Breen, Chandra F (DHS)

From: Zimmerman, Marie L (DHS)
Sent: Monday, January 11, 2010 4:48 PM
To: Peed, Karen (DHS); Breen, Chandra F (DHS); Wiley, R Jason J (DHS); Masson, Steven M (DHS); Hahn, Barbara A (DHS)
Subject: MCO Payment Data Reporting - DRAFT Instructions and template

I would appreciate any feedback on this. I still have some refining to do on definitions, etc. Jason is helping me with the provider rate increases/decreases. The aggregate reimbursement rate piece (#4) I just started today. Steve, I may ask for help on that one. I'm not sure if the current categories I have there now as a placeholder are useful for what we need. I may also need your help along w/ someone from CMH on the CD and MH codes. I will follow up with you.

Thanks much,
Marie

Payment Data
Reporting Instruc...

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MANAGED CARE ORGANIZATION (MCO) PAYMENT DATA REPORTING
MINNESOTA HEALTH CARE PROGRAMS (MHCP)

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1. AGGREGATE PAYMENT DATA

Instructions: For each provider type or service category and sub-category, provide the total paid amount (see definition below) by the managed care organization for each program listed in in worksheet #1 for the defined reporting period. For Medicare integrated products, this includes the amount paid by both Medicare and Medicaid. *Please insert data directly into the template in worksheet #1.*

Definition of paid amount: paid amount means the amount the managed care organization (MCO) pays to a provider including sub-contracted services that are capitated. The paid amount excludes the following: third-party liability and enrollee co-payments.

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.

Provider/Service Type	Category for MDH financial reporting	Definition
ADVANCED PRACTICE NURSE SERVICES **1. Primary Care Specialties (American Board of Specialties)** Family Practice General Practice Internal Medicine Pediatrics OBGYN **2. All Other Non-Primary Care Specialties**	Other health professional services	These are costs for all services provided by licensed nurse practitioners, nurse anesthetists, nurse midwives, clinical nurse specialist, and public health nurses. Advanced practice nurse services expenses should exclude the costs of mental health services and chemical dependency services.
PHYSICIAN SERVICES **1. Primary Care Specialties (American Board of Specialties)** Family Practice General Practice Internal Medicine Pediatrics OBGYN **2. All Other Non-Primary Care Specialties**	Physician services	These are costs for all services provided by or under the supervision of licensed medical doctors and doctors of osteopathy, including pharmaceuticals and supplies administered or dispensed from the physician office and billed directly through the physician. Physician services expenses should exclude the costs of mental health services and chemical dependency services.
CHEMICAL DEPENDENCY TREATMENT SERVICES	Chemical Dependency and Mental Health	These are costs related to chemical dependency services

		and mental health services expense, for inpatient and outpatient services, coded using the following codes or amended equivalent codes: ICD-9 diagnosis code ranges 303.00 to 305.92, 290 to 302.9, and 306 to 319; CPT codes 90801, 90841, 90843, 90844, 90844.22, 90846, 90847, 90847.22, 90849, 90853, 98900, 98902, 98910, 98912, 90801, 90841, 90843, 90844, 90844.22, 90846, 90847, 90847.22, 90849, 90853, 98900, 98902, 98910, and 98912.
CHIROPRACTIC SERVICES	Other health professional services	These are costs for all services provided by a licensed chiropractor.
DENTAL SERVICES	Dental services	These are all costs, professional and other, provided under dental services contracts or riders.
INPATIENT HOSPITAL SERVICES	Inpatient hospital services	These are costs for those services furnished by a hospital for inpatient services, including inpatient hospice care. Inpatient hospital services expenses should exclude costs of mental health and chemical dependency services.
ACCESS SERVICES	N/A	These are costs for interpreter services (language & hearing) and access transportation which includes transit, taxi or volunteer transportation.
LAB, DIAGNOSTIC, & RADIOLOGICAL SERVICES	Other health professional services Emergency Services	These are costs for all laboratory and radiology services provided outside of a hospital facility.
DURABLE MEDICAL EQUIPMENT & MEDICAL SUPPLIES	Durable medical goods	These are costs for such items as wheel chairs, eyewear, hearing aids, surgical appliances, bulk and cylinder oxygen, equipment rental, and other devices or equipment that can withstand repeated use.
MEDICAL TRANSPORTATION	Emergency services	These are costs for all emergency and non-emergency transportation provided by an ambulance or a special transportation service (STS) provider.
MENTAL HEALTH SERVICES Adult Mental Health Services Adult MH-TCM Children's Mental Health Services	Chemical Dependency and Mental Health	These are costs related to chemical dependency services and mental health services expense, for inpatient and outpatient services, coded using the following codes or amended equivalent codes: ICD-9 diagnosis code ranges

		303.00 to 305.92, 290 to 302.9, and 306 to 319; CPT codes 90801, 90841, 90843, 90844, 90844.22, 90846, 90847, 90847.22, 90849, 90853, 98900, 98902, 98910, 98912, 90801, 90841, 90843, 90844, 90844.22, 90846, 90847, 90847.22, 90849, 90853, 98900, 98902, 98910, and 98912.
OUTPATIENT HOSPITAL SERVICES	Outpatient services	These are costs for those services offered by a hospital (or free-standing ambulatory surgical centers) which are furnished to ambulatory patients not requiring emergency care and for which there is not a room and board charge. Outpatient services expenses should exclude the costs of mental health services and chemical dependency services.
Medical Emergency	Emergency services	These are costs for medical care provided in the emergency room of a hospital. This includes the room, board and any services such as x-ray and laboratory services billed by the facility. It does not include expenditures for physician services.
PODIATRIC SERVICES	Other health professional services	These are costs for all services provided by a licensed podiatrist.
PRESCRIPTION DRUGS & OTCs	Pharmacy and other nondurable medical goods	These are only costs paid by the health plan company to a pharmacist or medical supply company to provide pharmaceuticals and non-reusable supplies or pieces of equipment that are used to treat a health condition. These data do not include the cost of pharmaceuticals and other nondurable medical goods administered or dispensed which are billed directly through a hospital or health care provider.
PROSTHETIC & ORTHOTIC DEVICES	Durable medical goods	Should this be included under DME?
REHABILITATIVE & THERAPEUTIC SERVICES	Other health professional services	These are costs for all services provided by a licensed physical therapist, speech therapist, occupational therapist, audiologist, and respiratory therapist. This does not include costs for rehabilitative provided in a patient's home.
VISION CARE SERVICES	Other health professional services	These are costs for all services provided by a licensed

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ophthalmologist, optometrist, and optician. This does not include the cost of eyewear or contact lenses.

2. PROVIDER RATE CHANGES

Instructions: 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 scope of provider types/service categories described in "**1. Aggregate Payment Data.**"

MCO's can enter information directly into the template under worksheet #2 or provide an attachment in Microsoft Word.

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 MCO rates for the most recent completed contract year.

3. RATE METHODOLOGIES

Instructions: MCOs are required to annually report to DHS information on the reimbursement rate methodology for the defined reporting period for the defined reporting period for the scope of provider types/service categories described in "**1. Aggregate Payment Data.**"

MCO's can enter information directly into the template under worksheet #3 or provide an attachment in Microsoft Word.

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, 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

4. AGGREGATE REIMBURSEMENT RATES

Instructions: MCOs are required to annually report to DHS an aggregate array of provider reimbursement rates for the defined reporting period for the scope of provider types/service categories described in "**1. Aggregate Payment Data.**"

MCO's can enter information directly into the template under worksheet #4 or provide an attachment in Microsoft Word.

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, 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

QUESTIONS?

If you have questions regarding MCO Payment Data Reporting for Minnesota Health Care Programs, please contact Marie Zimmerman at 651-431-4233 (direct office) or marie.zimmerman@state.mn.us

MCO PAYMENT DATA REPORTING
MINNESOTA HEALTH CARE PROGRAMS (MHCP)
1. AGGREGATE MCO PAYMENT DATA - CY 2009

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Provider/Service Type	PMAP-Families & Children	General Assistance Medical Care (GAMC)	MinnesotaCare Families & Children	MinnesotaCare Adults w/o Children	Minnesota Senior Care Plus (MSC+)	Minnesota Senior Health Options (MSHO)	Minnesota Disability Health Options (MnDHO)	Special Needs Basic Care (SNBC)
ADVANCED PRACTICE NURSE SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
1. Primary Care Specialties	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Family Practice								
General Practice								
Internal Medicine								
Pediatrics								
OBGYN								
2. All Other Non-Primary Care Specialties	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PHYSICIAN SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
1. Primary Care Specialties	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Family Practice								
General Practice								
Internal Medicine								
Pediatrics								
OBGYN								
2. All Other Non-Primary Care Specialties	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CHEMICAL DEPENDENCY TREATMENT SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CHIROPRACTIC SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
DENTAL SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
INPATIENT HOSPITAL SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
ACCESS SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
LAB, DIAGNOSTIC, & RADIOLOGICAL SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
DURABLE MEDICAL EQUIPMENT & MEDICAL SUPPLIES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MEDICAL TRANSPORTATION	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MENTAL HEALTH SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
OUTPATIENT HOSPITAL SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

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Provider/Service Type	PMAP-Families & Children	General Assistance Medical Care (GAMC)	MinnesotaCare Families & Children	MinnesotaCare Adults w/o Children	Minnesota Senior Care Plus (MSC+)	Minnesota Senior Health Options (MSHO)	Minnesota Disability Health Options (MnDHO)	Special Needs Basic Care (SNBC)
Medical Emergency	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PODIATRIC SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PRESCRIPTION DRUGS & OTCs	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PROSTHETIC & ORTHOTIC DEVICES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
REHABILITATIVE & THERAPEUTIC SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
VISION CARE SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

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Please provide a description for each legislative mandated provider rate increase or decrease and how it was passed on to providers for calendar year 2009. Please include in the description if there are difference across programs.

Provider rate changes implemented beginning January 1, 2009:

1. Inpatient hospital ratable reduction (MA, GAMC) - 1%

Provider rate changes implemented beginning October 1, 2009:

1. Inpatient hospital ratable reduction (MA, GAMC, MinnesotaCare) - 1%

2. Basic care ratable reduction (MA, GAMC, MinnesotaCare) - 4.5%
   *Includes: outpatient, medical supplies/DME, ambulatory surgical centers, eyeglasses/contact lenses, prosthetics/orthotics, hearing aids, lab, renal dialysis, and public health nursing.

3. Physician and professional services ratable reduction (MA, GAMC, MinnesotaCare) - 6.5%
   *Includes: physician, physical therapy, speech therapy, occupational therapy, podiatry, chiropractic, audiology, vision, radiology, nurse midwife, nurse practitioner for non-primary care specialties and family planning services.

4. Birth Payments: Professional and Inpatient (MA, MinnesotaCare)

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Please provide a description of the MCO's rate methodologies for the provider types listed below. Please include in the description the differences across programs.

Examples of rate methodologies include:
*Resourced-based method such as Resource-based Relative Value Scales (RBRVS) - physician
*Medicare's Ambulatory Payment Classification (APC) - outpatient
*Diagnostic Related Groups (DRGs) - inpatient
*Medicare rate multiplied by X conversion factor - various

1. Physician
A. Primary Care Providers
B. Non-Primary Care Providers

2. Advanced Practice Nurses
A. Primary Care Providers
B. Non-Primary Care Providers

3. Other all professional services

3. Inpatient Hospital

4. Outpatient Hospital

5. Dentists, dental hygienists

6. Pharmacies

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4. AGGREGATE REIMBURSEMENT RATES - CY 2009

Please provide the aggregate reimbursement rate(s) for the provider types listed below. Please include in the description the differences across programs.

1. Physician
   A. Primary Care Providers
   B. Non-Primary Care Providers

2. Advanced Practice Nurses
   A. Primary Care Providers
   B. Non-Primary Care Providers

3. Other all professional services

3. Inpatient Hospital

4. Outpatient Hospital

5. Dentists, dental hygienists

6. Pharmacies

Physician services expenses	These are costs for all services provided by or under the supervision of licensed medical doctors and doctors of osteopathy, including pharmaceuticals and supplies administered or dispensed from the physician office and billed directly through the physician. Physician services expenses should exclude the costs of mental health services and chemical dependency services.
Other health professional services expenses	These are costs for all services provided by health professionals other than physicians and dentists, including chiropractors, therapists, social workers, nurse practitioners, and medical dental services. Other health professional services should exclude the costs of mental health services and chemical dependency services.
Inpatient hospital services expenses	These are costs for those services furnished by a hospital for inpatient services, including inpatient hospice care. Inpatient hospital services expenses should exclude costs of mental health and chemical dependency services.
Outpatient services expenses	These are costs for those services offered by a hospital which are furnished to ambulatory patients not requiring emergency care and for which there is not a room and board charge. Outpatient services expenses should exclude the costs of mental health services and chemical dependency services.
Skilled nursing facilities expenses	These are costs for services furnished by a facility primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care or rehabilitation services. These expenses should include room and board incurred at skilled nursing facilities. Skilled nursing facilities expenses should exclude costs of mental health and chemical dependency services.
Home health care expenses	These are costs for medical care services delivered in the home under the direction of a physician. This includes non-inpatient hospice care expenses.
Emergency services expenses	These are costs for medical care provided in the emergency room of a hospital. This includes the room, board and any services such as x-ray and laboratory services billed by the facility. It does not include expenditures for physician services.
Pharmacy and other nondurable medical goods expenses	These are only costs paid by the health plan company to a pharmacist or medical supply company to provide pharmaceuticals and non-reusable supplies or pieces of equipment that are used to treat a health condition. These data do not include the cost of pharmaceuticals and other nondurable medical goods administered or dispensed which are billed directly through a hospital or health care provider.

Durable medical goods expenses	These are costs for such items as wheel chairs, eyewear, hearing aids, surgical appliances, bulk and cylinder oxygen, equipment rental, and other devices or equipment that can withstand repeated use.
Chemical dependency and mental health expenses	These are costs related to chemical dependency services and mental health services expense, for inpatient and outpatient services, coded using the following codes or amended equivalent codes: ICD-9 diagnosis code ranges 303.00 to 305.92, 290 to 302.9, and 306 to 319; CPT codes 90801, 90841, 90843, 90844, 90844.22, 90846, 90847, 90847.22, 90849, 90853, 98900, 98902, 98910, 98912, 90801, 90841, 90843, 90844, 90844.22, 90846, 90847, 90847.22, 90849, 90853, 98900, 98902, 98910, and 98912. Do not include prescription drugs or supplies administered or dispensed that are billed directly through a hospital or health care provider. Expenses include all costs related to inpatient, outpatient, and other professional chemical dependency services and mental health services that are coded using codes from another coding system, where the commissioner determines that the codes indicate diagnoses or procedures comparable to or consistent with codes listed above. Health plan companies may use a nationally recognized standardized reporting system that captures chemical dependency or mental health inpatient, outpatient, and other professional services.
Dental services expenses	These are all costs, professional and other, provided under dental services contracts or riders.
Indirect health care expenses	These are costs for administrative parts of the business. Use the total from section 8 to allocate indirect health care expenditures across the product categories as outlined in the report. Do not include taxes and assessments in this line. **Please note:** The sum of indirect expenses across categories in section 7 should **equal** the total indirect health care expenses in section 8.
Expenses not itemized above	These are all costs not itemized in the preceding categories. For coverage designed solely to provide payments on a per diem, fixed indemnity, or non-expense incurred basis, you may report total expenses in this line, rather than the categorized expenses (for example: fixed indemnity, capitated, stop-loss, and Medicare supplement payments that cannot be itemized).