Minnesota Department of **Human Services**

Memo

August 20, 2010

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 2011 contracts. Each MCO 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. The data reporting described below are non public as defined in Minnesota Statutes §13.02.

PHASE 1 REPORTING

Section 1. Aggregate Provider Payment Data

MCOs are required to annually report to DHS aggregate provider payment data for the defined reporting period for the major categories of service described below according to the hierarchy in attachment A of the payment data reporting template..

Collection format: MCO Payment Data Reporting Microsoft Xcel template

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 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.

Categories of Service included in aggregate data collection

- Advanced Practice Nurse (APN) Services
  - Primary Care Providers
  - Non-Primary Care Providers
- Physician Services
  - Primary Care Providers
  - Non-Primary Care Providers
- Maternity Care
- Chemical dependency
- Chiropractic services
- Dental Services
- Inpatient hospital

- Access services
- Lab, Diagnostic, Radiological services
- Durable Medical Equipment/Medical supplies
- Medical transportation
- Mental health services
    - Children (0-19)
    - Adults
- Outpatient hospital services
- Ambulatory surgery center
- Medical emergency services
- Podiatric services
- Prescription drugs & OTCs
    - Brand
    - Generic
- Rehabilitative & Therapeutic professional services
- Vision care services
- Home care services
- Nursing facility expenses
- Medicare cost-sharing
- Other expenses

Due Date: August 15, 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.

Section 2. Provider Rate Changes

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 Section 1.

Collection format: Narrative Format, MCO Payment Data Reporting Microsoft Xcel template or equivalent Microsoft Word template

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.

Due Date: August 15, 2010 and every year thereafter

Section 3. Provider Rate Methodologies

MCOs are required to annually report to DHS information on the reimbursement rate methodology for the defined reporting period for the provider types or service categories described below.

Collection format: Narrative Format, MCO Payment Data Reporting Microsoft Xcel template or equivalent Microsoft Word template

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

Provider Types/Services Categories:
- Physician Services
    - Primary Care Providers
    - Non-Primary Care Providers

- Advanced Practice Nurse (APN) Services
    - Primary Care Providers
    - Non-Primary Care Providers
- Chiropractors
- Providers of rehabilitative & therapeutic services
- Inpatient hospital services
- Outpatient hospital (facility)
- Dentists, dental hygienists
- Prescription drugs
    - Dispensing fee
    - Benchmark
    - Benchmark adjustment factor
- Home care providers
- Chemical dependency services (outpatient)
- Mental health services (outpatient)

Due Date: August 15, 2010 and every year thereafter

4. Aggregate Provider Reimbursement Rates

MCOs are required to annually report to DHS information on provider reimbursement rates for the defined reporting period for the provider types or service categories described below.

Collection format: MCO Payment Data Reporting Microsoft Xcel template

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

Due Date: August 15, 2010 and every year thereafter

PHASE 2 REPORTING

Reporting provider paid amount and allowed amount on encounter claims

MCOs are required to annually report to DHS provider payment data for all services as defined in the MCO's contract (i.e. state plan and waiver services) on encounter claims in the field listed below.

Collection format: Encounter claim
Paid amount and allowed amount 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. The paid amount excludes the following: third-party liability, Medical Assistance (MA) co-payments (except for seniors; see below), and provider withholds and incentives.

For seniors, MCOs should not exclude the MA co-payment from the provider paid amount since the co-payments are waived by the MCO. The sub-workgroup for seniors and people with disabilities in managed care will address the reporting on this issue.

For dual eligible enrollees, MCOs should report the total amount paid to the provider for Medicare Part A & B services, which includes Medicare cost-sharing paid by Medical Assistance. MCOs are not required to report the paid amount for Medicare Part D claims, but may choose to do so. MCOs are required to report drugs covered under MA for dual eligible enrollees.

Definition of allowed amount: "Allowed amount" means the provider contracted rate prior to any exclusions or add-ons.

For dual eligible enrollees, MCOs should report the total amount paid to the provider for Medicare Part A & B services, which includes Medicare cost-sharing paid by Medical Assistance. MCOs are not required to report the paid amount for Medicare Part D claims, but may choose to do so. MCOs are required to report drugs covered under MA for dual eligible enrollees.

Claim Type	4010 Section/Title	X12 4010 Loop/Segment	5010 Section/Title	X12 5010 Loop/Segment
837 P/D				
Allowed amount	Service Line/Contract Information	L2400/CN102 (09)	Service Line/Contract Information	L2400/CN102 (09)
Paid amount	Service Line/Sales Tax Amount	L2400 AMT (T)	Service Line/Sales Tax Amount	L2400 AMT (T)
837 I				
Allowed amount	Claim Information	L2300/CN102 (09)	Claim Information	L2300/CN102 (09)
Paid amount	Claim Information	L2300/AMT (F3)	Claim Information	L2300/AMT (F3)
NCPDP,D.0	**Description/Segment**	**Field**	**Description/Segment**	**Field**
Allowed amount	Flat Sales Tax Amount/ Pricing	482-GE	Flat Sales Tax Amount/Pricing	482-GE
Paid amount	Percentage Sales Tax Amount Submitted/Pricing	481-HA	Percentage Sales Tax Amount Submitted/Pricing	481-HA

Payments outside of the claims process: MCOs will also be required to report payments to provider that cannot be attributed to an individual separately under the aggregate reporting requirement. DHS will revise the aggregate reporting template to reflect this separate reporting beginning in 2012. This may include: some capitated arrangements, provider settlements, provider performance/incentive payments, provider withholds, gain/risk-sharing arrangements, pharmacy rebates, care coordination, health care home, medical case management, certain transportation expenses, and reinsurance recoveries.

Anticipated start date: July 1, 2011 (services or admissions on or after July 1, 2011)
DHS anticipates a July 1 start date based on systems changes needed internally and for the MCOs

- **Updated Companion Guide: TBD**
- **Additional sub-workgroup for seniors and people with disabilities in managed care**
  - methodology for allocating the Medical Assistance share of Medicare Part A & B services
  - methodology and/or reporting MA co-payment waived by MCOs
  - methodology and/or reporting certain payments outside the claims process (e.g. care coordination, health care home, medical case management)

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.