Mercer

MERCER GOVERNMENT
HUMAN SERVICES
CONSULTING

Health-Based Risk Adjustment

For over 3 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

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.

We help ready our clients for what's next: the next policy, the next budget, the next administration, the next opportunity.

We deliver an individualized focus, powered by industry-leading experience, integrated capabilities and passionate people. We help clients achieve better outcomes, develop and deploy defensible strategies, and reshape the delivery of health care.

Offices in Atlanta, Minneapolis, Phoenix and Washington, DC
Contact us at (612) 642 8889
mercer-government.mercer.com

CREDIBLE TRUSTED STANDARD-BEARERS DEFENSIBLE

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.

RESULTS

- 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.

6009740b(12)