



California ICD-10 Site Visit

Training segments to assist the State of California with ICD-10 Implementation

Segment 4: Managed Care

June 10 - 11, 2013





Agenda
Managed Care

- **Background**
 - Cost Containment
 - Managed Care as a Policy Instrument
- **Contract Management**
 - Policies, Procedures, and Plans
 - Encounter Data
 - Performance Measurement
- **Payment**
 - Risk Adjustment
 - Rate Setting
 - Value-Based Purchasing

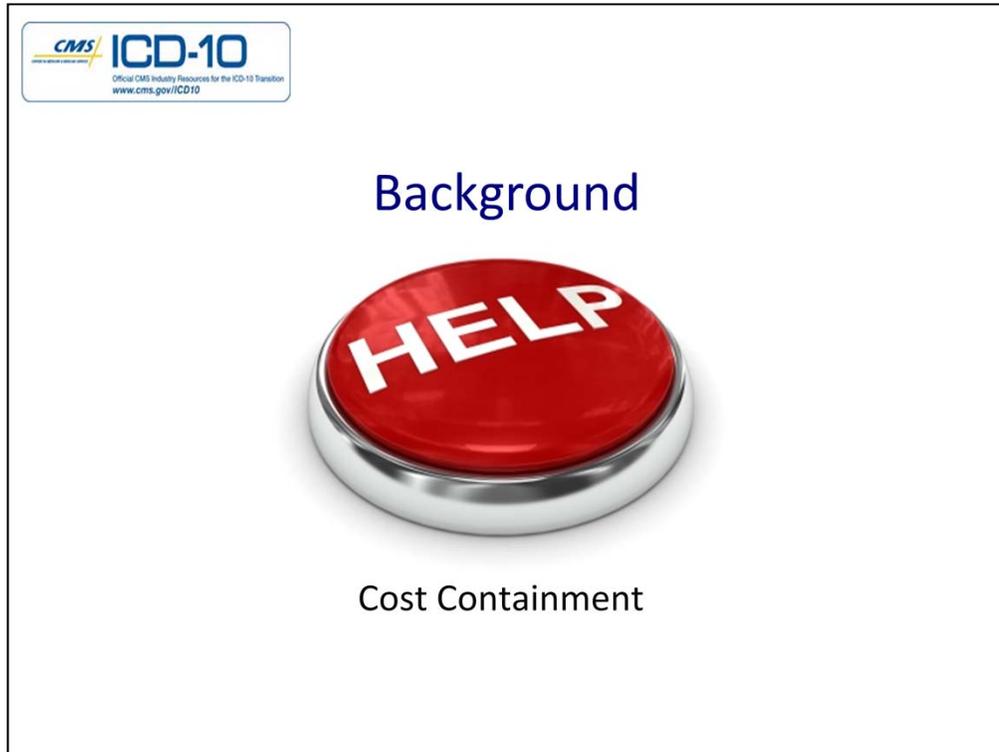
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Purpose of the slide

Introduce the agenda for a session covering ICD-10 impacts, opportunities, and examples specific to SMA operations in the area of managed care.

Talking Points

- None



Purpose of the slide

Introduce background slides in order to consider the financial pressures facing States and an understanding of the expansion of managed care strategies.

Talking Points

- None

Cost Containment

The Stormy World of Medicaid

- **Factors causing rapid growth in Medicaid costs for states**
 - increased enrollment (because of both the weak economy and expanded eligibility under health care reform)
 - per capita health care costs increasing faster than the economy
- **General Fund increase in FY13 of 4.1%**
- **CMS estimates Medicaid spending will increase by average of 8.3% annually over next 10 years**
- **Medicaid is 23.6% of total state spending**
- **13 states cut Medicaid in FY13 by reducing benefits, tightening eligibility, or reducing provider payments**



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Purpose of the slide

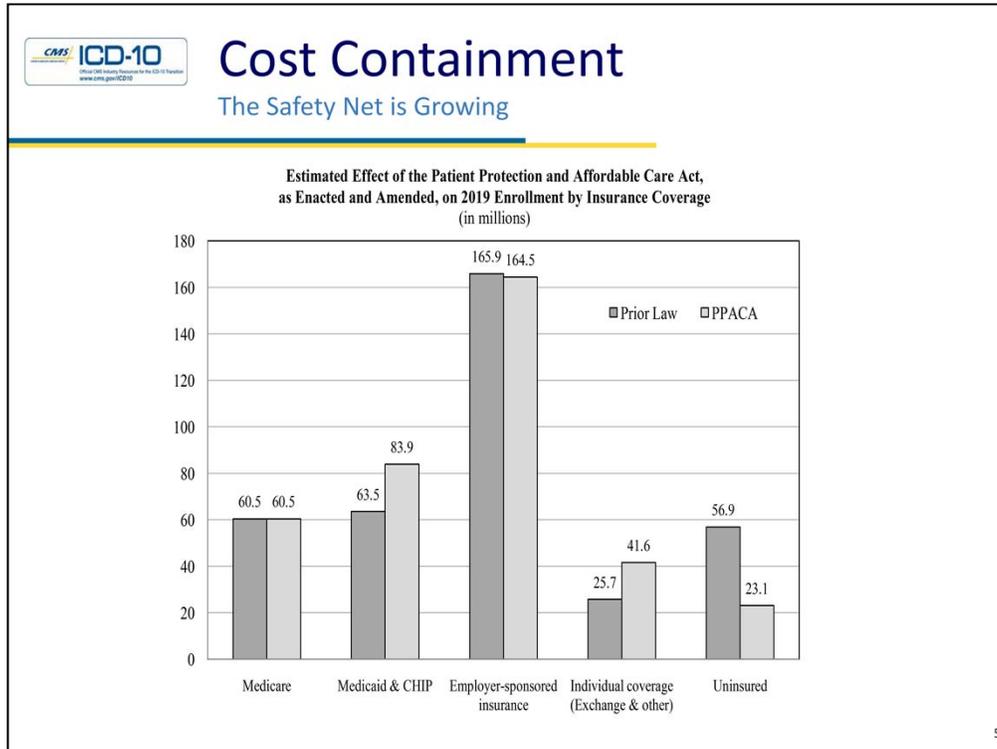
Discuss the stormy world of Medicaid finance

Talking Points

- State spending on Medicaid rose 20.4 percent in fiscal year 2012, and federal spending dropped 8.2 percent.
- The projected rate of growth for states is much slower for fiscal 2013, 3.9 percent.

Source(s)

- National Governor's Association and National Association of State Budget Officers. "The Fiscal Survey of States (Spring 2012)." <http://www.nasbo.org/sites/default/files/Spring%202012%20Fiscal%20Survey%20of%20States.pdf>. Accessed 6/12/12.
- <http://www.kaiserhealthnews.org/Stories/2012/July/25/Medicaid-Cuts-Chart.aspx>. Accessed 6/12/12.
- CMS. "National Health Expenditure Projections: Modest Annual Growth Until Coverage Expands And Economic Growth Accelerates." Health Affairs 31, No. 7 (2012). <http://content.healthaffairs.org/content/early/2012/06/11/hlthaff.2012.0404.full.pdf>. Accessed 6/12/12.
- Kaiser Family Foundation. "Update: State Budgets in Recession and Recovery." October 2011. <http://www.kff.org/medicaid/upload/8253.pdf>. Accessed 12/27/2011.



Purpose of the slide

Show that recent and coming actions are expected to increase Medicaid enrollment but the full impact is yet unclear

Talking Points

- CMS projects approximately 20M new Medicaid enrollees by 2019
- Congressional Budget Office estimated that 16M will enroll by 2019
- Recent simulation model published in Health Affairs found that the number of additional people enrolling in Medicaid under health reform may vary by more than 10 million, with a base-case estimate of 13.4 million and a possible range of 8.5 million to 22.4 million. In the end, Medicaid enrollment will be determined largely by the extent to which federal and state efforts encourage or discourage eligible people from enrolling.

Source(s)

- CMS Office of the Actuary letter dated April 22, 2010. https://www.cms.gov/ActuarialStudies/downloads/PPACA_2010-04-22.pdf. Accessed 09/30/2011.
- <http://capsules.kaiserhealthnews.org/index.php/2011/10/harvard-study-highlights-wide-range-of-medicaid-expansion-estimates/>
- Congressional Budget Office. <http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf>
- Sommers, B, et al. "Policy Makers Should Prepare For Major Uncertainties In Medicaid Enrollment, Costs, And Needs For Physicians Under Health Reform." Health Aff (October 2011). <http://content.healthaffairs.org/content/early/2011/10/24/hlthaff.2011.0413>. Accessed 12/26/2011.



Cost Containment

Working Smarter Not Harder

- **As opposed to the traditional across the board cuts in eligibility, coverage, and/or payments, States are increasingly looking to new strategies and new partners for budget predictability and cost containment**
 - Managed Care
 - Fraud and Abuse
 - Health Information Technology
 - Value-Based Purchasing
- **These strategies should improve financial and patient-centered outcomes but some will take time to realize**

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Purpose of the slide

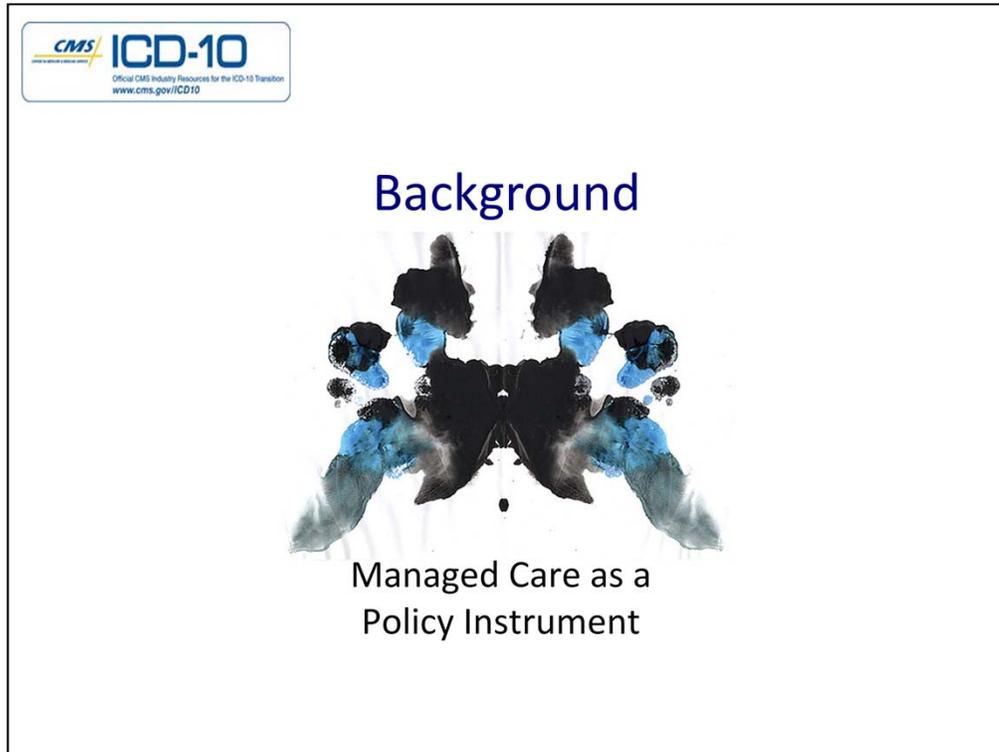
Discuss how States are looking to work smarter by investing in health system reform, aligning incentives, and investing in technologies that assist with cost containment.

Talking Points

- On 5/6/11, CMS issued proposed rule on access measurement and rate setting.
- On the first day of the fall 2011 session, the U.S. Supreme Court heard arguments on State Medicaid rate cuts in CA. On Feb 22, 2012, the Supreme Court declined to take up the case and sent it back to the Court of Appeals.
- In a May 23, 2012 letter to the State of NH, CMS asked state officials to provide data on access levels for services within 30 days in light of significant payment cuts to hospitals.
- Managed care includes a full spectrum of management from comprehensive managed care (e.g. HMOs) to accountable care organizations and provider service networks to medical homes and PCCM models to fee-for-service.
- Consequently, most states have already tried to contain Medicaid spending by restricting provider reimbursements or reducing certain Medicaid benefits, and are now looking to further expand “managed care and coordinated care options, using health homes for those with chronic conditions, pursuing dual eligible initiatives to provide managed care services for those eligible for both Medicare and Medicaid.”
- A few States successfully use medical home or other provider-based models (e.g. NC, OK, CT, and UT) but the overall trend is toward increasing use of full-risk managed care predominantly featuring health plans.
- For example, over the past few months, FL, KY, CA, TX, and KS have passed legislation or received approval to significantly expand their use of comprehensive managed care.

Source(s)

- Kaiser Family Foundation. Medicaid and Managed Care: Key Data, Trends, and Issues. February 2010. <http://www.kff.org/medicaid/upload/8046.pdf>. Accessed 12/27/2011.
- Kaiser Family Foundation. “Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends - Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012.” <http://www.kff.org/medicaid/upload/8248.pdf>. Accessed 12/27/2011.
- Kaiser Health News. “Connecticut Drops Insurers from Medicaid.” <http://www.kaiserhealthnews.org/Stories/2011/December/29/Connecticut-Drops-Insurers-From-Medicaid.aspx>. Accessed 1/11/12.
- Milliman. “Analysis of Community Care of North Carolina Cost Savings.” 12/15/11. <http://www.communitycarenc.org/elements/media/files/milliman-executive-summary.pdf>. Accessed 1/1/12.



Purpose of the slide

Introduce background slides on the increased use of managed care as a policy instrument in order to consider the implications of ICD-10 on SMA operations.

Talking Points

- None

Dirty words in healthcare



"Managed healthcare was a great idea when it first emerged, before the term got hijacked by insurance companies that claimed to manage care but in many cases only managed money...We practiced medicine in one of the best managed-care systems in the nation: the former Harvard Community Health Plan. What made it great was the freedom of staff to think creatively about what patients really needed, and to reinvent care to meet those needs.

[We] pioneered innovations that most still pine for:

- electronic medical records,
- patient reminders,
- creative roles for advanced practice nurses and physician assistants,
- quality measurement,
- and more."

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Purpose of the slide

Discuss managed care as a tool in the policy toolbox – it is best when used properly.

Talking Points

- Who wrote this opinion piece for the Boston Globe on 2/28/08? It was co-authored by Dr. Donald M. Berwick, the outgoing CMS Administrator.

Source(s)

- Dorsey, J. and D. Berwick. Dirty Words in Healthcare. Boston Globe. http://www.boston.com/bostonglobe/editorial_opinion/oped/articles/2008/02/27/dirty_words_in_healthcare/. Accessed 12/26/2011.
- Photo is from "A Christmas Story." Metro Goldwyn Mayer. 1983.



Managed Care as a Policy Instrument

Potential Advantages

- **Medicaid managed care offers several potential advantages over the traditional Medicaid fee-for-service system**
 - Predictable and lower costs
 - Access to additional providers
 - Increased emphasis on preventive care and care coordination
 - Delivery system innovation
 - Increased accountability (e.g. Quality Assessment and Performance Improvement and Payment for Performance)
 - Fraud and abuse prevention

- **By transferring financial risk to health plans, costs to state budgets are more predictable. Additionally, many States have reported cost savings under Medicaid managed care.**

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Talking Points

- Predictable Costs – a large factor that drives States to Medicaid health plans is the improved predictability of costs and potential cost savings. By transferring financial risk to health plans through capitation, state budgets are not subjected to as much variability experienced with fee-for-service. States have reported cost savings under Medicaid managed care models. For example, according to a report by the Lewin Group, Medicaid health plans saved Pennsylvania \$2.7 billion over a 5-year period.
- Access and Care Coordination - Medicaid health plans often negotiate payment rates with providers that are above fee-for-service provider payments, therefore Medicaid health plan enrollees often enjoy better access to providers than those in traditional Medicaid. Medicaid health plans coordinate care for Medicaid populations with special needs, including those with multiple chronic conditions and 8 million dual eligibles, through care coordination and disease management programs.
- Innovation in delivery system reform - collaborating with Medicaid programs and state stakeholders, Medicaid health plans have been able to implement innovative delivery system reforms like patient-centered medical homes, coordinating benefits for dual-eligibles, and state health care coverage expansions.
- Preventing fraud and abuse - Medicaid managed care has also experienced significantly less fraud and abuse than traditional Medicaid fee-for-service. CMS reported that in FY 2008 payment error rates for Medicaid managed care were 0.1% compared to 2.6% for Medicaid fee-for-service.
- Quality assurance and improvement - one of the most significant potential benefits of Medicaid health plans is quality measurement and improvement. Medicaid health plans are required to report performance measures, such as HEDIS, to the state. Performance measures provide valuable data to health plans, states, researchers and policymakers for demonstrating the quality of care in Medicaid programs, identifying gaps in care, and creating quality improvement projects.

Source(s)

- Lewin Group. "An Evaluation of Medicaid Savings from Pennsylvania's HealthChoices Program." <http://www.lewin.com/content/publications/MedicaidSavingsPAHealthChoices.pdf>. Accessed 12/27/2011.
- Lewin Group. "Medicaid Managed Care Cost Savings - A Synthesis of 24 Studies : Final Report." March 2009. Accessed at <http://blogs.chicagotribune.com/files/lewinmedicaid.pdf>. Accessed 12/27/2011.
- Kaiser Family Foundation. "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey." September 2011. <http://www.kff.org/medicaid/upload/8220.pdf>. Accessed 12/27/2011.
- B. Landon et al. "Comparison of Performance of Traditional Medicare vs Medicare Managed Care." *JAMA*. 2004;291:1744-1752. <http://jama.ama-assn.org/content/291/14/1744.full.pdf>. Accessed 12/27/2011.



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www.cms.gov/ICD10

Managed Care as a Policy Instrument

Managed Care Strategies

- Integrated Models for Medicare-Medicaid Enrollees 
- Carve-ins for drug coverage
- Pharmacy Benefit Managers (focus on specialty drugs) 
- Managed Care Organizations / Accountable Care Organizations / Specialty Plans 
- Medical Homes – blended payment featuring management fee, FFS, and shared savings tied to quality 
- Payment for Performance 



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Purpose of the slide

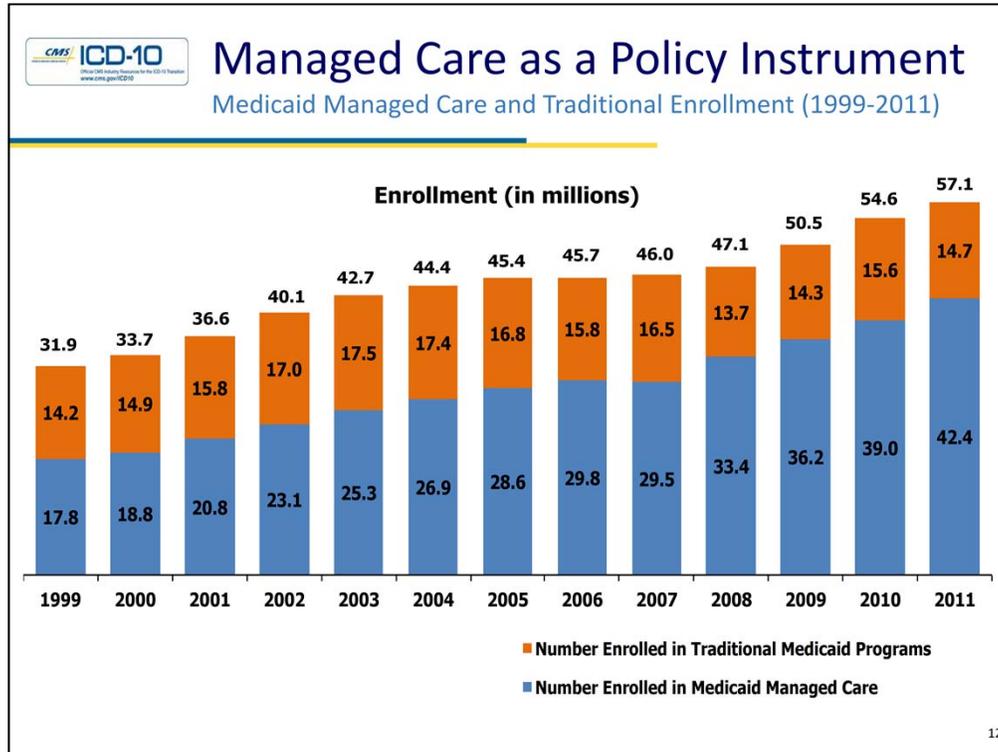
Discuss some emerging and/or expanding strategies in Medicaid managed care.

Talking Points

- Seventeen states in FY 2011 and nearly half (24 states) in FY 2012 reported that they were expanding their managed care programs primarily by expanding the areas and populations covered by managed care programs.
- Some states including Kentucky, Louisiana, New Jersey, New York, Texas, Florida, and West Virginia are implementing either new or significant expansions of comprehensive managed care programs.
- States are also expanding the use of disease and care management programs and patient centered medical homes to help coordinate care and focus on high-cost and high-need populations.
- States are using managed care as a vehicle to implement quality and performance strategies such as tying payment or default enrollment to performance and adding quality measures for reporting.

Source(s)

- *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012*, Appendix A-2. Kaiser Commission on Medicaid and the Uninsured, October 2011. Available at: <http://www.kff.org/medicaid/8248.cfm>.



Purpose of the slide

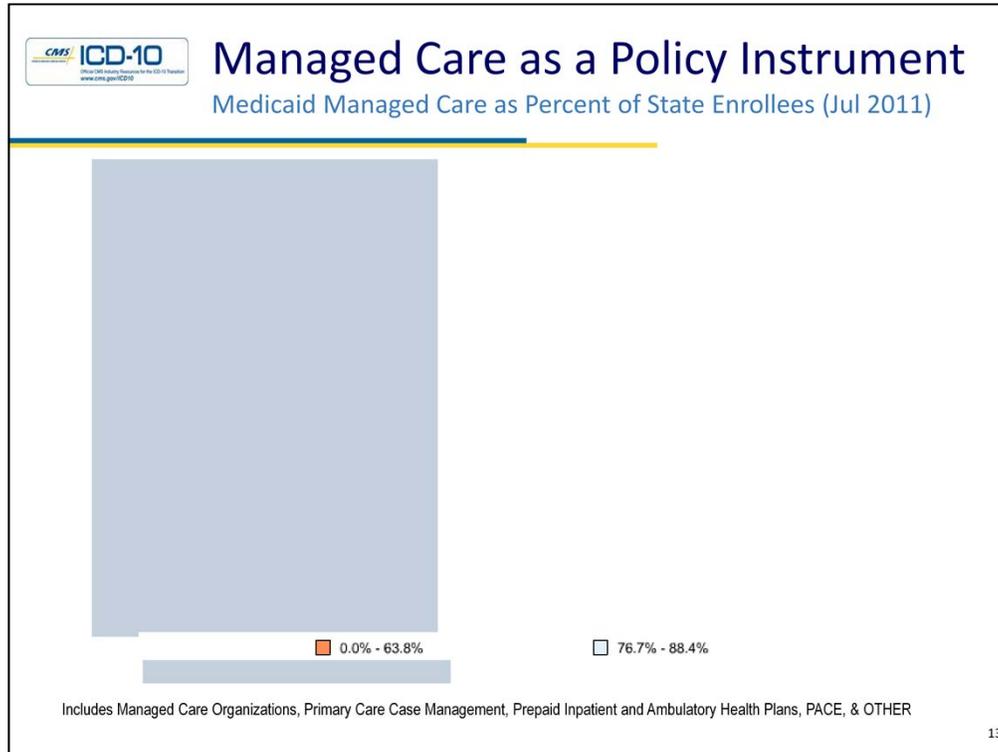
Show the historical growth of Medicaid and its fee-for-service and managed care components.

Talking Points

- None

Source(s)

- CMS. "Medicaid Managed Care Enrollment Report: Summary Statistics as of July 1, 2011."
<http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicare-MC-Enrollment-Report.pdf>



Purpose of the slide

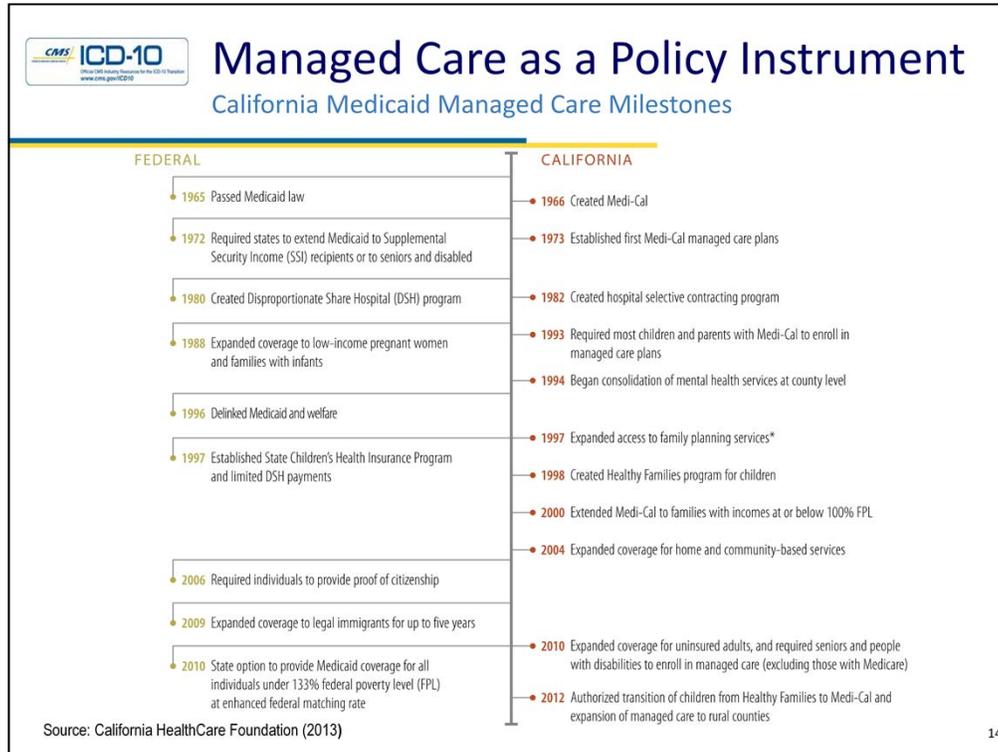
Show the penetration of comprehensive managed care in Medicaid programs across States.

Talking Points

- Includes Managed Care Organization, Primary Care Case Management, Prepaid Inpatient Health Plan, Prepaid Ambulatory Health Plan, PACE, and OTHER

Source(s)

- <http://www.statehealthfacts.org/comparemaptable.jsp?typ=2&ind=985&cat=4&sub=56&sortc=1&o=a>
- Kaiser Family Foundation and Health Management Associates, "Medicaid Today; Preparing for Tomorrow: Look at State Medicaid Program Spending, Enrollment and Policy Trends: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013 (October 2012)." Available at: <http://www.kff.org/medicaid/upload/8380.pdf>. Accessed 1/12/13.



Purpose of slide

Discuss the form and function of California's use of managed care in their Medicaid program.

Talking Points

- The program is in the midst of a major transformation, as it shifts most enrollees to managed care and prepares for a major expansion due to the Patient Protection and Affordable Care Act (ACA). Enrollment will surge in 2013 as more than 850,000 children transition to Medi-Cal from the Healthy Families Program. Medi-Cal will see an estimated total increase of one million or more enrollees due to the ACA, including 680,000 people in 2014, the first year of Medi-Cal expansion under health reform.

Source(s)

- California HealthCare Foundation. **Medi-Cal Facts and Figures: A Program Transforms (2013)**. <http://www.chcf.org/publications/2013/05/medical-facts-figures>. Accessed 5/20/13.

 **Managed Care as a Policy Instrument**
California Medi-Cal Waivers

	1915(B)	1915(C)	1115
Purpose	Allow states to limit an individual's choice of provider	Allow states to provide long term care services in community settings	Give states broad authority to test policy innovations, so long as federal spending is no greater than it would have been otherwise (without the waiver)
Examples (number of beneficiaries)	Specialty Mental Health Services (425,710)	Home- and Community-Based Services (HCBS) for Persons with Developmental Disabilities (92,000) In-Home Operations (140) AIDS (2,371) Assisted Living (16,335) Multipurpose Senior Services Program (1,560) Pediatric Palliative Care (70)	Bridge to Reform (4,910,963)

- In 2013, CA announced a new demonstration program *Cal MediConnect* for Medicare-Medicaid enrollees

Source: California HealthCare Foundation (2013) and DHCS (2013)

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- Medi-Cal operates 11 waiver programs, including the 2010 Bridge to reform waiver that includes the majority of Medi-Cal enrollees.

Source(s)

- California HealthCare Foundation. **Medi-Cal Facts and Figures: A Program Transforms (2013)**. <http://www.chcf.org/publications/2013/05/medical-facts-figures>. Accessed 5/20/13.
- DHCS. <http://www.dhcs.ca.gov/formsandpubs/publications/opa/Documents/2013/13-04DemonstrationProgram.pdf>. Accessed 5/20/13.



Purpose of slide

Discuss the form and function of California's use of managed care in their Medicaid program.

Talking Points

- California has a unique system of managed care, with three different models operating across 30 counties, covering about 65% of the total Medi-Cal population. Beginning in September 2013, the state will expand managed care to the 28 rural counties that currently operate fee-for-service delivery systems using the two-Plan and County organized Health System models.

Source(s)

- California HealthCare Foundation. **Medi-Cal Facts and Figures: A Program Transforms (2013)**. <http://www.chcf.org/publications/2013/05/medical-facts-figures>. Accessed 5/20/13.



Official ICD-10 Coding System for the United States
www.cms.gov/ICD10

Managed Care as a Policy Instrument

California Medicaid Managed Care Models

- **County Organized Health Systems (COHS)**
 - About 1M beneficiaries through six health plans in 14 counties
 - DHCS contracts with a health plan created by the County Board of Supervisors and run by the county
 - Everyone is in the same managed care plan
- **Geographic Managed Care (GMC)**
 - About 600K beneficiaries in two counties
 - DHCS contracts with several commercial plans
- **Two-Plan Model**
 - About 3.6M beneficiaries in 14 counties
 - In most Two-Plan model counties, there is a “Local Initiative” (LI) and a “commercial plan” (CP)

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Purpose of slide

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Source(s)

- California HealthCare Foundation. **Medi-Cal Facts and Figures: A Program Transforms (2013)**. <http://www.chcf.org/publications/2013/05/medical-facts-figures>. Accessed 5/20/13.
- DHCS. **MEDI-CAL MANAGED CARE PROGRAM FACT SHEET - Managed Care Models**. <http://www.dhcs.ca.gov/provgovpart/Documents/MMCDModelFactSheet.pdf>. Accessed 5/20/13.



Purpose of the slide

Introduce slides covering contract management in order to discuss ICD-10 impacts, opportunities, and examples in the area of health services contractors.

Talking Points

- None



Office of Management Services
www.cms.gov/ICD10

Contract Management

A Good Foundation Helps

- **Health services contractors (e.g., health plans) are used for the provision of Medicaid services on behalf of the State**
- **This is NOT the contracting experience we want**



- **Surveys and reporting will change significantly with ICD-10**
 - Policies, Procedures, and Plans (e.g. QI, G&A, F&A, coverage)
 - Encounter data
 - HEDIS or other performance reporting

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Purpose of the slide

Understand the contractual risk that ICD-10 poses for SMAs.

Talking Points

- Contracts for health plans and other health services contractors need to be amended and SMA tools to determine contract compliance and provide incentives (if applicable) need to be updated

Source(s)

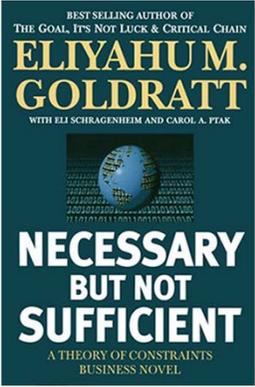
- Scott Adams, Inc. 2010. www.dilbert.com.



Official CMS Codes, Approved for ICD-10 Transition
www.cms.gov/ICD10

Contract Management

ICD-10 is a Business Initiative – Not a Code Set Update



BEST SELLING AUTHOR OF
THE GOAL, IT'S NOT LUCK & CRITICAL CHAIN
**ELIYAHU M.
GOLDRATT**
WITH ELI SCHRAGENHEIM AND CAROL A. PEAK
**NECESSARY
BUT NOT
SUFFICIENT**
A THEORY OF CONSTRAINTS
BUSINESS NOVEL

- **Compliance with ICD-10 simply means the ability to accept and send transactions**
- **Focus on minimal compliance not sufficient for successful ICD-10 implementation**
 - Receiving an ICD-10 code from a contractor does not demonstrate their business processes were remediated correctly
 - If a contractor does not remediate their processes for ICD-10, overutilization or barriers to access may occur
- **SMA's need to understand both the 'what' and the 'how' contractors and trading partners are remediating ICD-10**

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Purpose of the slide

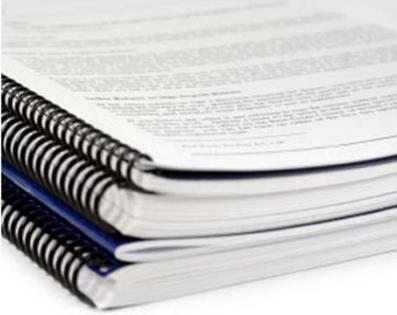
To discuss steps that may assist the SMA's with managing contractors during ICD-10 implementation.

Talking Points

- Receiving an ICD-10 code does not mean that it is the 'right' volume of codes or the 'right' codes.
- Being compliant with HIPAA and compliant with the contract are two different things. The SMA and its vendor may be compliant with HIPAA but the particular business process is 'broken.' This is one of the primary ways that ICD-10 is different from 5010, NPI, and other previous HIPAA implementations – remediation and testing should go all the way back to the business process that is the source of the transaction.

 Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

Contract Management



Policies, Procedures, & Plans

Purpose of the slide

Introduce slides covering specific contract provisions in order to discuss ICD-10 impacts, opportunities, and examples in the area of managed care.

Talking Points

- None



Policies, Procedures, and Plans

Some Impacted Contract Language (1 of 4)

- **Coverage**
 - “Contractor shall cover services for bone marrow transplants and high-dose chemotherapy for adult (age twenty-one (21) or over) enrollees diagnosed with breast cancer, leukemia, lymphoma and myeloma, as set forth in 12 VAC 30-50-570.”
[Virginia Medallion II contract - II.G.21, pages 76-78]

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Purpose of the slide

Review some Medicaid managed care contract provisions that are impacted by ICD-10.

Talking Points

- None



Official CMS Website, Approved for the 2013 Year
www.cms.gov/ICD10

Policies, Procedures, and Plans

Some Impacted Contract Language (1 of 4)

- Case Management**

 - “Health Plan shall ensure that appropriate resources are available to address the treatment of complex conditions that reflect both mental health and physical health involvement.
 - Mental health disorders due to or involving a general medical condition, specifically ICD-9-CM 293.0 through 294.1, 294.9, 307.89, and 310.1; and
 - Eating disorders – ICD-9-CM Diagnoses 307.1, 307.50, 307.51, and 307.52.

[Florida Health Plan Contract Amendment II - 10.A, page 109]
- Disease Management**

 - “The MCO shall make available a Disease Management Program for its Enrollees with diabetes, asthma and heart disease.”

[Minnesota Families & Children Contract – 7.3, page 131]

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Purpose of the slide

Review some Medicaid managed care contract provisions that are impacted by ICD-10.

Talking Points

- None



Policies, Procedures, and Plans

Some Impacted Contract Language (2 of 4)

- **Payment**
 - “Pursuant to § 2702 of the Patient Protection and Affordable Care Act and CMS’ final rule when published, the Contractor must establish payment guidelines pertaining to Health Care Acquired Conditions in accordance with the Department’s State Plan (SP).”
[Virginia Medallion II Contract – IV.K, page 171]

- **Supplemental Payments**
 - “(b) CHIP and STAR MCOs will receive a Delivery Supplemental Payment (DSP) from HHSC for each live or stillbirth by a Member [Texas Uniform Managed Care Terms and Conditions – 10.09, page 37]
 - “...the procedure and/or diagnosis code submitted is a valid delivery related procedure/diagnosis code.” [Texas Uniform Managed Care Manual, Delivery Supplemental Payment (DSP) Report – 5.3.5]

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Purpose of the slide

Review some Medicaid managed care contract provisions that are impacted by ICD-10.

Talking Points

- None



Official CMS Website, Approved for the ICD-10 Transition
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Policies, Procedures, and Plans

Some Impacted Contract Language (3 of 4)

■ Payment for Performance

- For calendar year 2010, a health plan shall be eligible for a performance incentive payment if the health plan’s performance:
 - Meets or exceeds the HEDIS 2010 Medicaid 75th percentile rate for measure of LDL-C Control under the Comprehensive Diabetes Care Measures; or
 - Meets or exceeds the rate that is an improvement, of 50% of the difference between the health plan’s rate in calendar year 2009 and the HEDIS 2010 Medicaid 75th percentile rate, above the health plan’s rate in CY 2009.

[Hawaii Quest MCO Contract – 60.330, pages 277]

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Purpose of the slide

Review some Medicaid managed care contract provisions that are impacted by ICD-10.

Talking Points

- None



Policies, Procedures, and Plans

Some Impacted Contract Language (4 of 4)

- Reinsurance**

 - “For members diagnosed with hemophilia, Von Willebrand’s Disease and Gaucher’s Disease, all medically necessary covered services provided during the contract year shall be eligible for reimbursement at 85% of the allowed amount or the Contractor’s paid amount, whichever is lower, depending on the subcap code.”
[Arizona AHCCCS CYE’ 12 Acute Care Contract – 57, page 81]
- Encounter Data**

 - “...utilizes encounter data to determine the adequacy of medical services and to evaluate the quality of care rendered to members... Encounter data from the Contractor also allows DCH to budget available resources, set contractor capitation rates, monitor utilization, follow public health trends and detect potential fraud.
[Georgia Families Contract – 4.16.3.1, page 152]

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Purpose of the slide

Review some Medicaid managed care contract provisions that are impacted by ICD-10.

Talking Points

- None



CMS ICD-10
Official CMS Website, Approved for the ICD-10 Transition
www.cms.gov/ICD10

Policies, Procedures, and Plans

Some Impacted Contract Language (4 of 4)

- **Required Plans and Reports**
 - Case Management
 - Disease Management
 - Fraud and Abuse
 - Quality Assessment and Performance Improvement
 - Encounter Data



The diagram illustrates the 'Policy and Procedure Life Cycle' as a continuous loop of five stages: Create, Review, Distribute, Test, and Audit & Report. The stages are arranged in a circle, with arrows indicating a clockwise flow. The 'Create' and 'Review' stages are highlighted in yellow, while the others are in blue.

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Purpose of the slide

Review some Medicaid managed care contract provisions that are impacted by ICD-10.

Talking Points

- None

 Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

Contract Management



Encounter Data

Purpose of the slide

Introduce slides covering encounter data in order to discuss ICD-10 impacts, opportunities, and examples in the area of managed care.

Talking Points

- None



ICD-10
Official ICD-10 Standard for the United States
www.cms.gov/ICD10

Encounter Data

Concerns

- **Using encounter data for rate-setting, risk-adjustment, and contract management provides incentives for contractors to collect and submit complete and accurate encounter data**
- **SMA's who incorporate encounter data in their payments to health plans (e.g. rate-setting, risk adjustment, payment for performance) are concerned about a few things:**
 - Collecting complete and accurate encounter data from health plans to implement payment model
 - Using data for fraud & abuse detection
 - Guarding against under-utilization
 - Monitoring performance
 - Accurately capturing risk



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Purpose of the slide

Understand the role of encounter data to support SMA operations.

Talking Points

- Encounter data should be treated the same as any other claim data (just \$0 pay). All other data should be consistent with the 837 claim standard or the data will not be consistent, which will hinder comparisons and consolidations
- (1) Understanding data completeness / incompleteness
 - Plans may be missing encounter data from some providers
 - Plans may truncate the number of diagnoses per encounter supplied by the provider
 - (2) Compare data
 - Utilization in the encounter data to an estimated fee-for-service benchmark
 - Individual MCO data with that of the plan with the most complete data
 - Submitted encounter data with other state data, such as data from external quality review organizations and chart reviews
 - Individuals who moved from fee-for-service Medicaid into an MCO
 - (3) Incentives for clean data
 - Adjust MCO reimbursement rates to compensate for missing data
 - MCOs will eventually realize the alternative to submitting their encounter data is potential drop in payment

Source(s)

- "Getting to Yes: How Encounter Data Become Good Enough for Health-based Risk Adjustment": Rachel Halpern, David J. Knutson, Jinnet B. Fowles, PhD



Encounter Data

Some Best Practices

- **Tennessee uses a three step process to verify & validate encounter data**
 - 1) Encounters are processed through a software program which assesses data quality and accuracy prior to adjudication. The software selectively rejects “bad” data based on a standard set of edits and audits and sends the “bad” data back to the MCOs for cleaning and resubmission.
 - 2) Encounters are then processed through the FFS claims engine using the same edits and audits as applied to FFS claims.
 - 3) Lastly, TennCare uses a contractual withhold every month that requires a certain percentage of clean claims. As a result, there is currently less than a 1 percent error rate for encounter data in the Medicaid Management Information System.

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Purpose of the slide

Discuss some best practices in the collection of encounter data.

Talking Points

- None

Source(s)

- Centers for Medicare & Medicaid Services. Medicaid Integrity Program. “Tennessee Comprehensive Program Integrity Review Final Report.” August 2010.
<https://www.cms.gov/FraudAbuseforProfs/Downloads/tnfy08compireport.pdf>. Accessed 12/27/2011.



Official CMS Codes Approved for the ICD-10 Transition
www.cms.gov/ICD10

Encounter Data

Affordable Care Act (2010)

- **In 2007, HHS Office of Inspector General report found challenges with the reporting of encounter data**
 - 15 of 40 applicable States did not report encounters
- **Section 6402(c): Withholding of Federal matching payments for States that fail to report enrollee encounter data in the Medicaid Statistical Information System**
 - Authorizes the Secretary to withhold the Federal matching payment to States for medical assistance expenditures when the State does not report enrollee encounter data in a timely manner to the State's Medicaid Management Information System (MMIS)
 - Federal regulations have not yet been promulgated regarding incentives and/or sanctions for States...but it's just a matter of time!

31

Purpose of the slide

Understand Federal efforts to improve encounter data.

Talking Points

- None

Source(s)

- COMPILATION OF PATIENT PROTECTION AND AFFORDABLE CARE ACT [As Amended Through May 1, 2010] INCLUDING PATIENT PROTECTION AND AFFORDABLE CARE ACT HEALTH-RELATED PORTIONS OF THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010. <http://docs.house.gov/energycommerce/ppacacon.pdf>. Accessed 12/27/2011.

 Official CMS Industry Resources for the ICD-10 Transition
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Contract Management



Performance Measurement

Purpose of the slide

Introduce slides covering performance measurement in order to discuss ICD-10 impacts, opportunities, and examples in the area of managed care.

Talking Points

- None



Office of Medicare Programs for the ICD-10 Transition
www.cms.gov/ICD10

Performance Measurement

Measures

- Measures are a valuable tool to determine health system, contractor, and provider performance for the purposes of contracting, public reporting, and value-based purchasing
- For measures to be valuable, they need to be impactful, transparent, valid, reliable, timely, usable, and feasible – NOT like the cartoon following cartoon

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Purpose of the slide

Understand the impact of ICD-10 on SMA efforts to measure, report, and incentivize improvements in quality for recipients.

Talking Points

- On 1/4/02, CMS posted the initial core set of health care quality measures for Medicaid-eligible adults, as required by section 2701 of the Affordable Care Act, for voluntary use by State programs, health insurance issuers and managed care entities that enter into contracts with Medicaid, and providers of items and services under these programs.
- 25 State Medicaid programs require NCQA accreditation and HEDIS
- CMS, NCQA, and NQF have developed robust measure development and maintenance processes.
- For a full discussion on the use quality measures in Medicaid managed care across States, refer to NCQA report below.
- For an excellent discussion on measurement in fee for service, see CHCS document below.

Source(s):

- CMS. "Medicaid Program: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults." This document is scheduled to be published in the Federal Register on 01/04/2012 and available online at <http://federalregister.gov/a/2011-3375>
- National Committee for Quality Assurance. "State Recognition of NCQA and HEDIS." <http://www.ncqa.org/tabid/135/Default.aspx>. Accessed 12/27/2011.
- National Committee for Quality Assurance. "Medicaid Managed Care Quality Benchmarking Project: Final Report." August 23, 2010. <http://www.cms.gov/MedicaidCHIPQualPrac/downloads/NCQAMBench.pdf>. Accessed 12/27/2011.
- Center for Health Care Strategies, Inc. "Performance Measurement in Fee-for-Service Medicaid: Emerging Best Practices." October 2010. http://www.chcs.org/usr_doc/CA_FFS_Performance_Measures_Final_102610.pdf. Accessed 12/27/2011.
- See CMS Measures Manager Blueprint for discussion of measure development, evaluation, and maintenance at https://www.cms.gov/MMS/19_MeasuresManagementSystemBlueprint.asp

- National Quality Forum. Measure Evaluation Criteria. http://www.qualityforum.org/docs/measure_evaluation_criteria.aspx. Accessed 12/27/2011.
- Watzlaf, V. et al. "The Effectiveness of ICD-10-CM in Capturing Public Health Diseases." *Perspectives in Health Information Management*. 4;6 (Summer 2007). Accessed 7/1/2011. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2047296/>
- Scott Adams, Inc. 2010. www.dilbert.com.



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Performance Measurement

Measure Maintenance

- **Good news is that over time, ICD-10 will improve the accuracy and reliability of population and public health measures**
- **Bad news is that more than 100 national organizations are involved in quality measure maintenance and reporting**
 - Measure maintainers (e.g. including States) need to remediate measures and end-users need to update reporting for ICD-10
 - Measure clearinghouses (e.g. NQF and AHRQ) expect maintainers to remediate measures



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Purpose of the slide

Understand the impact of ICD-10 on SMA efforts to measure, report, and incentivize improvements in quality for recipients.

Talking Points

- Much of the focus is on provider and plan performance but ICD-10 also significantly improves public health measures.
- Each maintainer will need to remediate their own measures and for those States that use multiple systems, States will have to coordinate

Source(s):

- Watzlaf, V. et al. "The Effectiveness of ICD-10-CM in Capturing Public Health Diseases." *Perspectives in Health Information Management*. 4:6 (Summer 2007). Accessed 7/1/2011. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2047296/>
- Society of Actuaries. Measurement of Healthcare Quality and Efficiency Resources for Healthcare Professionals: Inventory of Programs and Organizations. <http://www.soa.org/files/pdf/research-quality-efficiency-inventory-2009.pdf>. Accessed 6/17/2011.
- National Committee for Quality Assurance. "HEDIS and ICD-10 Information." <http://www.ncqa.org/tabid/1260/Default.aspx>. Accessed 7/1/2011.
- National Quality Forum. ICD-10-CM/PCS Coding Maintenance Operational Guidance: A CONSENSUS REPORT. Accessed 7/1/2011. http://www.qualityforum.org/Publications/2010/10/ICD-10-CM/PCS_Coding_Maintenance_Operational_Guidance.aspx
- Also, see CMS Measures Manager Blueprint for discussion of measure development, evaluation, and maintenance at https://www.cms.gov/MMS/19_MeasuresManagementSystemBlueprint.asp



CMS ICD-10
Office of Medicare Programs for the 21st Century
www.cms.gov/ICD10

Performance Measurement

The Data Fog

- **A 'Data fog' will challenge measurement during the transition for a number of reasons**
 - A new model with little coding experience
 - Changes in terminology
 - Changes in categorizations
 - The sheer number of codes
 - Complex coding rules
 - Productivity pressures

Consistent



Accurate



Accurate & Consistent



Purpose of the slide

Understand the 'Data Fog' associated with ICD-10 that will impact analytics and dissipate over a period of 3-5 years, eventually leaving SMAs with improved ability to measure performance.

Talking Points

- Based on the experience of other countries (e.g., Canada), ICD-10 will create a 'data fog' that will dissipate over a period of 3 to 5 years.
- Any time data are mapped from ICD-9 to ICD-10 or vice versa, the resulting data may either assume something that is not true or lose information that is true.
- Because of the numerous issues related to mapping existing data points (e.g. claims) coded in ICD-9 to ICD-10, it will be easier and often more accurate to store data in the format it was received and update policies and analytics on the back-end to process either ICD-9 or ICD-10 natively. To perform these updates (see later section on Equivalent Groups), SMAs will still use maps but only as a starting point as maps often capture only a minority of codes that categorize a clinical concept.
- Changes in coding rules and the substantial changes in terminology for the ICD-10-PCS codes may result in considerable confusion in coding interpretation and therefore result in considerable coding variance.



Official ICD-10 Codes, Approved for the 2013 Transition
www.cms.gov/ICD10

Performance Measurement

Changes in Definitions Used in Diagnoses

- **During the ICD-10 transition, it may be difficult to determine if changes in quality measurements are an actual change in performance or simply due to the change in the code sets**
- **For example, the definition of AMI has changed**
 - ICD-9: Eight weeks from initial onset
 - ICD-10: Four weeks from initial onset
- **Subsequent vs. Initial episode of care**
 - ICD-9: Fifth character defines initial vs. subsequent episode of care
 - ICD-10: No ability to distinguish initial vs. subsequent episode of care
- **Subsequent (MI)**
 - ICD-9 – No ability to relate a subsequent MI to an initial MI
 - ICD-10 – Separate category to define a subsequent MI occurring within 4 weeks of an initial MI

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Purpose of the slide

Understand that changes in definitions used for diagnoses will impact measurements.

Talking Points

- In this case, even if we assume that coders will code exactly in ICD-10 as they did in ICD-9 and that all codes map exactly from ICD-9 to ICD-10, measurements may be different some definitions that inform codes are different between the code sets (see AMI example)



Official Medicare Reimbursement for ICD-10 Transition
www.cms.gov/ICD10

Performance Measurement

Example - Comprehensive Diabetes Care (CDC)

- The Comprehensive Diabetes Care (CDC) measures are often used by State Medicaid Agencies to determine performance

Description

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following.

<ul style="list-style-type: none"> • Hemoglobin A1c (HbA1c) testing • HbA1c poor control (>9.0%) • HbA1c control (<8.0%) • HbA1c control (<7.0%) for a selected population* • Eye exam (retinal) performed 	<ul style="list-style-type: none"> • LDL-C screening • LDL-C control (<100 mg/dL) • Medical attention for nephropathy • BP control (<140/80 mm Hg) • BP control (<140/90 mm Hg)
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*Additional exclusion criteria are required for this indicator that will result in a different eligible population from all other indicators. This indicator is only reported for the commercial and Medicaid product lines.

- Diagnosis and procedure codes are used to determine both the denominators and numerators

Source: National Committee for Quality Assurance (NCQA), HEDIS 2012 Volume 2: Technical Specifications.

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Purpose of the slide

Discuss a specific example of a quality measure and the impacts of ICD-10.

Talking Points

- See exhibit Technical Specifications for the Comprehensive Diabetes Care (CDC) measures.

Source(s):

- National Committee for Quality Assurance. HEDIS 2012 Volume 2: Technical Specifications.



Performance Measurement

Remediation

- The National Committee for Quality Assurance (NCQA) is remediating approximately one-third of their measures each year so that they are complete by 10/1/2013
- On 3/15/2012, NCQA will post ICD-10 codes applicable to a second set of measures, including Comprehensive Diabetes Care, for 30-day review and comment
- “HEDIS will begin the phase-out of ICD-9 codes in HEDIS 2015. Codes will be removed from a measure when the look-back period for the measure, plus one additional year, has been exhausted. This is consistent with NCQA’s current policy for removing obsolete codes from measure specifications”

Source: NCQA. <http://www.ncqa.org/tabid/1260/Default.aspx>

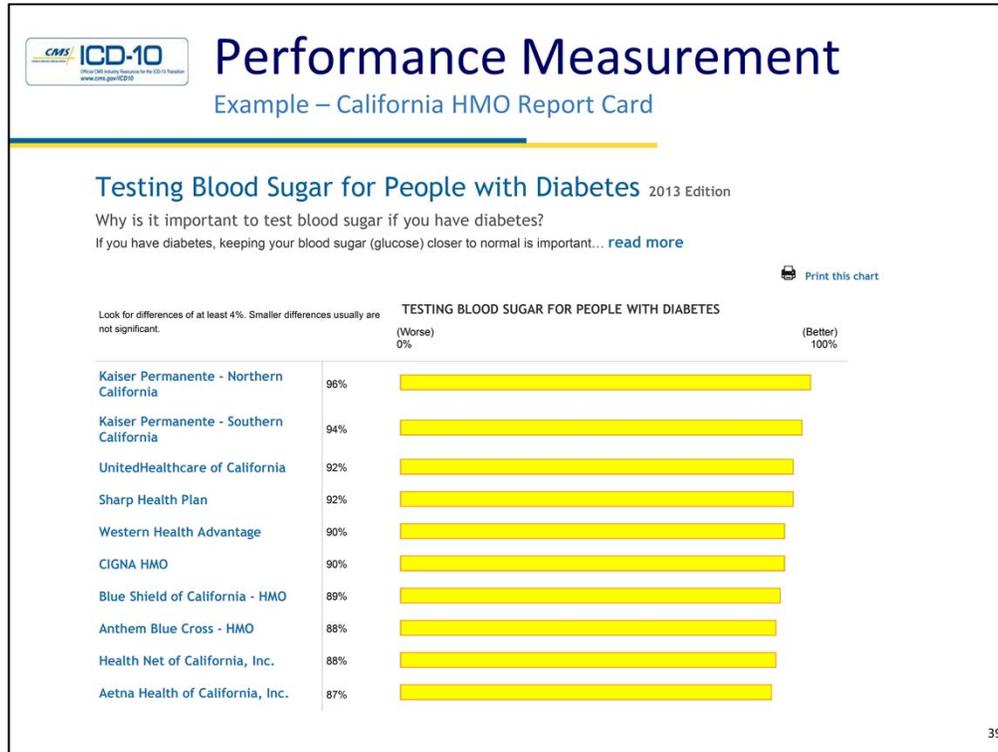
38

Talking Points

- Measures in the 3/15/2012 set include:
 - **Prevention and Screening:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Childhood Immunization Status, Immunizations for Adolescents, Breast Cancer Screening, Cervical Cancer Screening, Colorectal Cancer Screening, Chlamydia Screening in Older Women, Glaucoma Screening in Older Adults
 - **Respiratory Conditions:** Appropriate Testing for Children With Pharyngitis, Appropriate Treatment for Children With Upper Respiratory Infection, Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis, Use of Spirometry Testing in the Assessment and Diagnosis of COPD, Pharmacotherapy Management of COPD Exacerbation, Use of Appropriate Medications for People With Asthma
 - **Cardiovascular Conditions:** Cholesterol Management for Patients With Cardiovascular Conditions, Controlling High Blood Pressure, Persistence of Beta-Blocker Treatment After a Heart Attack
 - **Musculoskeletal Conditions:** Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis, Osteoporosis Management in Women, Use of Imaging Studies for Low Back Pain
 - **Diabetes:** Comprehensive Diabetes Care
 - **Behavioral Health:** Antidepressant Medication Management, Follow-Up Care for Children Prescribed ADHD Medication, Follow-Up After Hospitalization for Mental Illness
 - **Medication Management:** Potentially Harmful Drug-Disease Interactions in the Elderly
 - **Access/Availability of Care:** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
 - **Use of Services:** Identification of Alcohol and Other Drug Services, Mental Health Utilization

Source(s)

- National Committee for Quality Assurance. HEDIS 2012 Volume 2: Technical Specifications.
- National Committee for Quality Assurance. <http://www.ncqa.org/tabid/1260/Default.aspx>. Accessed 12/22/2011.
- National Committee for Quality Assurance. <http://www.ncqa.org/tabid/1261/Default.aspx>. Accessed 12/22/2011.



Purpose of the slide

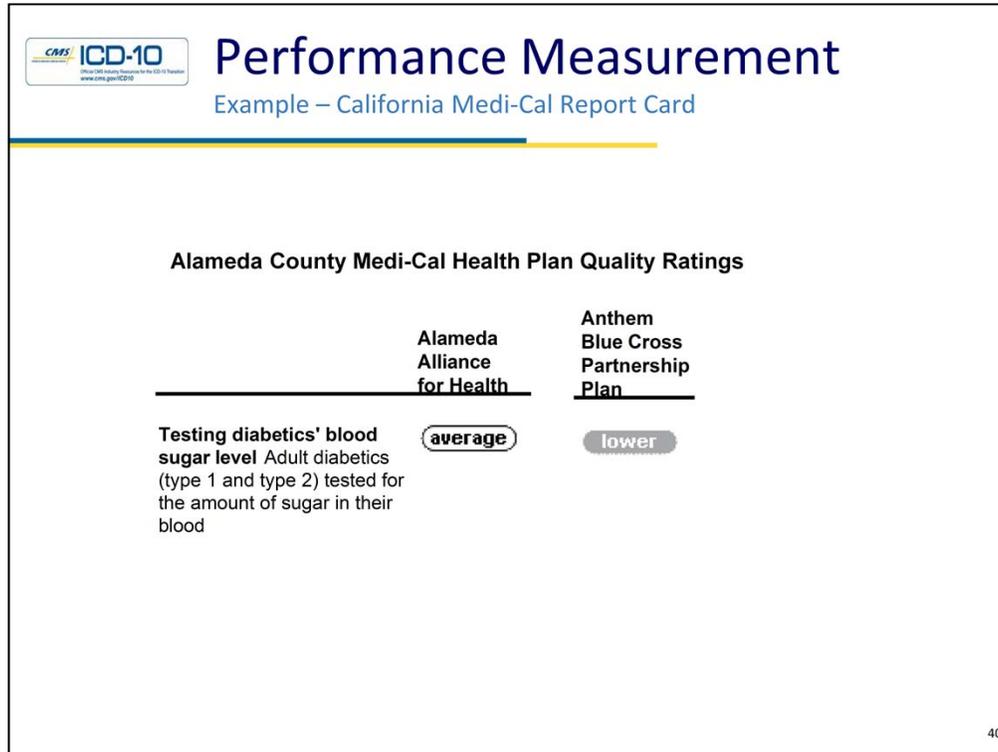
Discuss a State-specific example of using performance measures impacted by ICD-10.

Talking Points

- This Report Card shows the quality of health care for over 9 million Californians who get their care through Health Maintenance Organizations (HMO). The 10 largest HMOs in the state are included in this Report Card.
- Benchmarks, standards, and trend need to be re-evaluated in light of ICD-10.

Source(s)

- <http://reportcard.opa.ca.gov/rc2013/HMOmeasure.aspx?Category=HMOHEDIS&Topic=DiabetesCare&Measure=TestingBloodSugarForDiabetesPatients>



Purpose of the slide

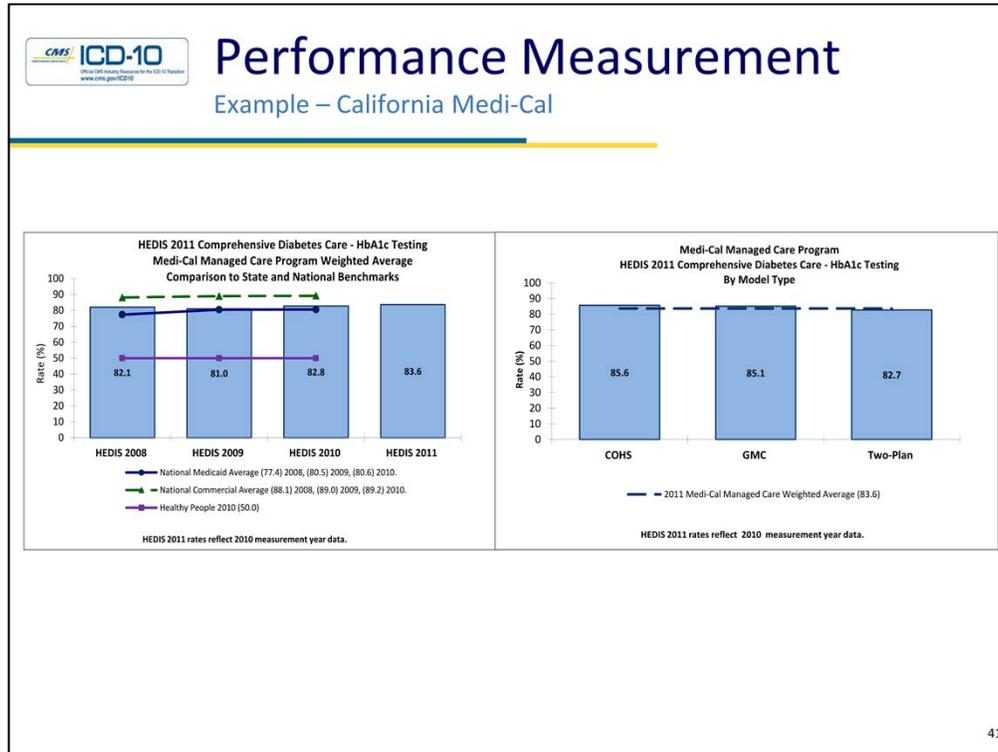
Discuss a State-specific example of using performance measures impacted by ICD-10.

Talking Points

- Ratings for vaccines for children, checkups for teens, checkups for children, pregnancy care, testing diabetics' blood sugar, and care for adults with bronchitis is from records of Medi-Cal members' services during 2011. This is the most up-to-date information available.
- Benchmarks, standards, and trend need to be re-evaluated in light of ICD-10.

Source(s)

- <http://reportcard.opa.ca.gov/rc/medi-calmeasure.aspx?County=ALAMEDA>



Purpose of the slide

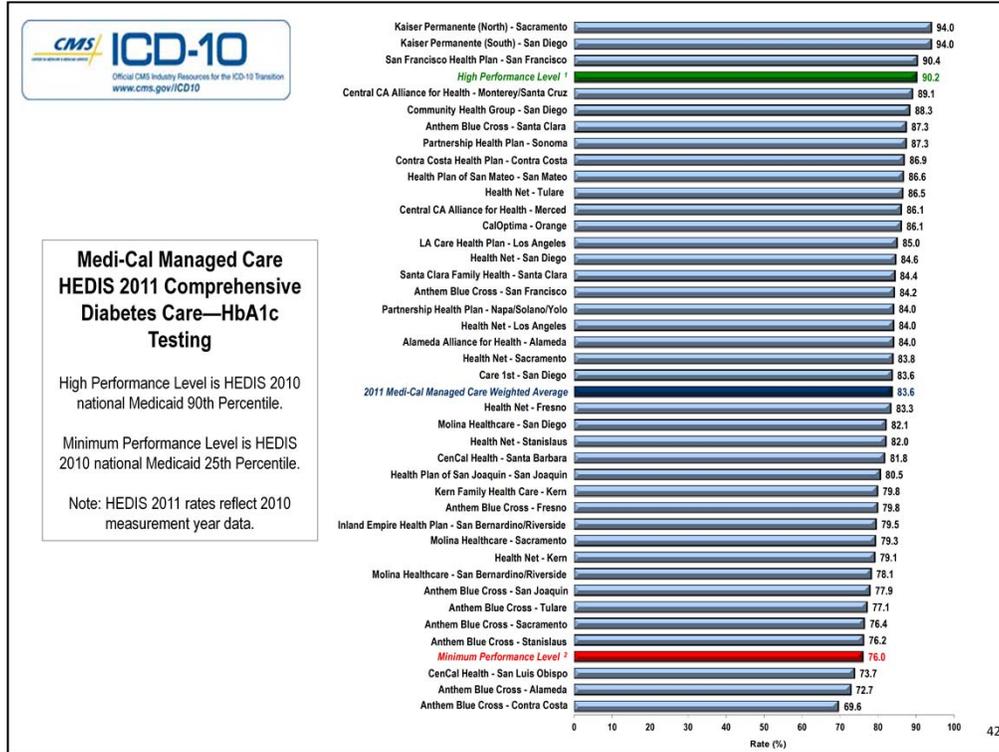
Discuss a State-specific example of using performance measures impacted by ICD-10.

Talking Points

- Benchmarks, standards, and trend need to be re-evaluated in light of ICD-10.

Source(s)

- Michigan Department of Community Health. **Michigan Medicaid HEDIS 2012 Results Statewide Aggregate Report (Oct 2012)**. http://www.michigan.gov/documents/mdch/MI2012_HEDIS-Aggregate_Report_F1_402790_7.pdf. Accessed 1/12/13.



Purpose of the slide

Discuss a State-specific example of using performance measures impacted by ICD-10.

Talking Points

- Benchmarks, standards, and trend need to be re-evaluated in light of ICD-10.

Source(s)

- DHCS. **2011 HEDIS Aggregate Report for the Medi-Cal Managed Care Program (Dec 2011).**
http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/HEDIS_Reports/CA2011_HEDIS_Aggregate_F2.pdf. Accessed 5/20/13.
- DHCS. **Performance Evaluation Report Kaiser Permanente (KP Cal, LLC) Sacramento County (Jun 2012).**
http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/1011PlanSpecificPerfEvals/Kaiser-Sac_CA2010-11_PerfEval_Report_F2.pdf. Accessed 5/20/13.



Performance Measurement

Example – California Medi-Cal

Table 3.2—2010–2011 Performance Measure Results for Kaiser—Sacramento County

Performance Measure ¹	Domain of Care ²	2010 HEDIS Rates ³	2011 HEDIS Rates ⁴	Performance Level for 2011	Performance Comparison ⁵	MMCD's Minimum Performance Level ⁶	MMCD's High Performance Level (Goal) ⁷
AAB	Q	61.4%	54.8%	***	↔	19.7%	35.9%
AWC	Q,A,T	32.1%	39.0%	**	↑	38.8%	63.2%
BCS	Q,A	73.9%	74.1%	***	↔	46.2%	63.8%
CCS	Q,A	81.9%	84.1%	***	↑	61.0%	78.9%
CDC–BP	Q	79.0%	77.8%	***	↔	53.5%	73.4%
CDC–E	Q,A	70.1%	67.5%	**	↔	41.4%	70.1%
CDC–H8 (<8.0%)	Q	64.6%	63.1%	***	↔	38.7%	58.8%
CDC–H9 (>9.0%)	Q	23.6%	21.5%	***	↔	53.4%	27.7%
CDC–HT	Q,A	92.8%	94.0%	***	↔	76.0%	90.2%
CDC–LC (<100)	Q	63.3%	62.7%	***	↔	27.2%	45.5%
CDC–LS	Q,A	89.9%	92.1%	***	↔	69.3%	84.0%
CDC–N	Q,A	82.1%	83.1%	**	↔	72.5%	86.2%
CIS–3	Q,A,T	75.5%	80.2%	**	↑	63.5%	82.0%
LBP	Q	88.4%	87.5%	***	↔	72.0%	84.1%
PPC–Pre	Q,A,T	88.4%	91.6%	**	↔	80.3%	92.7%
PPC–Pst	Q,A,T	75.9%	71.7%	**	↔	58.7%	74.4%
URI	Q	97.0%	97.3%	***	↔	82.1%	94.9%
W34	Q,A,T	66.3%	69.0%	**	↑	65.9%	82.5%
WCC–BMI	Q	38.1%	52.8%	**	↑	13.0%	63.0%
WCC–N	Q	46.7%	60.3%	**	↑	34.3%	67.9%
WCC–PA	Q	24.5%	59.8%	***	↑	22.9%	56.7%

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Talking Points

- Benchmarks, standards, and trend need to be re-evaluated in light of ICD-10.

Source(s)

- DHCS. **2011 HEDIS Aggregate Report for the Medi-Cal Managed Care Program (Dec 2011)**. http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/HEDIS_Reports/CA2011_HEDIS_Aggregate_F2.pdf. Accessed 5/20/13.
- DHCS. **Performance Evaluation Report Kaiser Permanente (KP Cal, LLC) Sacramento County (Jun 2012)**. http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/1011PlanSpecificPerfEvals/Kaiser-Sac_CA2010-11_PerfEval_Report_F2.pdf. Accessed 5/20/13.

Note(s)

1 DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA). 2 HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T). 3 HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.

4 HEDIS 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.

5 Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.

6 The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.

7 The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

* = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.

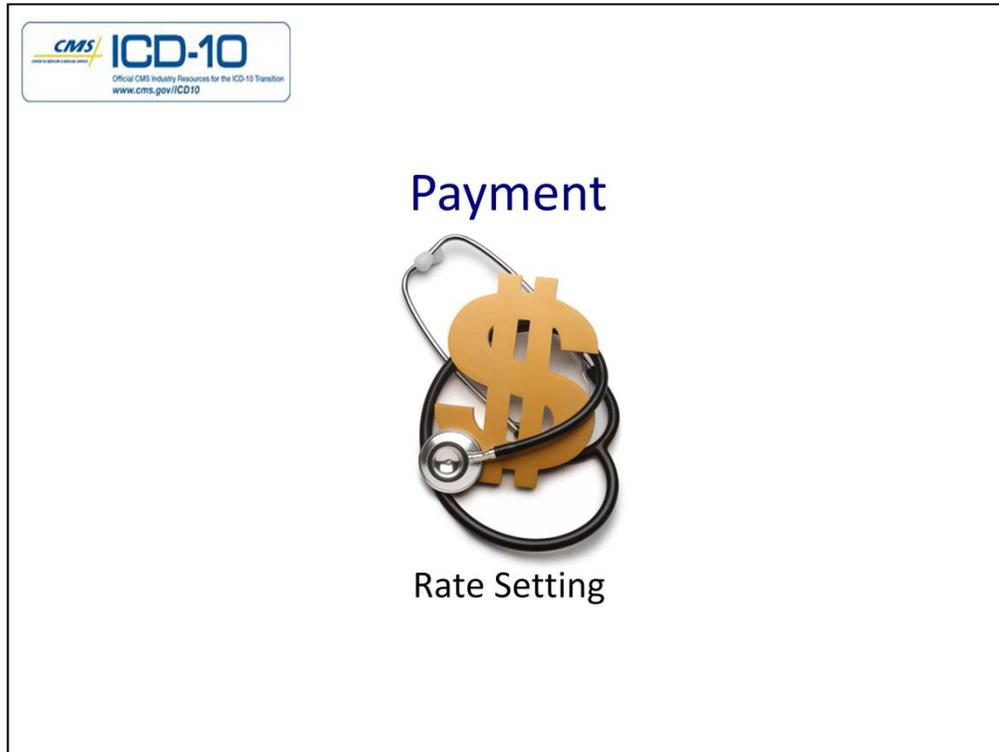
** = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.

*** = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (9.0%) measure, performance is relative to the national Medicaid 10th percentile.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

↑ = Statistically significant increase.



Purpose of the slide

Introduce slides covering payment to health services contractors in order to discuss ICD-10 impacts, opportunities, and examples in the area of managed care.

Talking Points

- None

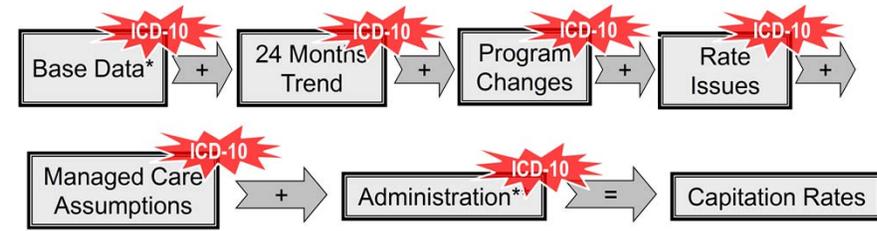


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Rate Setting

Setting a Good Base

- In determining capitation rates, States and plans use claims (fee for service and/or encounter) and other reference data to predict recipients' use of health care services
- Capitation rate development considerations for calculating Per Member Per Month (PMPM) capitation rates



* The completeness of data will be reviewed and completion factors may be applied
** Administration includes taxes/assessments

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Purpose of the slide

Discuss some of the short-term issues with rate setting resulting from the move to ICD-10.

Talking Points

- Base data (excluding carve-outs) and adjustments (e.g. IBNR)
- Medical trend
- State fiscal conditions and program/policy changes
- Evaluation of Rate Issues - on the first day of the fall 2011 session, the U.S. Supreme Court heard arguments on State Medicaid rate cuts and on 5/6/11, CMS issued proposed rule on access measurement and rate setting.
- Managed care adjustments
- Administration, profit, risk & contingency adjustment
- Premium tax / fees

Source(s)

- Mercer. "Rate-Setting Overview." 12/19/2011.
- American Academy of Actuaries. "Practice Note: Actuarial Certification of Rates for Medicaid Managed Care Programs (August 2005)." http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf. Accessed 11/30/2011.
- American Academy of Actuaries. "Medicaid Rate Setting 101." http://www.actuary.org/pdf/health/Medicaid_Work_Group_CMS_Presentation_Final.pdf. Accessed 11/30/2011.
- CMS. "PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Rate setting (July 22, 2003)". This 19-page document is used by CMS' Regional Offices in their review and approval of state capitation rate submissions. Accessed at http://www.azdhs.gov/phs/ocshcn/crs/RFP_Bidder_Library/CMSRateSettingChecklist.pdf. Accessed 11/30/2011.
- U.S. Government Accountability Office. "MEDICAID MANAGED CARE: CMS's Oversight of States' Rate Setting Needs Improvement (GAO-10-810)." August 2010. <http://www.gao.gov/new.items/d10810.pdf>. Accessed 11/30/2011.
- Medicaid and CHIP Payment and Access Commission. Report to Congress: The Evolution of Managed Care in Medicaid (June 2011). <http://docs.google.com/viewer?a=v&pid=sites&srcid=bWFJcGFjLmdvdnxtYWNwYWN8Z3g6NTM4OGNmMTJINjdKMDZiYw>. Accessed 11/30/2011.



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www.cms.gov/ICD10

Rate Setting

Building on the Base

■ Additionally, capitation rate development considerations beyond Per Member Per Month (PMPM) capitation rate

- Maternity and/or newborn “kick” payment 
- Risk adjustment: age / gender only vs. adding diagnosis and/or pharmacy based tools 
- Reinsurance (Commercial or State-sponsored) 
- Medical Loss Ratios / Profit Caps / Risk Sharing 
- Risk pools and Risk corridors 
- Performance incentives and/or withholds 

46

Purpose of the slide

Discuss some of the short-term issues with rate setting resulting from the move to ICD-10.

Talking Points

- None

Source(s)

- Mercer. “Rate-Setting Overview.” 12/19/2011.
- American Academy of Actuaries. “Practice Note: Actuarial Certification of Rates for Medicaid Managed Care Programs (August 2005).” http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf. Accessed 11/30/2011.
- American Academy of Actuaries. “Medicaid Rate Setting 101.” http://www.actuary.org/pdf/health/Medicaid_Work_Group_CMS_Presentation_Final.pdf. Accessed 11/30/2011.
- CMS. “PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Rate setting (July 22, 2003)”. This 19-page document is used by CMS’ Regional Offices in their review and approval of state capitation rate submissions. Accessed at http://www.azdhs.gov/phs/ocshcn/crs/RFP_Bidder_Library/CMSRateSettingChecklist.pdf. Accessed 11/30/2011.
- U.S. Government Accountability Office. “MEDICAID MANAGED CARE: CMS’s Oversight of States’ Rate Setting Needs Improvement (GAO-10-810).” August 2010. <http://www.gao.gov/new.items/d10810.pdf>. Accessed 11/30/2011.
- Medicaid and CHIP Payment and Access Commission. Report to Congress: The Evolution of Managed Care in Medicaid (June 2011). <http://docs.google.com/viewer?a=v&pid=sites&srcid=bWFJcGFJLmdvdnxtYWNwYWN8Z3g6NTM4OGNmMTJINjkdMDZiYw>. Accessed 11/30/2011.

 Official CMS Industry Resources for the ICD-10 Transition
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Payment



Risk Adjustment

Purpose of the slide

Introduce slides covering risk adjustment of payments to health services contractors in order to discuss ICD-10 impacts, opportunities, and examples in the area of managed care.

Talking Points

- None



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Risk Adjustment

Comparing Apples and Oranges

- Risk adjustment methods use different types of data and a variety of statistical methods to explain an outcome – resource use, events, etc.
- Risk adjustment is a tool to help understand variation between individuals or groups of individuals
- One can not make fair comparisons from observational data without adjusting for illness burden



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Purpose of the slide

Discuss some basics of risk adjustment.

Talking Points

- None

Notes

- Source: R Winkelman, FSA. "A Comparative Analysis of Claims-Based Tools for Health Risk Assessment." April 20, 2007. Accessed 09/13/2011. <http://www.soa.org/files/pdf/risk-assessmentc.pdf>
- Source: Kronick, R. "Improving Health-Based Payment for Medicaid Beneficiaries: CDPS." Health Care Financing Review. Spring 2000. 21(3). Accessed 09/1/2011. http://cdps.ucsd.edu/cdps_hcfr.pdf
- Actuarial Standards Board. "Actuarial Standard of Practice No. 45: The Use of Health Status Based Risk Adjustment Methodologies." http://www.actuarialstandardsboard.org/pdf/asop045_164.pdf. Accessed 2/23/2012.



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Risk Adjustment

Adjusters Wear Many Hats

- **Different adjusters have different characteristics...**
 - Additive or Categorical
 - Acute and/or chronic
 - Truncation (i.e. excludes some outliers)
 - Diagnosis, Pharmacy, or combined data
 - Prospective or Concurrent

- **...and different purposes**
 - Prospective capitation payments
 - Reconciliations
 - Performance measurement
 - Risk stratification for care management
 - Program evaluations

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Purpose of the slide

Covers some different characteristics and purposes of risk adjustment.

Talking Points

- None

Model Feature	Adjusted Clinical Groups (ACGs)	Chronic-Illness Disability Payment System (CDPS)	Clinical Risk Groups (CRGs)	Diagnostic Risk Group (DCG)	Episode Risk Groups (ERGs)
Background					
Model Developer	Johns Hopkins	University of California, San Diego (UCSD)	3M Health Information Systems	Verisk Health (formerly DxCG)	Ingenix (formerly Symmetry)
Marketplace Introduction	1992	1996	2000	1996	2001
Disease Classification					
Additive/Categorical Classification	Categorical	Additive	Categorical	Additive	Additive
Diagnoses (Dx)	Single diagnosis	Single diagnosis	Single diagnosis from inpatient facility or two diagnoses from professionals	Single diagnosis	Single diagnosis from face-to-face encounter or inpatient admissions
Conditions Included	Acute and chronic	Chronic only	Acute and chronic	Acute and chronic	Acute and chronic
Model Users					
Government Programs to Adjust Capitation Payments	4 Medicaid	10 Medicaid	1 Medicaid	Medicare	1 Medicaid
Commercial	175	None	7	300+	60
Estimation Capabilities¹ (Prospective R-Squared)					
Without Truncation	16.6%	14.7%	N/A ²	17.8%	16.4%
Truncated at \$100,000	21.8%	20.8%	N/A	24.9%	24.4%
Available Models					
Diagnosis (Dx) Only	✓	✓	✓	✓	3
Pharmacy (Rx) Only	✓	✓	✓	✓	✓
Dx-Rx Combined	✓	✓	✓	4	✓
Embedded Weights					
Time Period Measured	2002 – 2003	2001 – 2002	N/A ⁵	2002 – 2005 ⁶	2004 – 2006
Lines of Business Provided (Commercial, Medicare, and/or Medicaid)	Commercial, Medicare and limited Medicaid Managed Care experience	Medicaid	N/A	Separate models for each line of business. Medicaid model is based on a single program product	Commercial population for Dx-Rx model. Commercial and Medicaid for Rx-only product
Future Updates Scheduled	Fall 2009 with updates every 18 months	Updates are not regularly scheduled	N/A	Fall 2009 with updates every two years	2010 with updates approximately every two years
Allows for Variations in Benefit Package	Available upon request at an additional cost	Variations are available around behavioral health and pharmacy benefits	N/A	Available upon request at an additional cost	Available upon request at an additional cost

Purpose of the slide

Comparison of different risk adjustment models used by SMAs.

Footnotes from the original graphic

1. Based on a Medicaid case study, the CRG model's performance was in between the other two models within the study: ACG and CDPS.
2. ERG product can be run without drug data, but the embedded weights would not be appropriately calibrated.
3. Verisk does offer a product that uses inpatient diagnoses along with drug data to assess health risk.
4. The CRG product does not contain embedded weights. Weights would be provided to a Medicaid program upon request at no additional cost.
5. Varies by product line. Medicaid model based on July 2002 through June 2005 data. Commercial model based on 2004 – 2005 data.

Source(s)

- R Winkelman, FSA. "A Comparative Analysis of Claims-Based Tools for Health Risk Assessment." April 20, 2007. Accessed 09/13/2011. <http://www.soa.org/files/pdf/risk-assessmentc.pdf>
- Kronick, R. "Improving Health-Based Payment for Medicaid Beneficiaries: CDPS." Health Care Financing Review. Spring 2000. 21(3). Accessed 09/11/2011. http://cdps.ucsd.edu/cdps_hcfr.pdf
- Actuarial Standards Board. "Actuarial Standard of Practice No. 45: The Use of Health Status Based Risk Adjustment Methodologies." http://www.actuarialstandardsboard.org/pdf/asop045_164.pdf. Accessed 2/23/2012.



Risk Adjustment

Moving from ICD-9 to ICD-10

- Many risk adjusters are based on an analysis of historical information and are typically licensed and maintained by an entity who is responsible for their updates and revisions
 - In order to update risk adjusters for ICD-10, maintainers may use clinical and/or probabilistic maps to use historical ICD-9 data for developing adjusters for ICD-10
 - Some risk adjusters may not initially support native ICD-10 and will require States to map diagnosis codes to back to ICD-9
- To date, we just don't know as adjusters have not been publically specified for public review and comparison
- Maintainers attempt to make ICD-10 adjusters 'financially neutral' for plans/providers but this assumes coding conventions will be similar across two very different code sets

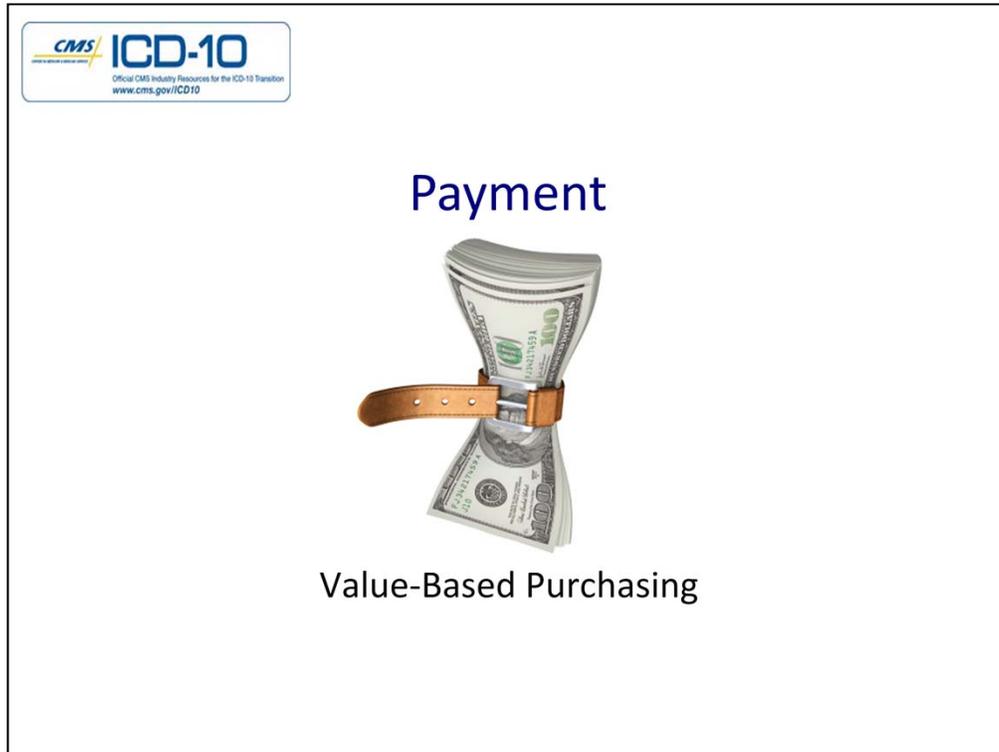
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Purpose of the slide

Discuss some of the short-term issues with risk adjusters resulting from the move to ICD-10.

Talking Points

- None



Purpose of the slide

Introduce slides covering value-based purchasing in order to discuss ICD-10 impacts, opportunities, and examples in the area of managed care.

Talking Points

- None



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Value-Based Purchasing

Aligning Incentives

- **In the State of New York, health plans earn rewards up to 3% of premium for good performance:**
 - HEDIS or NYS-specific quality measures
 - CAHPS measures
 - Regulatory compliance
- **Plans must qualify for incentive to receive auto-assignments**
- **ICD-10 will impact the measures, benchmarks, and improvement targets used in these programs**



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Purpose of the slide

To show another analytical and reporting output that would be affected by this scenario – Value-Based Purchasing

Talking Points

- Many states use payment-for-performance incentives for their managed care organizations and individual providers.
- Also note that New York Quality Alliance pools data across health plans to provide pay for performance incentives back to providers.
- ICD-10 will impact the measures, benchmarks, and improvement targets used in these programs.

Source(s)

- Center for Health Care Strategies. "Physician Pay for Performance in Medicaid: A Guide for States." March 2007. http://www.chcs.org/publications3960/publications_show.htm?doc_id=471272. Accessed 12/27/2011.
- Center for Health Care Strategies. "Descriptions of Selected PERFORMANCE INCENTIVE PROGRAMS." November 2005. http://www.chcs.org/usr_doc/State_Performance_Incentive_Chart_0206.pdf. Accessed 12/27/2011.
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- IPRO. "PAY-FOR-PERFORMANCE IN STATE MEDICAID PROGRAMS." April 2007. http://www.commonwealthfund.org/-/media/Files/Publications/Fund%20Report/2007/Apr/Pay%20for%20Performance%20in%20State%20Medicaid%20Programs%20%20A%20Survey%20of%20State%20Medicaid%20Directors%20and%20Programs/1018_Kuhmerker_payforperformance_state_Medicaid_progs_v2.pdf. Accessed 12/27/2011.
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www.cms.gov/ICD10

Budget Neutrality

A Quick Side-Note

■ Calculating Budget Neutrality

- The budget neutrality cap is usually calculated on either a per-member per-month (PMPM) or a per capita basis

$$\text{Medicaid Base Year Costs}^* \times \text{Growth Rate} = \text{"Without Waiver" Costs}$$

↔

$$\text{Demo Year Enrollment (actual or projected)} \times \text{Cost per Eligible Individual}^{\dagger} = \text{"With Waiver" Costs}$$

Budget Neutrality
"Without Waiver" Costs \geq "With Waiver" Costs

- States that exceed budget neutrality caps are at risk for the excess costs and either need to use state-only funds or scale back their programs
- In terms of capitation payments, good rate-setting creates a "bottom line neutrality" even if individual areas are not neutral

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Purpose of slide

Discuss budget neutrality for waivers and programs and impact of ICD-10

Talking Points

1. Determine a state's Medicaid costs in a base year, usually the 12-month period for which the most recent, complete program data are available
2. Growth rates are then applied to the base year data to project future expenditures to create the "without waiver costs" baseline. The growth rates are determined by using historical caseload and expenditure data over the prior five-year period.
3. The "with waiver costs" estimate, including any new populations or services, is then compared to the "without waiver costs" estimate to establish that the project is budget neutral.

Source(s)

- National Health Policy Forum. Medicaid Waivers and Budget Neutrality. 8/26/2009. http://www.nhpf.org/library/the-basics/Basics_MedicaidBudgetNeut_08-26-09.pdf. Accessed 11/30/2011.
- Also see "Georgia Families Financial Impact (Oct 2009)." http://www.georgia.gov/vgn/images/portal/cit_1210/11/31/152132927CMOSavings102109.pdf. Accessed 11/30/2011.



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Managed Care

Summary

- In a tight budget environment and increasingly complex population, States are looking to new strategies and new partners for improvements in financial and patient outcomes
- ICD-10 impacts these relationships as it is a business initiative and not just a code set update
 - Encounter Data
 - Performance Measurement
 - Rate Setting
 - Risk Adjustment
- Over time, the move to ICD-10 will allow for improved use of managed care strategies through more accurate and reliable tools to manage contracts and align incentives

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Purpose of the slide

Summarize the Managed Care session by discussing how ICD-10 will impact health services contracts in the short run but provide an opportunity to fine tune managed care strategies toward improved outcomes in the long-run.

Talking Points

- None

Questions

