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.

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

ATLANTA	MINNEAPOLIS	PHOENIX	WASHINGTON DC
+1 404 442 3100	+1 612 642 8600	+1 602 522 6500	+1 202 331 5200

www.mercer-government.mercer.com

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.

MARSH & McLENNAN COMPANIES

14242-HB 06052015