address these concerns, Mercer has performed medical efficiency analyses, using program encounter data, when developing Medicaid managed care capitation rates. Managed care organization (MCO) historical data are used as a base. If the historical MCO program experience contains evidence of inefficient medical management, efficiency adjustments are used to set appropriate rates. This approach ensures that using MCO historical experience does not result in cost-plus rate-setting. State Medicaid programs can demand optimal and achievable value from their contracted MCOs.

### Challenge

Action is needed to make our health care system more efficient and to ensure more consistent delivery of high-quality care while improving patient safety. As one of the largest groups of health care purchasers, states play an important role in identifying opportunities for implementing successful cost-containment strategies and enhancing efficiencies in the delivery of care, which can free up dollars for other state priorities. By emphasizing care provision in physician offices and other community settings, patient safety is also improved by avoiding escalations of manageable chronic conditions and preventing hospitalizations or unnecessary emergency room visits.

Mercer's medical efficiency analyses focus on drivers of health care costs and support value-based purchasing approaches that are consistent with a prudent purchasing strategy. These analyses are predicated on national guidelines/best practices and supported by national literature reviews and health services research. The underlying methodology was developed by an expert panel consisting of physicians, nurses, and pharmacists with managed care experience. Through this process, Mercer applies clinical expertise to various data-driven/analytical approaches using the managed care program encounter data to identify unnecessary health care expenditures that can be addressed through improved efficiencies and care management processes.

### Action

**Low Acuity Non-emergent (LANE) Emergency Room Analysis**

Emergency room (ER) visits are expensive, costing two to three times as much as visits in a physician's office. Research published by the Centers for Disease Control and Prevention indicates that approximately 31% of ER visits in the United States are for nonurgent events or visits requiring immediate service.<sup>1</sup> Mercer's LANE analysis employs approximately 500 ICD-9 codes, which research indicates can be representative of instances in which an ER visit could have been avoided had effective outreach, care coordination, and access to preventive care been available. Based on industry best practices and supporting literature, Mercer developed a data-analytic procedure to identify low to moderate acuity diagnosis codes that could potentially be avoided. Some examples of conditions included in this type of analysis are fever, headache, cough, rash, and removal of sutures.

### Potentially Preventable Admissions (PPA) Inpatient Analysis

Many hospitalizations represent ambulatory care failures. According to the Agency for Healthcare Research and Quality (AHRQ), one out of every 10 hospital stays was potentially preventable (based on 2008 data).<sup>2</sup> Mercer's PPA analysis identifies inpatient admissions that could have been avoided in the managed care programs through high-quality outpatient care and/or reflect conditions that could be less severe and not warrant an inpatient level of care if treated early and appropriately. These are identified through claims data using criteria from the AHRQ's Guide to Prevention Quality Indicators and Pediatric Data Indicators, with additional filters applied to better understand MCOs' ability to prevent the admissions in the Medicaid environment.

### Results

As a result of these clinically informed, data-driven analyses, Mercer actuaries have incorporated medical efficiency adjustments into the development of actuarially sound capitation rate ranges. These adjustments, based on sound clinical input, have reduced the MCO capitation rates to reflect clinical medical efficiency targets, even after factoring in the offset of expected increases in physician and other outpatient costs. The results vary by state, but the following ranges should help inform the magnitude of each measure:

- LANE adjustments: typically 5%–10% of total ER costs.
- PPA adjustments: typically 3%–5% of total inpatient hospital costs.

<sup>1</sup> Nawar EW, Niska RW, and Xu J. "National Hospital Ambulatory Medical Care Survey: 2005 Emergency Department Summary," Division of Health Care Statistics *Advanced Data for Vital and Health Statistics*, Number 386 (2007), available at <http://www.cdc.gov/nchs/data/ad/ad386.pdf>.

<sup>2</sup> Stranges E and Stocks C. "Potentially Avoidable Hospitalizations for Acute and Chronic Conditions, 2008," AHRQ's *Healthcare Cost and Utilization Project (HCUP) Statistical Brief*, Number 99 (2010), available at <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb99.pdf>.

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## MERCER GOVERNMENT HUMAN SERVICES CONSULTING

### HEALTH-BASED RISK ADJUSTMENT

States dedicated to fair payments and data-driven results should consider risk adjustment models for assessing population risk and adjusting capitation payments. In the late 1990s, Mercer worked alongside several early-adopter states that were pioneers in the area of risk adjustment. Since that time, Mercer has assisted more than a dozen states in implementing and maintaining Medicaid risk adjustment payment systems.

#### APPLYING TECHNOLOGY TO GAIN BETTER OUTCOMES

Health-based risk adjusters are statistical models that correlate disease burden with underlying population costs. These models are an improved method for evaluating risk. In fact, research studies sponsored by the Society of Actuaries and other organizations have found that health-based risk adjustment models perform significantly better than traditional demographic approaches alone.

#### PROACTIVELY ADDRESSING THE ISSUE OF “FAIR” PAYMENTS

Adverse selection can be a large concern within any payment arrangement. Payment structures should be designed to reward providers appropriately. Conversely, providers should be discouraged from targeting healthier members through “cherry picking” practices. While remaining revenue neutral to the state, risk adjustment effectively differentiates enrolled risk by the actual illness burden of each entity’s service population.



## BROAD IMPLEMENTATION OF RISK MODELS

Risk adjustment was first implemented in the 1990s by a few state Medicaid programs. Since then, many other states and government-based programs have adopted health-based risk adjustment models, including:

- More than 20 state Medicaid programs.
- Medicare Part C (Medicare Advantage).
- Affordable Care Act individual and small group exchanges.

## ARE RISK ADJUSTMENT MODELS ONLY USED TO ADJUST CAPITATED PAYMENT RATES?

Risk adjustment models can be used for a variety of purposes. Understanding the health risk of the general population allows actuaries and policymakers to better evaluate programs by:

- Identifying population disease prevalence.
- Targeting high-risk members for disease and case management.
- Benchmarking provider financial performance.

- Evaluating changes in population risk within observed trends over time.
- Estimating the risk of newly eligible or expansion populations.
- Assessing clinical efficiencies and predictive modeling.

## CATALYST FOR ENCOUNTER DATA IMPROVEMENT

Since risk adjustment requires detailed administrative claims data, reporting entities have a large financial incentive to produce accurate and timely information. Many of our clients that have implemented risk adjustment payment systems have seen significant data improvements.

## MERCER IS DEDICATED TO IMPLEMENTING THE BEST APPROACH

Involved from the beginning, Mercer has built a robust team of highly skilled individuals to assist clients with developing risk adjustment payment methodologies. Our approach is to walk step by step through each policy decision to make certain our clients use the right method for each unique environment.

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## CASE STUDY

### Situation

Through legislative authority, a state was required to expand Medicaid managed care to populations traditionally covered through the state's fee-for-service (FFS) program. The state planned the expansion as a county-by-county phase-in over several months.

### Challenge

Since the expansion population was not in managed care, no formal financial/cost information was being collected and summarized. Further, the impact on capitation rates was difficult to forecast due to: a) differences in contracting and network affiliations between FFS and managed care, b) challenges with the financial information reported on FFS claims, and c) ramp-up of managed care enrollment through the state fiscal year.

### Action

Mercer worked with the state to develop risk scores for both programs to evaluate the expected costs for each group. The state used the risk score information to adjust existing managed care rates to account for the underlying risk of the incoming FFS group. It then applied monthly risk adjustment to ensure health plans were receiving appropriate payments as the phase-in occurred.

### Result

- This state was able to fully transition FFS members into managed care within the desired timeframe.
- Health plans reported consistent financial performance before and after the transition.
- The state further expanded risk adjustment for payments statewide to all populations covered under managed care.
- Using risk scores to evaluate the health plans' cost effectiveness, the state negotiated rate adjustments that lowered the overall cost of the program.
- The more risk adjustment was applied for payments, the better the health-plan-reported encounter data became.

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### MEDICAID MANAGED LONG-TERM CARE

The Medicaid population, like that of the United States as a whole, is steadily aging. Even though people are generally living longer, it is a statistical fact that as people age, the prevalence of disabilities and disease increases. Typically, individuals with disabilities require more assistance and supportive services — whether from unpaid or paid caregivers, private health insurance, or government-sponsored programs such as Medicaid. As state populations age and Medicaid budgets continue to expand, states are faced with increasing costs from this growing cohort but have limited resources to meet the growing need.

Furthermore, surveys and studies of consumers indicate the same result: **People prefer to remain in their homes and communities rather than be institutionalized.** Despite their preferences, consumers may be directed toward institutional services because of public funding or public-policy preferences.

Many policymakers have looked to managed care as a tool to help improve long-term care (LTC) and the overall health care systems, including institutional and home and community-based services (HCBS). Many see the benefits of having a dynamic and consumer-friendly care delivery system in which the needs of the elderly and individuals with disabilities

are met through various community-based care settings, with quality of life, functional health status, and consumer input promoted, measured, and evaluated. The goal is to improve the quality of life and health status of individuals who lack the financial, physical, or cognitive resources and abilities to completely care for themselves.

Managed LTC models have been effective in a number of states in reducing unnecessary hospitalizations and nursing home utilization, increasing access to HCBS, streamlining administration, increasing consumer satisfaction, and developing capitation rates and contracts to reflect and





incentivize the provision of HCBS. Removing system fragmentation, rebalancing nursing home utilization with HCBS alternatives, and improving the quality of care through better care coordination are reasons cited by many states for considering integrated managed care models for their Medicaid-eligible populations. Some programs focus on individuals needing LTC services and support, while others focus on those services, while additionally integrating services for healthy enrollees (that is, physical and/or behavioral health services).

**A benefit of Medicaid-capitated managed care** is the flexibility to adjust the capitation rates and contracts to create incentives for the provision of HCBS. This approach can be accomplished in multiple ways, such as:

1. Using specific waiver authority and provisions to use savings in state plan services to contractually require plans to provide additional non-state plan services, such as HCBS.
2. Building non-state plan community-based services into managed care rates, considering cost-effective alternatives, such as HCBS, to more costly covered state plan services, such as institutional care.
3. Including community-based services in managed care contracts and rates if separate waivers or state plan provisions make such services available.

## MERCER CAN HELP

With an interdisciplinary team of policy consultants, actuaries, accountants, clinicians, and information technology experts, Mercer can help bring an entirely new managed care program to reality or assist states in expanding or improving existing programs. Mercer has assisted states with the following:

- Strategic program planning, including program design and waiver development.
- Support in CMS negotiations.
- Facilitation of stakeholder meetings to determine the level of support and identify potential barriers.
- Development of budget and savings estimates.
- Procurement assistance.
- Actuarial rate development and analysis.
- Health plan financial reporting and monitoring.
- Review and assistance in the modification of assessment instruments.
- Contractor readiness reviews.
- Design of an encounter data collection system and evaluation of encounter data.
- Financial reporting tools.
- Development and monitoring of performance measures for the LTC population.

## CASE STUDY

### Situation

The state governor and Medicaid agency had approved exploration of a statewide Medicaid managed care model to serve Medicaid eligibles, with full service coordination including acute and LTC services. The costs for LTC services were rapidly increasing, creating additional strains on the state Medicaid budget.

### Challenge

The state policymakers wanted to start managed LTC for Medicaid eligibles very quickly after obtaining approval. The state already provided Medicaid managed care for physical health services.

### Action

Mercer worked with the state, potential managed care plans, and the Centers for Medicare and Medicaid Services (CMS) to make the Medicaid managed LTC program fully operational.

The project included:

- Developing an options paper for review by state policymakers.
- Facilitating an options discussion and developing a better understanding of option implications.
- Developing the concept paper and waiver application, participating in negotiations with CMS and the state.
- Revising contract language, adding LTC service requirements.
- Conducting readiness reviews to confirm that contractors were ready to provide LTC services.
- Calculating the actuarially sound rates to ensure appropriate payments to the contractors.
- Creating strategies to overcome implementation and operational challenges.

### Result

The state successfully implemented the Medicaid managed care model, meeting state policymaker requirements. The state received approval from CMS on the waiver and was able to add the additional services to currently functional managed care plans.

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### MEDICAL LOSS RATIO: NOT AS BAD AS IT SEEMS

New medical loss ratio (MLR) requirements play a prominent role in the Centers for Medicare and Medicaid Services (CMS) Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, including impacts on capitation rate setting. With all the MLR provisions put forward, it suggests a lot of work ahead for states; however, things may not be as bad as they seem. Although formal CMS MLR rules are new to Medicaid, they're in alignment with the Affordable Care Act private market and Medicare Advantage MLR standards, with minor deviations. Additionally, capitation rating processes may already be achieving the applicable MLR requirements.

#### MLR REQUIREMENTS

The CMS Medicaid and CHIP Managed Care Final Rule's MLR requirements go into effect for contract rating periods beginning on or after July 1, 2017. At least 85% of after-tax premium must go toward paying claims (including quality improvement activities). In other words, no more than 15% of after-tax premium can go toward administrative costs (which exclude taxes/fees) and underwriting gain (cost of capital and risk loading). For managed care contract rating periods starting July 1, 2019, or later, actuaries must certify that each capitation rate is set to reasonably achieve an MLR at or above an 85% minimum.

Here's what Mercer's seeing evolve from these requirements:

- **No later than rating period for contracts starting on or after July 1, 2017 – MLR Standards**
- **No later than rating period for contracts starting on or after July 1, 2019 – Section 438.4(b)(9): Develop capitation rates so that health plan can reasonably achieve an MLR of at least 85%**

#### WHAT ARE STATES CURRENTLY UP TO?

##### Updating MCO Contracts

For contracts that start on or after July 1, 2017, many states are requiring the calculation and reporting of MLR by the MCOs within 12 months after the end of the contract year.

Requirements of MCOs include providing calculation back-up detail,





demonstrating consistency (or a comparison) with financial reports, attesting to calculation accuracy and revising MLR if rates are adjusted retroactively.

Considerations made by states include determining when an MCO calculates, reports and attests to its MLR; establishing a minimum MLR higher than 85% — such as for managed long-term services — that supports populations that typically require lower administrative expenses on a percentage basis; and determining separation/aggregation of populations/contracts for measurement purposes, such as physical health, long-term care, CHIP and expansion populations. (MCOs may prefer MLR standards be set at the highest level of aggregation so that low/er MLRs on population segments can be offset by high/er MLRs on other segments. A state's decision about the level of aggregation will be significant.)

### Developing MLR Reporting Templates and Instructions

Many states are developing templates to be used by MCOs, including determining details of the MLR calculation's numerator and denominator.

### Considering Requiring Remittances From MCOs

These requirements may include:

- a) Having discretion to exempt newly contracted MCOs from MLR requirements during their first year
- b) Applying a credibility adjustment, to be developed by CMS for smaller MCOs, where lower membership leads to higher MLR volatility due to random statistical variation

### Preparing State Oversight Standards

Standards include:

- a) Reporting to CMS a summary of outcomes of MLR calculations
- b) Publicly displaying MCO MLR performance annually
- c) Specifying a methodology for the repayment of the federal share of any remittances
- d) Considering optional "auditing" of MCOs' MLR calculations and reporting

### Making a List of Challenging Aspects of the MLR Provisions

There may be alternatives, and states could be

afforded flexibilities by engaging CMS in discussion:

- a) For example, MCOs must submit MLR reports within 12 months of the end of the MLR reporting year. Is this enough time for states to reconcile incentive and withhold arrangements?
- b) The calculation formula is relatively straightforward. However, CMS acknowledges that a lot goes on in Medicaid that is not part of the private market or Medicare Advantage. States may need more details. Here are a few examples of questions from states:

*Should fiscal intermediary administrative costs for self-directed services be accounted for in the numerator of the calculation?*

*How are services rendered in an institution for mental disease accounted for in the calculation?*

*If Medicaid and CHIP are accounted for in the same actuarial rate certification in a blended manner, how is the CHIP MLR to be calculated and reported?*

### WHAT'S NEXT?

The Final Rule explicitly connects MLR to capitation rates. The good news is that capitation rating processes that use current Medicaid managed care base data experience are likely already achieving this Final Rule requirement. Generally, actuaries build in less than 15% of premium for administration and underwriting gain. On the flipside, capitation rating processes that use older Medicaid managed care base data; other base data sources, such as fee-for-service data for newer managed care programs; or have historically had more than 15% of premium allocated to administration and underwriting gain for some rate cells will require special attention. Actuaries will be reviewing priced-for MLRs in rate development, but they will also consider that historical MLR is just one of many factors considered, and historical MLR results alone do not necessitate prospective rate adjustments. Higher targeted MLRs in capitation rates are allowable as long as rates "are adequate for reasonable, appropriate, and attainable non-benefit costs." – 42 CFR 438.4(b)(9).

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### OVERCOMING THE VBP CHALLENGE

How will you maximize your Medicaid dollar while increasing access and quality in an uncertain healthcare environment?

Medicaid directors are challenged to answer this question and to accelerate transition of their programs to value-based payment models. Maximizing Medicaid funds while improving access and quality is critical at this time. Designing a value-based purchasing (VBP) program in this environment can be difficult, as states are expected to function with fewer resources. It is important that a VBP plan address the unique program needs, goals and challenges particular to a state's Medicaid program.

In CMS's November 22, 2013 (letter four in a series) State Health Official letter, five key components were outlined regarding designing and implementing care delivery and payment reforms in Medicaid and CHIP programs.

The five key components include:

- Goals
- Interventions
- Metrics
- Targets
- Transparency and feedback

### LET'S LOOK DEEPER

#### GOALS

Defining your VBP goals is integral to developing your VBP plan and your quality strategy. Clear program goals lead to the identification of appropriate quality metrics to measure whether value and quality goals are being met. It is important to identify goals that offer the greatest return on investment while navigating the complex stakeholder landscape, including gaining approval from state legislators and CMS. A well-defined quality strategy and VBP plan should incorporate short-term and long-term program goals.



## INTERVENTIONS

Having the right tools and the right experience is critical for states during the implementation of interventions that achieve VBP goals. Understanding clinical quality and delivery system innovation ensures a smoother implementation and continuous improvement process. States will also need partners to help with translating interventions to policy, revising quality strategy documents and ensuring managed care contracts include VBP. States may want to consider building alternative payment methods, from pay-for-performance to bundled payments and shared savings models.

## METRICS

Selection of quality metrics is a surprisingly complex process and one of the primary areas that can lead to VBP program success or failure. States may face barriers to measure selection due to incomplete and unreliable data, or lack of availability of data or inability of providers to submit data, particularly in the early implementation stages of a VBP program. However, appropriate measure selection is critical to effectively assess the impact of the interventions and calculate savings or performance awards/penalties. Although we advocate for the use of nationally recognized measures, a state should also consider the development of state-specific technical specifications for “homegrown” outcome measures that evaluate preventable high-cost utilization, including low-acuity, non-emergent emergency department utilization, preventable admissions and readmissions and address gaps in care and population health discrepancies.

## TARGETS

Establishing expectations for improvement in a VBP program and communicating those to stakeholders has proved critical in promoting the type of transparency

that providers and other VBP partners demand. We believe it's important to model a variety of improvement scenarios and commensurate incentives/disincentives. These scenarios include improvement above set thresholds, percent and percentage-point improvement, and improvement relative to others in the market.

## TRANSPARENCY AND FEEDBACK

Accurate, consistent and timely feedback is needed to ensure that all stakeholders in a VBP program are aware of the trajectory of their performance. This could include developing interim reporting to VBP partners to ensure they are able to address healthcare gaps, population health drivers, racial disparities and other key quality and utilization metrics. Transparency and feedback considerations must be designed to meet providers where they are and now require building provider readiness — only then can providers take the necessary steps to improve. Thus, developing reporting solutions that provide VBP partners with the information they need to achieve the VBP goals is essential, as is demonstrating VBP program success to stakeholders. We've learned that it's critical to provide clear data translated into meaningful information in a dynamic presentation for a wide variety of audiences.

## IN CONCLUSION

Value-based purchasing and alternative payment models are complex and require significant expertise and resources to develop a plan that ensures state value and quality goals are met while appreciating the pressure on providers to transform their care delivery models. Now is the time to prepare for these goals, even while the healthcare environment is fluid and uncertain.

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# MERCER GOVERNMENT HUMAN SERVICES CONSULTING

## ADDRESSING THE PROBLEM OF LOW ACUITY NON-EMERGENT ED VISITS

### A CLINICAL EFFICIENCY ANALYSIS APPROACH TO INFLUENCING QUALITY OF CARE STRATEGIES AND REDUCING AVOIDABLE HEALTH CARE COSTS

Since 1985, Mercer has consulted with more than 30 states and the federal government on a wide variety of health care and human services issues, including actuarial, data/systems analysis, clinical, policy, operations, and procurement.

Emergency departments (EDs) have become the front door to health care for many Americans — often for non-urgent and even routine health care problems. The costs of these low-acuity ED visits can be more than triple the cost of treatment in a primary or urgent care setting. In fact, according to medical-expenditure survey data from the Agency for Healthcare Research and Quality, the mean cost for ED visits in 2011 of \$1,354 was more than six times higher than the 2009 mean cost of a physician office visit (primary and specialty care average) of \$218. Overall, estimates of waste in the health care system related to unnecessary ED visits totaled approximately \$14 billion in 2010, not including replacement costs had services been delivered in a more appropriate setting.

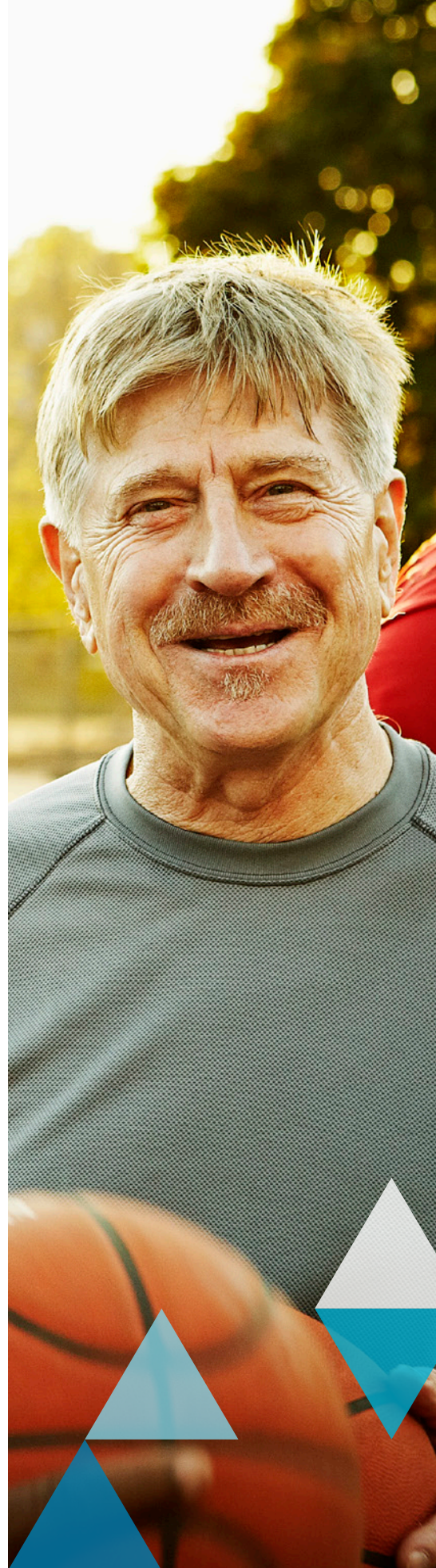
As rising health care expenditures continue to contribute to both federal and state budget costs, many Medicaid directors, state policymakers, and stakeholders are interested in understanding and curtailing inappropriate and avoidable use of the ED. A January 2014 CMCS Informational Bulletin documented that Medicaid beneficiaries used the ED at almost a twofold higher rate than privately insured counterparts.<sup>1</sup>

From the perspective of achieving the triple aim (better health quality, better experience of care, and sustainable cost), consider that EDs were designed to treat the most critically ill and injured patients as well as to act as a safety net during public health emergencies such as catastrophic events, epidemic outbreaks, and even terrorist attacks. Inappropriate ED utilization can negatively impact hospital resources (resulting in overcrowding and long wait times), contribute to fragmented care, and cost health programs significantly more than alternative settings. A 2010 RAND Corporation study indicated that between 14% and 27% of all ED visits

<sup>1</sup> Center for Medicaid and CHIP Services. "Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings," *CMCS Informational Bulletin* (2014).

<sup>2</sup> Rand Health Corporation. *The Evolving Role of Emergency Departments in the United States* (2013).

<sup>3</sup> Stange KC. "The Problem of Fragmentation and the Need for Integrative Solutions," *Annals of Family Medicine*, Volume 7, Number 2 (2009).



for non-urgent reasons could take place in an alternate location, resulting in potential cost savings of \$4.4 billion annually.<sup>2</sup> Additionally, fragmented care increases inefficiency, ineffectiveness, and inequality within the health system.<sup>3</sup>

## A STANDARDIZED APPROACH

There is no lack of research on the topic of ED usage. However, nationally, there is a shortage of consistent terminology and methodology for studying inappropriate and/or avoidable/preventable ED usage. This makes it difficult for researchers, Medicaid program directors, hospital administrators, and even managed care organizations (MCOs) to analyze, compare, and study interventions to address aberrant ED utilization patterns.

Mercer's Low-Acuity, Non-Emergent (LANE) analysis was built specifically to identify and quantify the impact of LANE ED usage. Our analysis is underpinned by extensive health-services research, with additional input from an expert panel that includes ED physicians, state Medicaid chief medical officers, and other clinical providers with Medicaid and MCO experience.

Mercer's LANE ED analysis provides a systematic and evidence-based approach for evaluating trends and patterns of ED utilization. Mercer's approach is differentiated in the marketplace, as we analyze a number of data points — such as diagnosis, physician evaluation and management coding, and treatment rendered during the ED event — to quantify the preventable LANE utilization in a given state or population. Mercer's analysis includes methodology to identify potentially unavoidable costs (that is, treatment cost for services such as laboratory and radiology testing that would have occurred regardless of treatment setting), considers the cost of

providing the care in an alternate setting, and adjusts the results to account for these costs. Thus, our analysis identifies both the avoidable costs and the “replacement” costs for services provided at an alternate setting.

## IMPACT AND INFLUENCE

Mercer's approach to management of LANE ED utilization is based on robust clinical and actuarial analysis. This approach can be used to assist states as they focus their attention on value-based purchasing strategies and eliminating inefficiency and waste. The LANE analysis provides objective data in a useful dashboard format for state Medicaid agencies to leverage in improving collaboration with their health care delivery partners — such as MCOs, accountable care organizations, medical homes, and fee-for-service providers.

Through our extensive and ongoing research, we have identified consistent themes of **actionable barriers** that vested stakeholders, such as Medicaid MCOs and state Medicaid agencies, can focus on to make an impact. The most common include:

- Access to providers (primary and specialty care).
- Availability:
  - Lack of timely available appointments for providers.
  - Lack of after-hours and weekend care with primary providers.
- Inadequate or lack of chronic condition care coordination.
- Lack of integrated electronic health information systems available for use by ED staff and physicians.
- Payment strategies that do not promote use of alternative ED settings.
- Travel/transportation to services.
- Lack of enrollee education on signs and symptoms appropriate for an ED visit.

Each of these causes can be addressed and appropriately managed to mitigate the inclination to seek care in an ED setting. Despite the complexities involved, LANE analysis can provide a standardized and consistent approach for measuring and quantifying the impact of LANE ED utilization on the health care system. This standardized approach facilitates meaningful discussion with multiple stakeholders to drive sustained improvement.

## APPLICATION OF THE LANE ANALYSIS

The LANE analysis can be applied in many ways. Some states choose to use LANE as part of the actuarial rate-setting process for managed care contractors, while others may use LANE as a measure within a pay-for-performance program or as a quantifiable measure within a performance-improvement project.

As states continue to implement innovative health care reform initiatives, Mercer's LANE analysis can play a critical role in informing health system performance, as uncontrolled ED utilization is often a signal for inefficiencies in other areas of the health care service delivery continuum.

For more information, please contact a Mercer representative at one of the following offices:

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# MERCER GOVERNMENT HUMAN SERVICES CONSULTING

## LEVERAGING MEDICAID

### STRATEGIES FOR EFFICIENT USE OF FUNDS

Since 1985, Mercer has consulted with more than 30 states and the federal government on a wide variety of health care and human services issues, including actuarial, data/systems analysis, clinical, policy, pharmacy, operations, and procurement.

As states face declining tax revenues and the changing health care environment, the efficient use of state funds is more critical than ever. Leveraging Medicaid through state plan design and the strategic use of waivers can help finance critical services. States cannot afford to ignore strategies that leverage Medicaid and “braid” state funds and block grants to provide cost-effective services with proven outcomes.

#### HOW MERCER CAN HELP

Mercer’s team offers state health and human services leaders opportunities for improved leveraging of state funds, increased accountability, and sound strategies that accomplish service and financial goals by:

- Comparing a state’s current Medicaid program to options for leveraging additional funds.
- Braiding other state-only and block-grant funding sources to leverage Medicaid funds.





# MERCER GOVERNMENT HUMAN SERVICES CONSULTING

## DESIGN OF MEDICAID MANAGED CARE OVERSIGHT MODELS FOR STATES

Since 1985, Mercer has consulted with more than 30 states and the federal government on a wide variety of health care and human services issues, including actuarial, data/systems analysis, clinical, policy, operations, and procurement.

Over the past two decades, there has been a proliferation of Medicaid managed care programs emerging across the country. States, traditionally providing Medicaid benefits through a fee-for-service system, are now shifting to managed care with the goals of decreasing costs while improving beneficiary outcomes. The Centers for Medicare and Medicaid Services reports that almost 50 million people receive benefits through some form of managed care, on either a voluntary or a mandatory basis.

Today, states show greater interest in operating Medicaid managed long-term services and support programs, as well as using managed care as a strategy to contain costs for individuals with other complex needs, such as children and adults with serious mental illness. These populations (for example, individuals with serious mental illness, chronic substance use disorders, intellectual/developmental disabilities [ID/DD], and

aging adults) are now being targeted through the use of fully integrated or specialty plans.

Medicaid managed care programs will almost certainly continue to grow in coming years, adding millions of newly eligible beneficiaries while also focusing more on the aged, the disabled, and the chronically ill. Additionally, state behavioral health and ID/DD agencies are increasingly responsible for oversight of managed care entities but often initially lack the necessary Medicaid and/or managed care expertise.

Mercer has an opportunity to offer a valuable service to states expanding their managed care programs through consultation focused on leadership, oversight, and monitoring of managed care contractors. Rather than the specific managed care model states employ, it is often contractual requirements, fiscal incentives, oversight, and leadership that have the most significant impact on how effectively and efficiently a managed care plan will meet the needs of the population. States must master key areas such as utilization and clinical management, provider-network management, quality assurance, rates and claims, customer service, and appeals and grievances in their oversight role.



## HOW MERCER CAN HELP

The menu of services and products Mercer could market to states include:

### Structural and Organizational Analysis and Enhancement

- Provide analysis of current roles of state agencies and personnel and recommend options to best operate and oversee Medicaid managed care operations. Facilitate development of a relevant, meaningful, and efficient monitoring team.
- Develop a flexible organizational structure/model that supports effective communication and contract-oversight.
- Identify state agency departments/functional units and personnel that will be actively involved with contract-oversight responsibilities, and clarify roles, intra- and interagency collaboration, and coordination needs.
- Identify and/or offer initial and ongoing training and technical assistance to ensure that state and other personnel responsible for oversight have the necessary knowledge, skills, and abilities.

### Optimal Impact of Contracts, Policies, and Standards

- Review and offer revised language for existing contracts (and applicable policies) with managed care organizations (MCOs) to ensure that appropriate contract requirements and standards across key operational aspects (for example, clinical and quality management, access to care, network sufficiency, financial sustainability, reporting) are in place to effectively monitor and hold contractors accountable.
- Identify and implement appropriate contractual remedies that allow for a tiered response to substandard contractor performance that includes technical assistance, training, performance-improvement activities, corrective-action plans, notice-to-cure provisions, and sanctions.

- Analyze, identify, and consolidate the most relevant goals and indicators that will support an ongoing evaluation of performance under the program and managed care contractors.
- Identify how to incorporate less prescriptive approaches to contract management to facilitate innovation and flexibility while preserving overall goals.

### Development of Reports and Effective Oversight Tools

- Identify a set of required reports and data to be included in managed care contracts that promotes the analysis and assessment of targeted system-level performance and summary-level information across contractors, when necessary.
- Identify performance goals, reporting specifications, and reporting frequencies to monitor contractor performance (satisfaction, service-utilization trends, access to care, etc.).
- Explore the use of contractual performance guarantees that can serve to incentivize contractors regarding effective fiscal, operational, and clinical management of the program.
- Develop and publish a system-level report card that facilitates state agency leadership assessment of contractor performance across established performance indicators, and permits statewide and contractor comparisons of performance, and serves as an early warning sign to trigger additional oversight and follow-up.
- Design and/or assist with implementation of targeted performance reviews to evaluate whether meaningful outcomes for recipients and family members (education, employment, reduced incarceration, success in school) are being consistently achieved.

## OUR EXPERTISE

With health care experience throughout the country, Mercer welcomes the opportunity to assist states with strategies to design and implement managed care oversight models. Our experience with state Medicaid clients includes the following:

- Reviewing the MCO's compliance with the state contract.
- Assessing whether the state's quality management strategy (QMS) is relevant and has a robust reporting and monitoring process.
- Writing the state's QMS.
- Proposing and developing the state's MCO oversight structure.
- Creating the reporting templates for MCO monitoring.
- Ensuring that the QMS data are integrated into the state's oversight process and flows to the right state committee for evaluation and action.
- Helping the state evaluate the MCO's performance.
- Evaluating whether the state's solution is working and meeting the QMS and waiver outcomes.
- Constructing data cubes to easily identify and remove costs to understand potential savings when evaluating for continuation of optional services.
- Developing and maintaining a financial dashboard of the MCO's performance that operates as an early warning system.
- Developing and maintaining a quality dashboard of the MCO's performance that operates as an early warning system on identified standards of care.
- Developing performance standards that foster physical health and behavioral health integration.

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