

BLIND CASE STUDY:

Strategic Advisory Services Develops Customized Map to Maximize Risk Adjustment Operational and Financial Success



Health plan issuers operating under the authority of section 1343 of the Patient Protection and Affordable Care Act (PPACA) must ensure they are capturing complete and accurate claims and enrollment data to HHS via their EDGE server by the annual April 30th deadline to ensure that their risk adjustment transfer payment is accurate. Risk adjustment transfers funds within a state market risk pool from issuers with lower-than-average actuarial risk to issuers with higher-than-average actuarial risk, so the overall integrity of transfers under the HHS-operated risk adjustment program depends upon the completeness and accuracy of paid claims data submitted by all issuers to their EDGE server.

In this market, risk adjustment more evenly spreads the financial risk carried by issuers that enroll higher-risk individuals in a particular state market risk pool (such as those with chronic conditions), reduces the incentives for issuers to avoid those enrollees, and lessens the potential influence of risk selection on the premiums that plans charge.

CHALLENGE

CLAIMS COSTS HIGHER THAN EXPECTED WITH A LOWER THAN FORECAST AVERAGE RISK SCORE

A qualified health plan that operates in three states in the Northwest and serves approximately 55,000 members wanted to improve their average member risk score by identifying and addressing operational issues that prevented claims data from being submitted to the EDGE server and thus more negatively affected their transfer payment than

forecasted. They felt that their claims costs were high, but the resultant average risk score was not as high as forecasted and wanted to identify the root causes. They also wanted to ensure that they were aligned with industry best practices and to develop appropriate key performance indicators and metrics for their risk adjustment program.

SOLUTION

A STRATEGIC ADVISORY ENGAGEMENT IDENTIFIED POINTS OF DATA AND REVENUE LEAKAGE AND RECOMMENDATIONS TO CLOSE THEM

The plan engaged Centauri to perform a holistic evaluation of their risk adjustment program, which included an operational assessment of the flow of data, starting with the providers who render services and file claims all the way through to the EDGE server final destination. This assessment identified points of data leakage that present revenue recovery opportunities

for improvement for the plan relative to the completeness, accuracy and timeliness of the paid claims data submitted to EDGE for the purposes of risk adjustment. The evaluation also recommended specific strategies for quantifying and addressing the root causes of the leakage based on the plan's unique people, processes, and technology.

RESULT

AVERAGE RISK SCORE BROUGHT MORE IN ALIGNMENT WITH CLAIM COSTS AND FORECAST AND INCREASED TRANSFER PAYMENT

The plan was able to bring their average risk score more in alignment with what was reflected in their claims costs. More specifically, they realized a 0.9% risk adjustment factor improvement overall and a 0.3% risk adjustment factor improvement average per member, all of which resulted in a net positive transfer payment improvement in the amount of \$10M. They were also able to affect a positive \$4M in total paid claims related to the submission timeliness of one specific group of high-

dollar claims that had previously missed the submission deadline due to operational issues. They did this by addressing enrollment system and medical review processes identified in the evaluation to be the root cause. They also improved the success of their prospective health assessment program by 19% with improvements to chart retrieval, and suspecting because the completeness and the accuracy of the data was improved.

