

Potentially Preventable Admissions (PPA)

February 27, 2012

PPA Analysis

- Objective
 - This analysis quantifies some potentially avoidable expenses present in the health plan encounter data.
- Potentially preventable hospital admissions are identified through the encounter data using criteria from the Agency for Healthcare Research and Quality (AHRQ) Guide to Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI).
- Additional exclusions for enrollment duration and risk are made as part of the analysis.

PPA

- Prior discussions and/or presentations on PPA
 - May 5, 2010
 - August 12, 2010
 - March 22, 2011
 - July 21, 2011
 - October 18, 2011

Methodology

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

[A]	[B]	[C]		[D]	[E]	[F]	[G]	[H]	[I]	[J]	[K]
PQI	PQI Description	PQI Grand Total		Exclusion Criteria	Unique Events After Considering Enrollment Duration	PQI Dollars After Considering Enrollment Duration	Reducing PQI Total - Resulting PPA				
		Unique Events	Grand Total PQI Dollars				Minimum Health Plan enrollment duration prior to admission date (in months)	Unique Events After Considering Enrollment Duration and Risk Assessment	PQI Dollars After Considering Enrollment Duration and Risk Assessment	Adjustment Factor	PQI Dollars After Applying Adjustment Factor
01	Diabetes Short-term Complications Admission Rate	6	\$ 3,000	4	6	\$ 3,000	4	\$ 2,000	75%	\$ 1,500	
02	Perforated Appendix Admission Rate	4	\$ 3,000	2	3	\$ 2,200	3	\$ 2,200	75%	\$ 1,650	
03	Diabetes Long-term Complication Admission Rate	4	\$ 3,000	6	4	\$ 3,000	3	\$ 2,200	75%	\$ 1,650	
05	Chronic Obstructive Pulmonary Disease Admission Rate	4	\$ 3,000	6	2	\$ 1,800	2	\$ 1,800	75%	\$ 1,350	
07	Hypertension Admission Rate	4	\$ 3,000	4	4	\$ 3,000	4	\$ 3,000	75%	\$ 2,250	
08	Congestive Heart Failure Admission Rate	4	\$ 3,000	4	4	\$ 3,000	4	\$ 3,000	75%	\$ 2,250	
09	Low Birth Weight										
10	Dehydration Admission Rate	4	\$ 3,000	2	2	\$ 1,800	2	\$ 1,800	75%	\$ 1,350	
11	Bacterial Pneumonia Admission Rate	4	\$ 3,000	2	4	\$ 3,000	3	\$ 1,600	75%	\$ 1,200	
12	Urinary Tract Infection Admission Rate	4	\$ 3,000	2	2	\$ 1,780	2	\$ 1,780	75%	\$ 1,335	
13	Angina Admission without procedure	4	\$ 3,000	2	4	\$ 3,000	3	\$ 1,200	75%	\$ 900	
14	Uncontrolled Diabetes Admission Rate	4	\$ 3,000	4	4	\$ 3,000	3	\$ 1,600	75%	\$ 1,200	
15	Adult Asthma Admission Rate	4	\$ 3,000	4	4	\$ 3,000	3	\$ 1,400	75%	\$ 1,050	
16	Rate of lower-extremity Amputation among Diabetics	4	\$ 3,000	12	4	\$ 3,000	3	\$ 2,200	75%	\$ 1,650	
Total		54	\$ 39,000		47	\$ 34,580	39	\$ 25,780		\$ 19,335	

PDI	PDI Description	PDI Grand Total		Exclusion Criteria	Unique Events After Considering Enrollment Duration	PDI Dollars After Considering Enrollment Duration	Reducing PQI Total - Resulting PPA			
		Unique Events	Grand Total PDI Dollars				Minimum Health Plan enrollment duration prior to admission date (in months)	Unique Events After Considering Enrollment Duration and Risk Assessment	PDI Dollars After Considering Enrollment Duration and Risk Assessment	Adjustment Factor
14	Asthma Admission Rate	6	\$ 3,000	3	5	\$ 2,600	4	\$ 2,000	75%	\$ 1,500
15	Diabetes Short-term Complications Admission Rate	-	\$ -	4	-	\$ -	-	\$ -	75%	\$ -
16	Gastroenteritis Admission Rate	4	\$ 4,000	2	4	\$ 4,000	3	\$ 3,400	75%	\$ 2,550
17	Perforated Appendix Admission Rate	-	\$ -	2	-	\$ -	-	\$ -	75%	\$ -
18	Urinary Tract Infection Admission Rate	-	\$ -	2	-	\$ -	-	\$ -	75%	\$ -
Total		10	\$ 7,000		9	\$ 6,600	7	\$ 5,400		\$ 4,050
Grand Total		64	\$ 46,000		56	\$ 41,180	46	\$ 31,180		\$ 23,385

Total CY2009 Inpatient Encounter Dollars	\$ 514,470
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Total Aged/Disabled Medi-Cal Only Inpatient Base Data Dollars	\$ 591,641
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Total PPA Dollars to be Removed	\$ 26,893
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Updated CY2009 Results

- CY09 encounters updated with additional runout (through September 2011). Prior version included CY09 encounter data with runout through October 2010.
- Represents the raw results for each health plan and county.
- Two files for each health plan
 - updated CY09 encounter data results using the paid field to calculate PPA
 - updated CY09 encounter data results using the inpatient days field to calculate PPA
- Zero paid encounters were excluded from the analyses based on the paid field, but included in the analyses using the inpatient days field.
- The PPA analysis using inpatient days captures utilization of PPA to determine a PPA adjustment. If applied as a rate adjustment, this PPA adjustment percentage would then be applied to the inpatient dollars in the base data used for rate setting.

Next Steps

- Run PPA analysis using CY2010 encounter data
- Review results
- Address questions/comments from health plans

Questions/Comments

Adult Day Health Care (ADHC) Transition - Community Based Adult Service (CBAS) and Enhanced Case Management (ECM)

ADHC Transition

Timeline

- October/November 2011
 - ADHC members enrolled in Medi-Cal managed care health plans
 - Health plans performed comprehensive assessments for CBAS (Not Health Net or LA Care)

- April 1, 2012
 - ADHC services will be discontinued
 - Health plans will have to provide ECM services for former ADHC/non-CBAS eligible members

- July 1, 2012
 - Health plans will be responsible for coverage/payment of CBAS services for eligible members

ADHC Transition and Capitation Rate Impacts

October/November 2011

- DHCS and Mercer are currently analyzing the risk of the newly enrolled ADHC members to determine how their risk/cost experience compares to the existing managed care SPD (dual and Medi-Cal only) members
 - A capitation rate adjustment may be necessary/appropriate to address any significant risk differential noted
- A capitation rate adjustment is anticipated to account for the cost of the comprehensive assessment performed in October/November

ADHC Transition and Capitation Rate Impacts

April 2012

- DHCS and Mercer are currently developing estimated cost of ECM services
 - A capitation rate adjustment may be necessary/appropriate to address the provision of this service effective 4/1/12
- It is anticipated that any rate adjustment for the October and April impacts will be made together (and applied for the period October 1, 2011 – June 30, 2012)

July 2012

- A capitation rate adjustment will be made to account for the cost of the CBAS services for eligible members
 - The resulting rate modification will be effective July 1, 2012 and forward

Questions/Comments

- Any comments or questions related to ADHC/CBAS/ECM?

Healthy Families Program

Rate Development Approach

Healthy Families Program Rate Development Approach - Background

- The Governor's budget includes the transition of Healthy Families Program (HFP) eligible children into Medi-Cal managed care
 - This transition will be accomplished in phases, starting October 1, 2012 and culminating January 1, 2013
 - It is anticipated that the covered services will align with the current Medi-Cal managed care covered services
- DHCS has asked Mercer to develop capitation rates for these HFP members to be enrolled in Medi-Cal managed care
- This presentation will outline the proposed rate development approach, but will not show rates, as actuarially sound capitation rates have not yet been developed
- The presentation will also highlight key assumptions and/or outstanding issues/questions that may impact the final rate development

Healthy Families Program Rate Development Approach

- Medi-Cal Managed Care currently serves well over 2.5 million Medi-Cal eligible children age 0-19. This provides a very robust data set to be used in developing capitation rates that may be applicable for the HFP children, if served through the Medi-Cal managed care program.
- Mercer proposes to utilize the Adult and Family category of aid (COA) group eligibility, encounter data, and related capitation rates as the bases for rate development, since this is the COA group that has the vast majority of Medi-Cal eligible children.
- In general, we will calculate the proportion of utilization and costs reported via managed care encounter data attributable to the children in the COA group and apply those proportions to the full COA group capitation rates. This approach will allow us to utilize actual Medi-Cal managed care experience, while not being impacted by any encounter reporting issues (e.g., missing or under reported data).

Healthy Families Program Rate Development Approach - continued

- The Medi-Cal managed care and HFP populations' demographic mixes, for members age 0-19, have been compared and significant differences were found. Therefore, an adjustment will be made to the Medi-Cal data to more closely align with the demographic mix of the HFP population. To accomplish this, the following age band groupings will be utilized: less than age 1, age 1-5, age 6-13, age 14-17 and age 18-20. The age 18-20 Medi-Cal data is assumed to be appropriate for the age 18-19 HFP population subset.
- Calculations will utilize Contract Period (CP) 2012–13 capitation rates, including maternity costs. The rates will be trended forward, or back (GMC), if appropriate to more closely align with the potential implementation date of any HFP member transition.
- Adjustments will have to be made to account for any member cost sharing responsibilities.

Healthy Families Program Rate Development Approach - continued

- Administrative loads (percentages) will be somewhat higher than what is used for the current rates, since this group of recipients has a lower average cost than the full Adult & Family COA group. This is to account for the fixed and variable components of the administrative costs.
- The profit/risk/contingencies loads will be based on the same loading percentages used in the existing Medi-Cal managed care rate development.
- Mercer will produce and certify a range of rates (rate range) for the HFP population.

Healthy Families Program Rate Development Approach – Outstanding Issues

- It is not clear if cost-sharing will continue for the transitioning HFP members.
- Acuity differences - between the HFP and Medi-Cal age 0-19 populations, outside of the aforementioned demographic adjustments. Without additional data, it is impossible to know how the acuity will compare. Some of the factors that will play into this issue include: A) in general, populations with higher income levels (i.e., HFP) tend to have lower acuity (i.e., better risk) than populations with lower income levels (i.e., Medi-Cal), B) in general, populations that have to pay a higher premium (HFP has member premiums and Medi-Cal does not) for health coverage tend to have higher acuity.
 - Currently lacking sufficient data to make any adjustment for acuity differences
- Other adjustments may be necessary/appropriate based on differences in eligibility processing and enrollment timing differences between HFP and Medi-Cal

Healthy Families Program Rate Development Approach - Questions

- Are there any questions or concerns related to the proposed approach?

