

HEALTH WEALTH CAREER

# MERCER GOVERNMENT HUMAN SERVICES CONSULTING

## INFORMATICS



READY FOR NEXT

*Together...We are Ready for What Comes Next*

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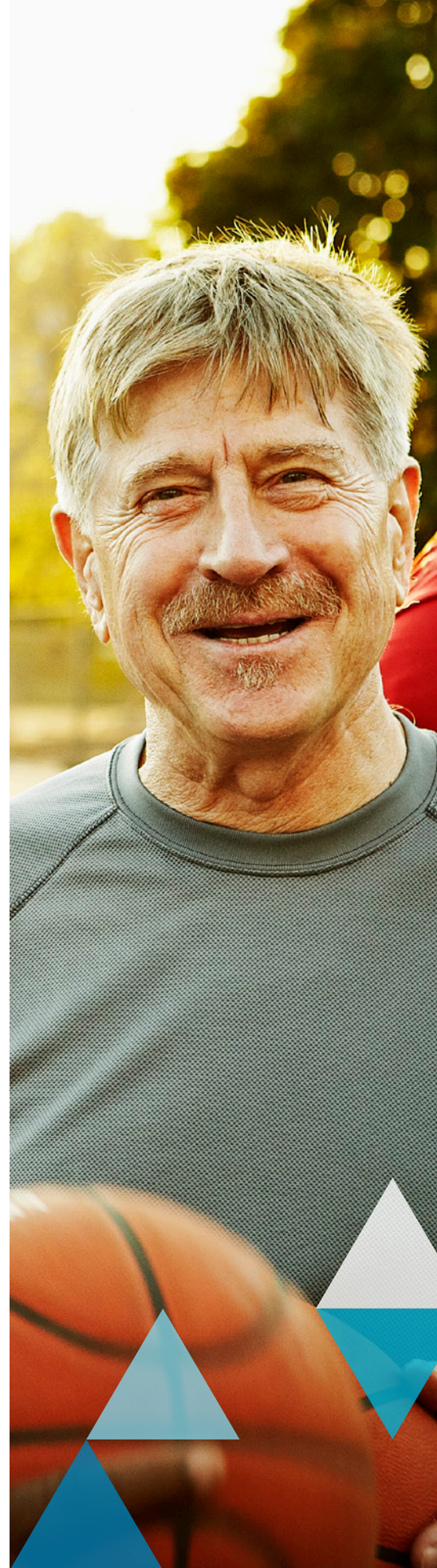
## OVERVIEW

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.

Mercer Government Human Services Consulting (Mercer) specializes in assisting government-sponsored programs in becoming more efficient purchasers of health services. Mercer brings a team of consultants, clinicians, actuaries, pharmacists, policy specialists, and accountants to a project to ensure a coordinated approach to the administrative, operational, actuarial, and financial components of public-sponsored health and welfare programs.

Mercer's consultant team has assisted state and local governments for more than 25 years and has experience in more than 30 states. Throughout an engagement, Mercer draws on the extensive experience gained in working with numerous states to develop a strategy that fits the unique needs and specifications of each of our clients.

Mercer's full range of consulting services, customized to your needs, geographic location, and budget, will help you streamline and maximize the benefits of your health services.



MAKE TOMORROW, TODAY



## MERCER OFFERS:

- **Actuarial consulting** — developing and reviewing rates, setting policy and methodology for future rate setting, and performing a range of financial and actuarial analyses, including risk adjustment.
- **Behavioral health consulting** — assisting with program design, policy, procurement, implementation, and evaluation of substance abuse and mental health programs.
- **Clinical quality consulting** — implementing unique strategies to improve program performance, contain costs, and enhance quality of care and services.
- **Informatics** — assisting in the interpretation and evaluation of detailed claims/encounter data, including data analysis and enhancement.
- **Long-term care consulting** — developing alternative, high-quality solutions to meet the needs of Medicaid members and dual eligibles in the most cost-effective setting.
- **Pharmacy management consulting** — designing and implementing effective pharmacy management for both FFS and managed care programs.
- **Reporting and monitoring** — developing comprehensive reporting and monitoring systems and assessing health plan financial efficiency.

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

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

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# MERCER GOVERNMENT HUMAN SERVICES CONSULTING

## INFORMATICS: PUTTING YOUR DATA TO WORK FOR YOU

Today's health care leaders are often data-rich but information-poor, and laboring under tight time constraints. Accurate analysis and use of health care data can ensure effective policy design and program management, ultimately supporting the overall program goal and budget.

Mercer Government Human Services Consulting (Mercer) understands the critical role health care data plays in key decisions around measuring, reporting, and policy-making within Medicaid and other health care programs. Our expert team has more than 15 years of experience assisting many of the nation's largest Medicaid programs in how to better use their detailed and summarized encounter and fee-for-service (FFS) data.

Mercer's expertise is unique because we are able to work side by side with actuaries, clinicians, pharmacists, and consultants to ensure an integrated approach

to addressing a client's data-related issues. Our experience includes using and analyzing encounter and FFS data in a wide array of analyses and reporting.

### ACTUARIAL

- Perform validation and analysis of encounter data.
- Manipulate and summarize detailed data for capitation-rate development.
- Analyze data to assess proposed or pending policy or legislative changes.
- Analyze validity and feasibility of data for use in developing risk-adjusted rates.



- Perform risk adjustment and risk profiling.
- Analyze and compare health plan efficiency.
- Shadow price data and perform benchmarking.
- Conduct predictive modeling.
- Complete claim grouping.

## CLINICAL/QUALITY IMPROVEMENT

- Identify and analyze populations to target disease management programs.
- Analyze the effectiveness of disease management programs.
- Assess health status of FFS or managed care recipients via disease-based risk scoring.
- Complete HEDIS performance measurements and validation.

## PHARMACY

- Model the impact of reimbursement methodology changes and drug utilization trends.
- Identify patterns of overusage or improper pharmacy usage based on clinical guidelines.
- Evaluate pharmacy usage patterns and projections under different reimbursement benchmarks.

## DATA CONSULTING

- Perform health plan claims-system-readiness reviews for new systems or programs.
- Perform health plan operational reviews.
- Compare encounters to claims data through onsite reviews.
- Analyze claims data for quality and missing data.
- Assist with MMIS implementation with edits for encounter data and system requirements.
- Improve encounter data through recommendations for best practices.
- Perform external quality review in conjunction with the clinical team to perform the Information Systems Capabilities Assessment and encounter data validation.
- Assist in writing and scoring request for proposals.

In addition to the support that we provide directly to our clients, we can also offer solutions for clients to use and manipulate the data themselves.

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## CASE STUDY #1

### Situation

The state hired a new data vendor to process its FFS and managed care data. However, the managed care encounter data lacked some key information, such as payment data.

### Challenge

The state has six health plans running on different systems. The current data vendor was not able to collect all the required data, process the information, and upload it to the state's data warehouse in time for rate-setting activities.

### Action

Mercer developed master data requests and liaised with multiple contractors to identify the data elements that satisfied the various required efficiency analyses. Mercer worked directly with the state's managed care organizations to ensure that data submission was consistent and accurate.

### Results

The data collection process provided complete and accurate data necessary to perform actuarial rate-setting analyses and efficiency analyses. The process identified existing inefficiencies — providing direct savings for the state. The state has used the collected data to update its data warehouse and to further instruct its health plans on the process of sending data directly to the state. The state has asked Mercer to perform the process again while the data warehouse issues are resolved.

## CASE STUDY #2

### Situation

The state compared financial data to encounters and found differences between the two sources. In particular, there were large differences for one specific health plan. The state wanted to know the reasons for the differences and to understand other concerns with encounter-data submissions.

### Challenge

The root cause(s) of the data issues needed to be determined. The data were necessary for important project work.

### Actions

Mercer performed onsite reviews at all health plans to determine whether encounter-submission issues existed. A data request went out to the plans in preparation for the meetings, which were to include a health plan demonstration of the plans' claims systems. Mercer extracted sample encounters to examine during the meetings.

### Results

The review found multiple issues, the biggest of which was a misunderstanding of the process for submitting adjustment encounter records to the State. Rather than voiding and replacing the original encounter, one health plan was submitting only the incremental adjustment, causing a dollar shortage. The state has now engaged Mercer to perform more regular onsite meetings with the health plans.

## 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.

## HOW MERCER CAN HELP

Mercer Government Human Services Consulting (Mercer) can help identify best practices in Medicaid BH-MCOs to maintain regulation compliance and effectiveness in program integrity.

- We have established review criteria to benchmark BH-MCO program-integrity efforts.
- We have created BH-MCO report cards to establish a method to compare BH-MCOs.
- We have identified promising practices in BH-MCO program-integrity efforts.

## OUR EXPERTISE

Mercer's program integrity team has experience in Special Investigations Unit operations, policy-setting at both the state and federal levels, data validation, and identification of program integrity best practices. We are experienced at designing evaluations that monitor

BH-MCOs' program-integrity efforts, and we have evaluated and monitored several states' unique MCO program-integrity systems. This is built upon our deep understanding of Medicaid. Our extended team of behavioral health specialists has public mental health experience at both the state and local levels, and understands the barriers and opportunities faced by those working in Medicaid. Our public sector and health care experience is complemented by our expertise in CMS policy and federal regulations, information systems, encounter-data management, actuarial rate-setting, strategic planning, and managed care. Our multidimensional approach of teaming our clinical experience and policy experts with actuarial and information planning consultants provides a unique depth and breadth of experience to help our clients increase the operational effectiveness of their program integrity.

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