

# MERCER

Consulting. Outsourcing. Investments.



MARSH MERCER KROLL  
GUY CARPENTER OLIVER WYMAN

**May 5, 2010**

## **Medi-Cal Managed Care Transparency**

## Transparency

- It is the goal of DHCS to continue to offer an appropriate level of transparency within the managed care rate development process. In determining an appropriate level of transparency the Department must balance the conflicting desires and requirements of the many stakeholders involved. On the one hand, the contracted Medi-Cal health plans desire complete transparency into every aspect of the rate development process. On the other hand, DHCS must keep some information as confidential such as PHI (per HIPAA), certain data submitted by the health plans themselves, as well as the proprietary Mercer models and processes. In addition, the State does have limited resources and time. These facts must all be considered in decision processes regarding transparency. We pledge to continue to refine and update the level of detail and information that will be made available to the health plans as we work together in seeking continuous improvement in our program.

## Transparency Discussion

Items currently being considered include:

- ✓ Continuation of All-Plan meetings with presentations and discussion
- ✓ Program/policy adjustment file
- ✓ Detailed capitation rate sheets (as provided in the past), but in Excel format (not PDF)
- ✓ Maternity supplemental payment summary
- ✓ Medicaid Rx model and Medi-Cal managed care specific cost weights
- ✓ Medicaid Rx prevalence reports
- ✓ Detailed Medicaid Rx individual member scores by plan
- ✓ Summary of approaches utilized for any efficiency analyses
- ✓ Other discussion?

# MERCER

Consulting. Outsourcing. Investments.



MARSH MERCER KROLL  
GUY CARPENTER OLIVER WYMAN

## Medi-Cal Efficiency Analyses

# Efficiency Analyses

## Background

- Efficiency analyses can be used to support and promote efficiency and effectiveness in the Medi-Cal managed care program
  - A consideration when using actual health plan experience as a base in rate-setting
  - Provide concrete examples of focus areas for health plans for achieving greater efficiency
  - Utilize available encounter data
  - Can be clinical or financial
- Used in several other States' capitation rate development processes

# Efficiency Analyses

## Criteria

- Clinical efficiency adjustments
  - Strong literature support that the service can be prevented or substituted with less expensive treatment or is not appropriate for the condition
  - Ability to evaluate using encounter data only (no chart review)
    - No medical necessity assessment required
  - Produces estimated lower cost in the short term; measures that are more likely to generate longer term savings may be more suitable for P4P approach



## Medi-Cal Managed Care Clinical Efficiency Analyses

### Potentially Preventable Admissions (PPA) Inpatient Hospital Analysis

## PPA Analysis

- Objective
  - Analyze historical encounter data to identify situations where an IP admission was potentially preventable using criteria in the Agency for Healthcare Research and Quality (AHRQ), Guide to Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PedQI).
  - Quantify the level of inefficiency and/or potentially avoidable expenses present in the base data.
- Potentially preventable hospital admissions are identified through the encounter data using criteria from the AHRQ, PQIs and PedQI.

## Overview

- Mercer believes the approach and analysis of PPA is consistent with recognized analyses and literature on both national and California-specific levels.
  - April 2009 from the Healthcare Cost and Utilization Project (HCUP) via AHRQ, "...However, 12 percent of uninsured hospitalizations were potentially preventable, significantly higher than the 9 percent of Medicaid hospitalizations." <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb72.jsp>
  - Milliman estimates "potentially avoidable" hospital days for California for Commercial and Medicare populations:
    - Commercial = 49 percent of days potentially avoidable  
<http://www.hospitalefficiencybenchmarks.com/CommercialChart.asp>
    - Medicare = 55 percent of days potentially avoidable  
<http://www.hospitalefficiencybenchmarks.com/MedicareChart.asp>

## Overview

Conservative approach to analyzing potentially unnecessary expenditures:

- The AHRQ definitions for each PQI and PedQI contain specific exclusions (i.e. deaths, transfers to other facilities, etc.).
- Only individuals with varying enrollment durations by PQI/PedQI (ranging from 2 to 12 months) or greater in the same Medi-Cal health plan are considered for the analysis.
- Only individuals meeting specific Medicaid Rx risk score criteria are considered for the analysis.
- A credibility adjustment will be applied to the analysis to account for replacement costs and to build in additional conservatism.

## Methodology

- Step 1: Identify IP related encounter data.
- Step 2: Define the PQIs and PedQIs.
- Step 3: Extract and summarize IP encounter data that satisfies the PQI and PedQI diagnosis code, procedure code and exclusion criteria.
- Step 4: Analyze IP PQI and PedQI data by Enrollment Duration.
- Step 5: Analyze IP PQI and PedQI data by Medicaid Rx Risk Score.
- Step 6: Determine the dollars associated with PQI/PedQI admissions and apply credibility factors.
- Step 7: Apply managed care model averages to health plan results determined to be unreliable due to data issues.

## Step 1: Identify IP Related Encounter Data

- Encounter data related to IP visits were extracted for this analysis
- Encounter data summarization logic consistent with data used for Medi-Cal capitation rate setting

## Step 2: Define the PQIs and PedQIs

As defined in the AHRQ Guide to PQIs:

- “The PQIs are a set of measures that can be used with hospital inpatient discharge data to identify ‘Ambulatory Care Sensitive Conditions’ (ACSCs). ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.”
- The 13 individual PQIs are shown in the following tables:

PQI	PQI Description
01	Diabetes Short-term Complications Admission Rate
02	Perforated Appendix Admission Rate
03	Diabetes Long-term Complication Admission Rate
05	Chronic Obstructive Pulmonary Disease Admission Rate
07	Hypertension Admission Rate
08	Congestive Heart Failure Admission Rate
10	Dehydration Admission Rate

PQI	PQI Description
11	Bacterial Pneumonia Admission Rate
12	Urinary Tract Infection Admission Rate
13	Angina Admission without procedure
14	Uncontrolled Diabetes Admission Rate
15	Adult Asthma Admission Rate
16	Rate of lower-extremity Amputation among Diabetics

## Step 2: Define the PQIs and PedQIs

As defined in the AHRQ Guide to PQIs:

- “The PedQIs are a set of measures that can be used with hospital inpatient discharge data to provide a perspective on the quality of pediatric healthcare. Specifically, PedQIs screen for problems that pediatric patients experience as a result of exposure to the healthcare system and that may be amenable to prevention by changes at the system or provider level.”
- The 5 individual PedQIs are shown in the following table:

PedQI	PedQI Description
14	Asthma Admission Rate
15	Diabetes Short-term Complications Admission Rate
16	Gastroenteritis Admission Rate
17	Perforated Appendix Admission Rate
18	Urinary Tract Infection Admission Rate

## Step 3: Extract and summarize IP encounter data that satisfies the PQI and PedQI diagnosis code, procedure code and exclusion criteria

- Each PQI or PedQI is defined by a set of diagnosis codes and/or procedure codes along with specific exclusions.
- IP encounter data were extracted based on the PQI and PedQI definitions developed by AHRQ.
- The encounter data was categorized into a PQI or PedQI based on the set of included diagnosis codes and procedure codes.
  - Admissions can only be assigned to one PQI or PedQI .

## Step 4: Analyze IP PQI and PedQI data by Enrollment Duration

- The PQI and PedQI data were analyzed by enrollment duration.
- The enrollment duration was calculated using the enrollment file.
  - All eligibility records were extracted for each individual in the PQI data.
  - Eligibility records for each recipient were “connected”, matching up the eligibility begin date and eligibility end date, as well as matching the health plan ID.
  - The final enrollment duration “spans” consisted of consecutive months of health plan eligibility by recipient and health plan.
- Individuals with an enrollment duration ranging from two to twelve months or greater (varies by PQI and PedQI) will be considered for the analysis.
- Applied so that the admits retained for the analysis reflect a reasonable opportunity for the health plan to engage the recipient and initiate assignment of a PCP, any appropriate treatment and education and/or enrollment into care management programs.

## Step 5: Analyze IP PQI and PedQI data by Medicaid Rx Risk Score

- Each recipient found in the PQI and PedQI analysis was assigned a risk score from Medicaid Rx.
- An average risk score is calculated for each quartile by population group and PQI or PedQI, along with the top-end risk score for the quartile.
- Admits associated with the top 25 percent of individuals in each population group who had the highest risk scores for each indicator are then excluded from the analysis.
- This provides an additional layer of conservatism, acknowledging that a subset of the PQI/PedQI admissions, even after the AHRQ exclusions for co-morbidities and the enrollment duration exclusions, may not be preventable within the Medi-Cal population.

## **Step 6: Determine the dollars associated with PQI/PedQI admissions and apply credibility factors**

- The total dollars for the remaining admits are then summarized by health plan, population and PQI/PedQI.
- A credibility adjustment is then applied to the resulting PQI/PedQI dollars in the analysis to account for replacement costs and additional conservatism.

## **Step 7: Apply managed care model averages to health plan results determined to be unreliable due to data issues**

- Calculated managed care model averages resulting from this analysis will be applied to those health plans' whose IP encounter data is determined to be unreliable due to data issues.

## Next Steps

- Request and collect health plan input
- Review health plan input and provide feedback as necessary
- Revise analysis as necessary



## Medi-Cal Managed Care Clinical Efficiency Analyses

### Emergency Department Low Acuity Non-Emergent (LANE) Visit Analysis

## LANE Analysis

- Objective
  - Historical encounter data is analyzed to identify situations where an Emergency Department (ED) visit was potentially preventable based upon a review of the primary diagnosis and procedure code associated with LANE.
  - This analysis quantifies some levels of inefficiency and/or inappropriate expenses present in the base data.

## Overview

- Mercer believes the approach and analysis of LANE is consistent with recognized analyses and literature on both national and California-specific levels.
  - December 2009 Medi-Cal Managed Care Program Quality Strategy: “...Harris Interactive Inc., sponsored by the California HealthCare Foundation (CHCF), conducted a telephone survey of 1,402 California residents who had visited the ER for care. Almost half (46 percent) of the respondents said their problem could have been treated by their primary care physician. Although Medi-Cal fee-for-service and managed care participants were included in the CHCF survey, the exact number of Medi-Cal managed care members represented in the survey is unknown.
  - Also consistent with the Medi-Cal Managed Care Statewide Collaborative QIP: *Reducing Avoidable Emergency Room Visits*

## Overview

- The LANE analysis takes a conservative approach to eliminating potentially unnecessary expenditures.
- Assumes not all LANE visits can be prevented.
  - Each potential LANE ED diagnosis code was reviewed by a practicing ED physician with managed care experience, with additional consultation from a Mercer physician and clinical staff.
    - Each diagnosis code was assigned a percentage of visits that a highly efficient managed care program could prevent.
    - Visits with a procedure code of 99284 or 99285 were determined to be too severe to be considered preventable.
- A limited list of low acuity diagnoses were considered.
- Visits resulting in an admission were excluded.

## Overview

- Congruence between facility and physician diagnoses.
  - Both the primary physician and primary facility diagnosis codes must appear on the low acuity diagnosis code list in order to be considered a LANE visit.
- For each unnecessary low acuity ED visit, Mercer replaces that visit with the cost associated with a doctor's visit. However, many of the low acuity ED visits would not require a doctor's visit if handled appropriately by nurse lines and/or through care coordination.

## LANE Analysis – Methodology

- Step 1: Identify ED related encounter data.
- Step 2: Group ED encounter data records into visits.
- Step 3: Identify diagnosis codes indicative of LANE (i.e., potentially preventable) visits.
- Step 4: Identify potentially preventable portion of LANE visits.
- Step 5: Determine dollars associated with LANE visits.
- Step 6: Determine “replacement costs” attributed to the identification of LANE visits.

## Step 1: Identify ED related encounter data

- Encounter data related to ED visits were extracted for this analysis
- Encounter data summarization logic consistent with data used for Medi-Cal capitation rate setting

## Step 2: Group ED encounter data records into visits

- A visit is defined as all ED coded services provided to an individual on a given DOS.
- Within one visit, the recipient may have multiple records in the encounter data.
  - Each record specifies a particular service received (e.g., physician, radiology, laboratory).
- Grouping the records into visits is necessary to get a total cost for each of the visits.

## Step 3: Identify diagnosis codes indicative of LANE (i.e., potentially preventable) visits

- The list of LANE diagnosis codes was created from publicly available studies (e.g., Blue Cross Blue Shield, Dr. Loren Baker, Dr. John Billings), as well as input from Mercer's and individual State's clinical staff, including practicing ED physicians and Medicaid Medical Directors.
- The total list numbered 507 diagnosis (primary) codes.
- Several of the diagnosis codes are also part of the Medi-Cal Managed Care Statewide Collaborative QIP: *Reducing Avoidable Emergency Room Visits*

## Step 4: Identify potentially preventable portion of LANE visits

- Each potential LANE diagnosis code was reviewed by:
  - Susan Lambe, MD – a practicing ED physician with managed care experience, and Assistant Clinical Professor at UCSF Division of Emergency Medicine
  - Medical Directors of Medicaid programs in other states
  - Mercer physician and nursing clinical staff
- Based upon this review, each diagnosis code was assigned a percentage of visits that an efficient managed care program could prevent.

## Step 4: Identify potentially preventable portion of LANE visits

- Preventable visits were categorized according to the following hierarchy:
  - Rank 1: 99281 – Self-limited or minor condition(s)
  - Rank 2: 99282 – Low to moderate severity condition(s)
  - Rank 3: 99283 – Moderate severity condition(s)
  - Rank 4: Unclassifiable
    - These were visits where there were no instances of a procedure code in 99281–99285.
    - Unclassifiable visits had cost per visit values comparable to 99281–99283 visits and were deemed acceptable for inclusion in this analysis.
- Visits with a procedure code of 99284 (moderate to high severity condition(s)) or 99285 (high severity condition(s)) were determined to be too severe to be considered preventable.

## Step 5: Determine dollars associated with LANE visits

- Preventable visits were calculated by using the procedure code hierarchy explained in Step 4.
- Dollars were calculated based upon the percentage of visits assumed to be preventable for the particular diagnosis code.

## Step 6: Determine “replacement costs” attributed to the identification of LANE visits

- If the person did not go to the ED, the visits/dollars could still have occurred but in a more appropriate setting (e.g., physician’s office).
- Therefore, the potential savings were offset with the cost of a regular physician’s office visit for each ED visit included in the calculation of potential savings.

## Next Steps

- Request and collect health plan input
- Review health plan input and provide feedback as necessary
- Revise analysis as necessary

# Medi-Cal Pharmacy Cost Management Efficiency Analyses

## Medi-Cal Efficiency Analyses

### Pharmacy Analyses

- Pharmacy expenses are valued at more than \$1 Billion for the entire Medi-Cal Managed Care program.
- The following analyses were completed to identify potentially avoidable pharmacy costs:
  - Maximum Allowable Cost (MAC) list evaluation.
  - Medicare Part D and Part B Drug cost avoidance evaluation.
- Analyses utilized both pharmacy and medical (Part B) claims data.

## Pharmacy – Achieving The Best Price

### MAC Reimbursement

- MAC list – a list of generic drugs and their associated maximum unit reimbursement rates.
- MAC rates are used in the pharmacy claim adjudication process at point-of-sale (POS) to reimburse pharmacy providers for dispensing generic medications.
- Why focus on generic reimbursement?
  - Increased number of blockbuster generics launched in recent years and expected in the future (Lipitor – 2011)
  - Many Medicaid MCOs and FFS programs nationally are reporting Generic Dispensing Rates (GDRs) over 70 percent

## Pharmacy – Achieving The Best Price

### MAC Reimbursement

- Efficient MAC programs focus on the appropriate breadth and depth of their MAC list.
  - A Medicaid MCO’s MAC list should reflect the drug utilization patterns of the population covered.
  - Timely management of MAC list updates is essential.
    - Reimbursement savings opportunities occur rapidly when multiple generic manufacturers’ products are introduced into the market.
    - Frequent updating is necessary so MAC pricing does not become “stale” or outdated.

## Pharmacy – Achieving The Best Price

### MAC Reimbursement

- Goal
  - Evaluate Medi-Cal health plan MAC programs for breadth of MAC list (number of generic product price points) and aggressiveness of reimbursement price points
  - Assess whether more aggressive MAC reimbursement is possible and calculate potential avoidable costs available based on comparison to a Medicaid-specific benchmark MAC list
    - Benchmark MAC list included 1,338 unique Generic Code Numbers (GCNs)

## Pharmacy – Achieving The Best Price

### MAC Reimbursement

- Approach
  - CY2008 pharmacy encounter data provided the base for this analysis.
  - Data adjustments:
    - Generic claims for which there was **not** a benchmark MAC price in place on the date of service were excluded from this analysis.
    - Claims with a negative or zero paid amount were excluded from the analysis.
    - MCO-specific adjustments were made to the encounter data based on feedback received by Mercer through the RDT calls.

## Pharmacy – Achieving The Best Price

### MAC Reimbursement

- Step 1: Claims re-pricing
  - Re-priced encounter data for generic drugs utilizing a Medicaid-specific benchmark MAC list based on the GCN for the same base time period (CY2008) to calculate a derived benchmark MAC paid amount.
    - The derived paid amount was calculated using the encounter's quantity units multiplied by the lower of FUL or benchmark MAC unit price on that date of service.
    - MCO reported generic dispensing fees were then added to the paid amount.
  - For generic claims with a benchmark MAC price in place on the date of service, the claim paid amount was compared to the derived (benchmark) paid amount.

## Pharmacy – Achieving The Best Price

### MAC Reimbursement

- Step 2: Avoidable cost calculation
  - Avoidable costs were calculated as the difference between the claim paid amount and the derived benchmark MAC paid amount.
    - For claims where the actual paid amount was less than the derived paid amount, the difference was counted against the benchmark MAC savings (i.e., negative avoidable cost value).

# Pharmacy – Achieving The Best Price

## MAC Reimbursement

Preliminary results

	% Total Avoidable Dollars
Avoidable Dollars as a % of Paid Amount for drugs on benchmark MAC list	24.4%
Avoidable Dollars as a % of Total Pharmacy Paid Amount	7.8%

## Pharmacy – Inappropriate Reimbursement

### Cost avoidance of Medicare Part D and Part B drugs

- The original Medicare program has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).
  - There are a limited number of prescription drugs that are covered by Medicare Part B.
  - Medicaid should always be the “payor of last resort” for drugs covered by Medicare Part B for dual eligible recipients.
- As of January 2006, Medicare Part D provided more comprehensive outpatient drug coverage.
  - Primary coverage of outpatient prescription drugs transferred from Medicaid to Medicare for dual eligible recipients under Medicare Part D.
  - Medicaid is still responsible for a few drug categories that are excluded from Medicare Part D (e.g., benzodiazepines, barbiturates).

## Pharmacy – Inappropriate Reimbursement

### Cost avoidance of Medicare Part D and Part B drugs

- Medicaid should not be reimbursing the total cost for Medicare Part B and/or D covered drugs for dual eligibles with Medicaid and Medicare Part D and/or B coverage.
- Goal
  - Evaluate pharmacy encounter claims for dual eligible recipients to determine whether Medi-Cal managed care health plans were inappropriately paying for prescription drugs covered by either Medicare Part D or Part B.

## Pharmacy – Inappropriate Reimbursement

### Cost avoidance of Medicare Part D and Part B drugs

- Approach
  - Review pharmacy encounters and identify all Medicare Part B or D eligible claims where the member had Medicare coverage on the corresponding date of service.
  - CY2008 pharmacy encounter claims provided the base for this analysis.
  - Data adjustments:
    - Claims were excluded for all non dual eligibles (dual eligible defined as eligible for Medicare Part D only, Part B only or both during the base time period) based on eligibility records.
    - Claims with a negative or zero paid amount were excluded from the analysis.
    - MCO-specific adjustments were made to the encounter data based on feedback received by Mercer through the RDT calls.

## Pharmacy – Inappropriate Reimbursement

### Cost avoidance of Medicare Part D and Part B drugs

- Step 1: Medicare Part B or D drug list identification:
  - As CMS has not published an inclusive list of Medicare Part B or D covered drugs, but rather set forth guidelines and restrictions of coverage, Mercer developed a comprehensive, proprietary, clinically peer-reviewed list of CY2008 NDCs to identify drugs that are excluded or included under Medicare Part B and D coverage.
- Step 2: Pharmacy encounter data for Medi-Cal dual eligibles:
  - Pharmacy encounter data were reviewed to identify all Medicare Part B or D eligible claims where the member had the corresponding Medicare coverage on the date of service.
  - Pharmacy claim reviews were done separately to identify potentially inappropriate reimbursement for Medicare Part D dual eligibles and Medicare Part B dual eligibles based on the specific Medicare Part B and D drug lists and coverage rules.

## Pharmacy – Inappropriate Reimbursement

### Cost avoidance of Medicare Part D and Part B drugs

- Step 3: Analysis
  - Where the identified claim had a validly populated crossover indicator (indicating the claim was submitted to Medicare first and then the remainder was submitted to the health plan), the claim was deemed as appropriate and excluded from the analysis.
    - This exclusion accounted for <1 percent of Medicare Part B or D eligible drugs.
  - Avoidable dollars were calculated to be the total health plan paid amount for Medicare Part B or Part D eligible drugs where Medicare should have been the primary payer.
    - A rebate adjustment was applied to lower total avoidable dollars, accounting for potential loss of rebates for these drugs using MCO specific rebates as reported during the RDT data request process.

## Pharmacy – Inappropriate Reimbursement

Cost avoidance of Medicare Part D and Part B drugs

### Preliminary Results:

- Similar analysis was completed on Medi-Cal FFS program for comparative purposes and found that Medi-Cal FFS reimbursed for a much smaller percent of Medicare Part D or B covered drugs across the dual eligible population

	% of Total Dual Eligible Pharmacy Prescriptions	% of Total Dual Eligible Pharmacy Spend
Medicare Part B and D Covered Drugs paid for by Medi-Cal managed care health plans	40.3%	73.2%

# MERCER

Consulting. Outsourcing. Investments.



MARSH MERCER KROLL  
GUY CARPENTER OLIVER WYMAN

## Medi-Cal Risk Adjustment

## J Code Analysis

### Background

- Concerns have been raised regarding the exclusive use of National Drug Codes (NDC) found on prescription drug data for identifying disease conditions within the Medicaid Rx risk adjustment model.
- J codes are drugs (often “injectable”) administered in a professional setting such as chemotherapy, immunosuppressive drugs, inhalation solutions, etc.
- NDCs are used to identify disease conditions within the Medicaid Rx model; however, the costs associated with each disease condition represent all medical/pharmacy services (including the cost for J codes).
- Mercer studied the impact of incorporating J codes into the Medicaid Rx disease identification process compared to the actual risk scores developed for the CY 2009/10 capitation rates (both Two-Plan and GMC models).

## J Code Analysis

### Study Findings

- Mercer's pharmacists were able to group roughly 95 percent of the J codes found in the HMO reported encounter data (outpatient and professional) to Medicaid Rx disease categories.
- Almost 70 percent of disease conditions identified using J codes were already being identified using NDCs.
- The use of J codes added less than 1 percent (0.7 percent) to identified disease conditions across both programs and populations.
- The average change (unweighted) in budget neutral risk scores by adding J codes was 0.2 percent for adult/child family and 0.6 percent for aged and disabled.

## J Code Analysis

### Study Conclusions

- No changes are anticipated to the current Medicaid Rx disease identification process to include J codes for CY 2010/11 due to the following considerations:
  - There were minimal impacts on the overall program risk scores by using J codes to identify additional disease conditions.
  - Pharmacy data have been deemed the most complete and accurate source of claim-level information. Incorporating J codes would require reliance on the submission and application of professional/outpatient encounters for all health plans.
  - Adding J codes to the disease identification process could potentially require fundamental changes to the currently published (and nationally vetted) Medicaid Rx model framework. This change would require significant time and resources.

## Medicaid Rx Model Update

- It is anticipated that Mercer will use an updated Medicaid Rx version 5.2 for the CY 2010/11 rates. The new model version consists of:
  - Updated 30+ states' Medicaid data through 2005 (total of 2001–2005).
  - Appropriate adjustments made to the model to account for updated NDCs and changes in drug usage.
  - The model will continue to reflect California-specific data adjusted to reflect the Medi-Cal managed care benefits.
- The updated model will be available for download upon completion:
  - <http://medicaidrx.ucsd.edu/>
- Mercer will provide Medi-Cal specific cost weights with the final risk adjustment results.

## County Averaging

- DHCS has not yet decided the plan-specific rate vs. county average risk adjusted rate mix for the 2010/2011 rate year.
- Safety Net Provider Discussion.

## Timing of Risk Adjustment for 2010/2011 Rates

- DHCS wants to release capitation rates on or about July 1, 2010.
- Based on this timing:
  - Study period will either be December 1, 2008 through November 30, 2009 or January 1, 2009 through December 31, 2009
  - Health plan assignment would be as of March 2010 or April 2010
  - Risk adjustment will have to run at a later time for the two new expansion Two-Plan counties (Kings and Madera)