Minnesota Department of **Human Services**

Memo

October 9, 2009

DRAFT

DEPARTMENT OF HUMAN SERVICES
PROJECT: **Managed Care Payment Data Collection & Reporting**
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Brief Description

In 2008, the legislature granted the Department of Human Services (DHS) authority to collect payment data from managed care organizations (MCOs) effective January 1, 2010. This legislation was in response to a 2008 report by the Office of the Legislative Auditor (OLA) on the Financial Management of Health Care Programs. The report recommended increased legislative oversight and reporting of MCOs under contract with DHS including the reasons for differences between DHS's targets for MCOs net income and the MCOs' actual net income.

The authority to collect payment data was amended by the 2009 legislature to include more specific MCO reporting requirements and report to the legislature.

Reporting Requirements

The managed care payment data collection & reporting will begin in the 2010 contracts. Each managed care organization must annually provide data to DHS in the format described below. Data provided must allow DHS to conduct the analyses for the legislative report described in the next section.

1. The amount of the payment made to the plan that is paid to health care providers for patient care

MCOs are required to annually report to DHS payment data for the categories of service described in Attachment A.

Collection format: Encounter claim
Paid amount and allowed amount are new fields on the encounter claim that will include both header and line amounts. This data will be secured in MMIS and the DHS data warehouse. Only a very limited number of DHS staff will be granted access.

Definition of paid amount: "Paid amount" means the amount the health plans pays to a provider including the fee-for-service equivalent for sub-contracted services that are capitated* and the Medicare cost-sharing paid by Medical Assistance for dual eligibles. The paid amount excludes the following: third-party liability, Medicare, enrollee co-payments, and provider withholds and incentives.

Definition of allowed amount: "Allowed amount" means the provider contracted rate prior to any of the exclusions listed under the paid amount.

Categories of Service included in data collection (see Attachment A for more detail):

- Inpatient hospital
- Outpatient hospital
- Clinic-based services: physician, physician-extenders (nurse practitioners, nurse midwives)
- Other services - chiropractic, podiatry, physical therapy, speech therapy, audiology, vision
- Medical supplies/DME
- Lab & Radiology
- Anesthesia

- Ambulatory surgery
- Dental
- Pharmacy
- Hearing Aids
- Eyeglasses/contact lenses
- Mental health
- Chemical dependency

Anticipated start date: July 1, 2010
DHS anticipates a July 1 start date based on systems changes needed internally and for the MCOs
*MCOs will also be required to report what services are sub-capitated and the amount of those contracts separately under the aggregate reporting requirement.

2. Aggregate provider payment data, categorized by inpatient payments and outpatient payments, with the outpatient payments categorized by payments to primary care providers and nonprimary care providers

MCOs are required to annually report to DHS aggregate provider payment data for the defined reporting period for the major categories of service described in Attachment B.

Collection format: Microsoft Xcel/Access or Other
The template format will be developed by DHS staff.

Definition of reporting period: "Reporting Period" means services provided from January 1 to December 31st of the most recent complete contract year. For the first report due in 2010, this would be calendar year 2009.

Categories of Service included in aggregate data collection (see Attachment B for more detail):

- Inpatient hospital (may be further categorized by admit type)
- Outpatient hospital
- Primary Care Providers
    - Clinic-based services: physician, physician-extenders (nurse practitioners, nurse midwives)
- Non-Primary Care Providers
    - Clinic-based services including physician, physician-extenders (nurse practitioners, nurse midwives)
    - Medical supplies/DME
    - Lab & Radiology
    - Anesthesia
    - Ambulatory surgery
    - Dental
    - Pharmacy
    - Other services - chiropractic, podiatry, physical therapy, speech therapy, audiology, vision
    - Hearing Aids
    - Eyeglasses/contact lenses
    - Mental health
    - Chemical dependency
    - Sub-capitated contracts

Anticipated Due Date: August/September 1, 2010 and every year thereafter
The aggregate data will be used initially for the legislative report described in the next section and to verify the amounts reported on the encounter claim in aggregate. The "paid amount" for the purposes of aggregate reporting should be the same as what is reported on the encounter claim.

3. The process by which increases or decreases in payments made to the plan, related to provider cost increases or decreases, or that are required by legislative action, are passed through to health care providers, categorized by payments to primary care providers and non-primary care providers

MCOs are required to annually report to DHS information on how legislatively mandated provider rate increases or decreases were passed on to providers for the defined reporting period for the major categories of service described in Attachment B.

Collection format: Microsoft Word or Other/Narrative Format
The template format will be developed by DHS staff.

Definition of reporting period: "Reporting Period" means payment for services provided from January 1 to December 31st for the most recent complete contract year. For the first report due in 2010, this would be calendar year 2009. This covers legislatively mandated provider increases or decreases that were in included in the health plan rates for the most recent completed contract year.

Categories of Service included in data collection (see Attachment B for more detail):
Same as the aggregate reporting under #2

Anticipated Due Date: August/September 1, 2010 and every year thereafter

4. Specific information on the methodology used to establish provider reimbursement rates paid by the managed care plans

MCOs are required to annually report to DHS information on the reimbursement rate methodology for the defined reporting period for the major categories of service described in Attachment B.

Collection format: Microsoft Word or Other/Narrative Format
The template format will be developed by DHS staff.

Definition of reporting period: "Reporting Period" means rates established for services provided from January 1 to December 31st for the most recent complete contract year. For the first report due in 2010, this would be calendar year 2009.

Definition of reimbursement rate: "Reimbursement Rate" means the provider contracted rate prior to any exclusions including: third-party liability, Medicare, enrollee co-payments, and provider withholds and incentives for the most recent complete contract year. For the first report due in 2010, this would be calendar year 2009

Categories of Service included in data collection (see Attachment B for more detail):
Same as the aggregate reporting under #2

Rate methodologies for smaller categories of service may be grouped together. The minimum level of reporting must include the following major categories: inpatient hospital, outpatient hospital, physician and professional services for primary care providers, physician and professional services for non-primary care providers, non-physician and professional services, dental, and pharmacy.

Anticipated Due Date: August/September 1, 2010 and every year thereafter

Report to the Legislature

DHS must analyze data provided by the MCOs to assist the legislature in providing oversight and accountability related to expenditures for managed care. The analysis must include information on payments to physicians, physician extenders, and hospitals, and may include other provider types as determined by the commissioner. The commissioner shall also array aggregate provider reimbursement rates by health plan, by primary care, and non-primary care categories. The commissioner shall report the analysis to the legislature annually, beginning December 15, 2010, and each December 15 thereafter. The commissioner shall also make this information available on the agency's Web site to managed care and county-based purchasing plans, health care providers, and the public.

DHS will use the data and information reported from each MCO to provide the legislature with aggregate payment and reimbursement rate data as described in the report above. Provider-specific payment and reimbursement rate data are considered non-public and will not be part of the legislative report or any other public report.

CATEGORIES OF SERVICE - ATTACHMENT A 10/09/2009

Service Type	Exceptions
Inpatient/Outpatient Hospital	
INPATIENT HOSPITAL GENERAL	
INPATIENT PSYCHIATRY	
INPATIENT HOSPITAL IMD	
INPATIENT LONG TERM HOSPITAL	
INPATIENT HOSP REHABILITATION	
OUTPATIENT HOSPITAL SERVICES	
Outpatient Non-Hospital	
PHARMACY SERVICES	
MEDICAL SUPPLY/DME	
TRANSPORT, SPECIAL	
TRANSPORT, AMBULANCE	
CHILD AND TEEN CHECKUP	
ANESTHESIA	
DENTAL	
AMBULATORY SURGERY	
EYEGLASSES/CONTACT LENSES	
PROSTHETICS AND ORTHOTICS	
HEARING AIDS	
MENTAL HEALTH	
LABORATORY	
END-STAGE RENAL DIALYSIS	
PUBLIC HEALTH NURSING	
PHYSICIAN SERVICES	
PHYSICAL THERAPY	
SPEECH THERAPY	
OCCUPATIONAL THERAPY	
PODIATRY	
CHIROPRACTIC	
AUDIOLOGY	
CHEMICAL DEPENDENCY	
VISION	
NURSE MIDWIFE SERVICES	
NURSE PRACTITIONER SERVICES	
RADIOLOGY	

Service Type	Exceptions	Notes
Inpatient/Outpatient Hospital		
INPATIENT HOSPITAL GENERAL		
INPATIENT PSYCHIATRY		Distinct psychiatric unit
INPATIENT HOSPITAL IMD		
INPATIENT LONG TERM HOSPITAL		
INPATIENT HOSP REHABILITATION		Distinct rehab unit
OUTPATIENT HOSPITAL SERVICES		FFS: For radiology, the rate for the technical component is set the same as the professional (global payment). Radiology on an outpatient claim is paid 60% of the fee schedule for COS 079 for the technical component.
Outpatient Non-Hospital: Primary Care Providers		
PHYSICIAN SERVICES		
Physician's Assistant		
Clinical Nurse Specialist		
Primary Care Provider Specialties		
Family Practice		
General Practice		
Internal Medicine		
OBGYN		
Pediatrics	Subspecialties are non-primary care	
Preventive Medicine		
NURSE MIDWIFE SERVICES		
NURSE PRACTITIONER SERVICES		
Adult Nurse Practitioner		
Family Nurse Practitioner		
Geriatric Nurse Practitioner		
OBGYN Nurse Practitioner		
Pediatric Nurse Practitioner	Subspecialties are non-primary care	
Women's Health Nurse Practitioner		
Outpatient Non-Hospital: Non-Primary Care Providers		
PHARMACY SERVICES		
MEDICAL SUPPLY/DME		
TRANSPORT, SPECIAL		
TRANSPORT, AMBULANCE		
CHILD AND TEEN CHECKUP		FFS: Grouping of procedure codes for C&TC screenings. Physician indicated C&TC screenings on claim and is paid a higher bundled rate for the identified procedure codes.
ANESTHESIA		FFS: Includes physician service, may include CRNA depending on whether the hospital has elected to include CRNA in the DRG
DENTAL		
AMBULATORY SURGERY		FFS: facility fee only for free-standing surgical centers. Professional services are paid separately.
EYEGLASSES/CONTACT LENSES		
PROSTHETICS AND ORTHOTICS		
HEARING AIDS		
MENTAL HEALTH		
LABORATORY		
END-STAGE RENAL DIALYSIS		FFS: Facility fee for dialysis centers receive bundled (composite) payment for dialysis session. Additional services such as lab or services beyond the periodicity schedule are paid separately.
PUBLIC HEALTH NURSING		FFS: Non physician-directed clinic. Limited number of procedures codes for public health nurses.
PHYSICIAN SERVICES		
All other non-primary care specialties		
PHYSICAL THERAPY		
SPEECH THERAPY		
OCCUPATIONAL THERAPY		
PODIATRY		
CHIROPRACTIC		
AUDIOLOGY		
CHEMICAL DEPENDENCY		
VISION		
NURSE MIDWIFE SERVICES		
NURSE PRACTITIONER SERVICES		
All other non-primary care specialties		
RADIOLOGY		FFS: Rates for radiology are priced the same as physician services and include both the professional & technical component.