



Kentucky ICD-10 Site Visit

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

Segment 4: Managed Care

November 15-16, 2012





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

Background



Cost Containment

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**

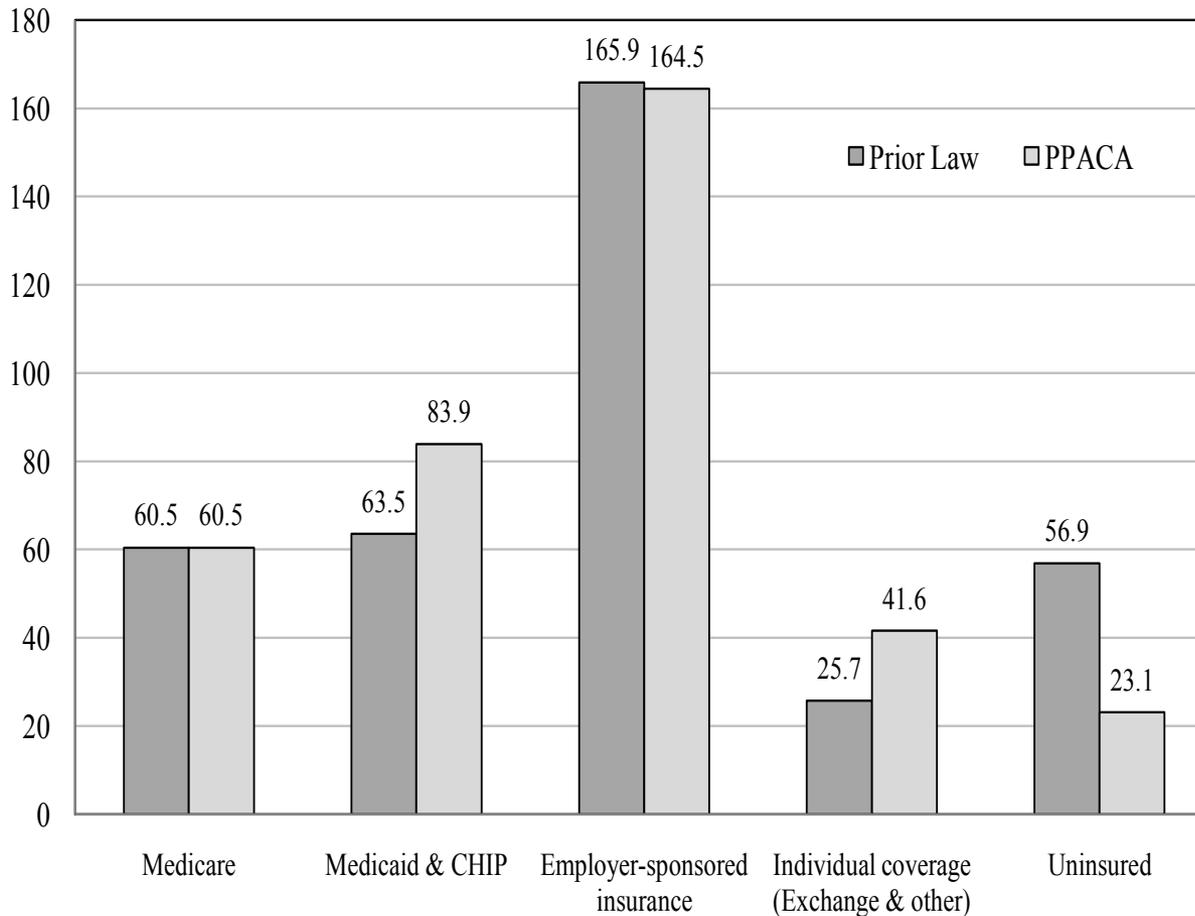


The following chart summarizes the estimated impacts of the PPACA on insurance coverage. The mandated coverage provisions, which include new responsibilities for both individuals and employers, and the creation of the American Health Benefit Exchanges (hereafter referred to as the “Exchanges”), would lead to shifts across coverage types and a substantial overall reduction in the number of uninsured, as many of these individuals become covered through their employers, Medicaid, or the Exchanges.

Cost Containment

The Safety Net is Growing

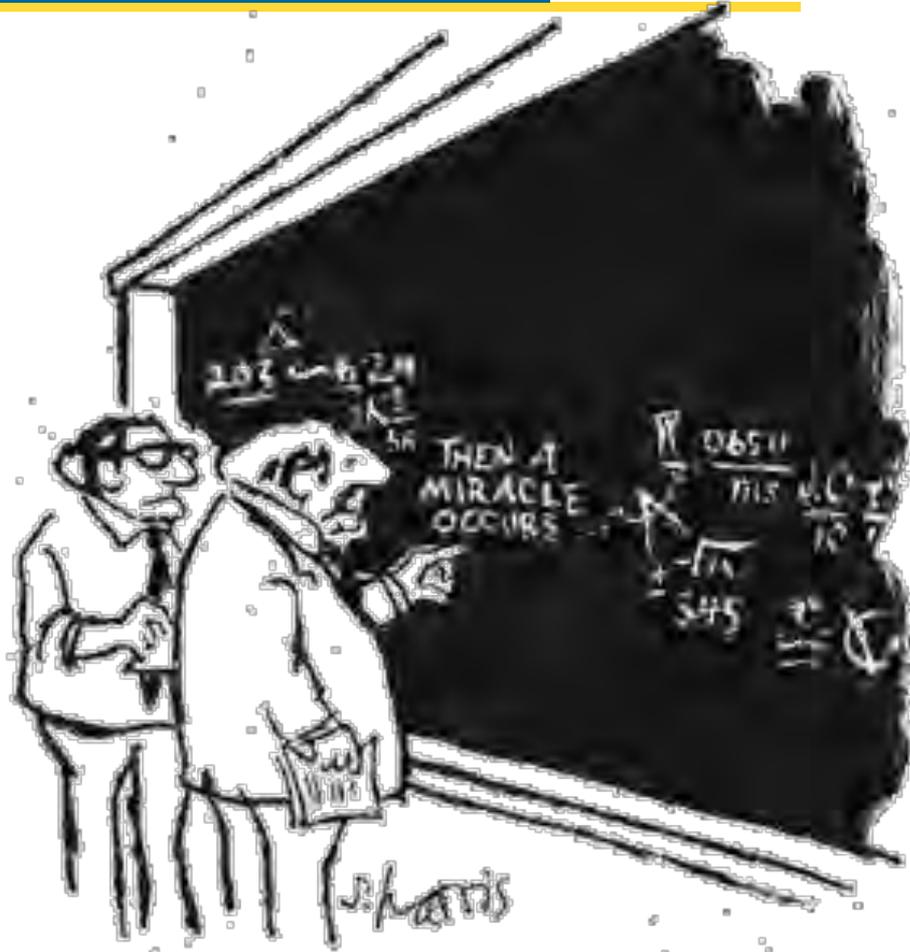
Estimated Effect of the Patient Protection and Affordable Care Act, as Enacted and Amended, on 2019 Enrollment by Insurance Coverage
 (in millions)



Note: Totals across categories are not meaningful due to overlaps among categories (e.g., Medicare and Medicaid).

Cost Containment

Budget "Alchemy"



"I THINK YOU SHOULD BE MORE EXPLICIT HERE IN STEP TWO."

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**

Background



Managed Care as a
Policy Instrument

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.”

- **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.**

Managed Care as a Policy Instrument

Managed Care Strategies

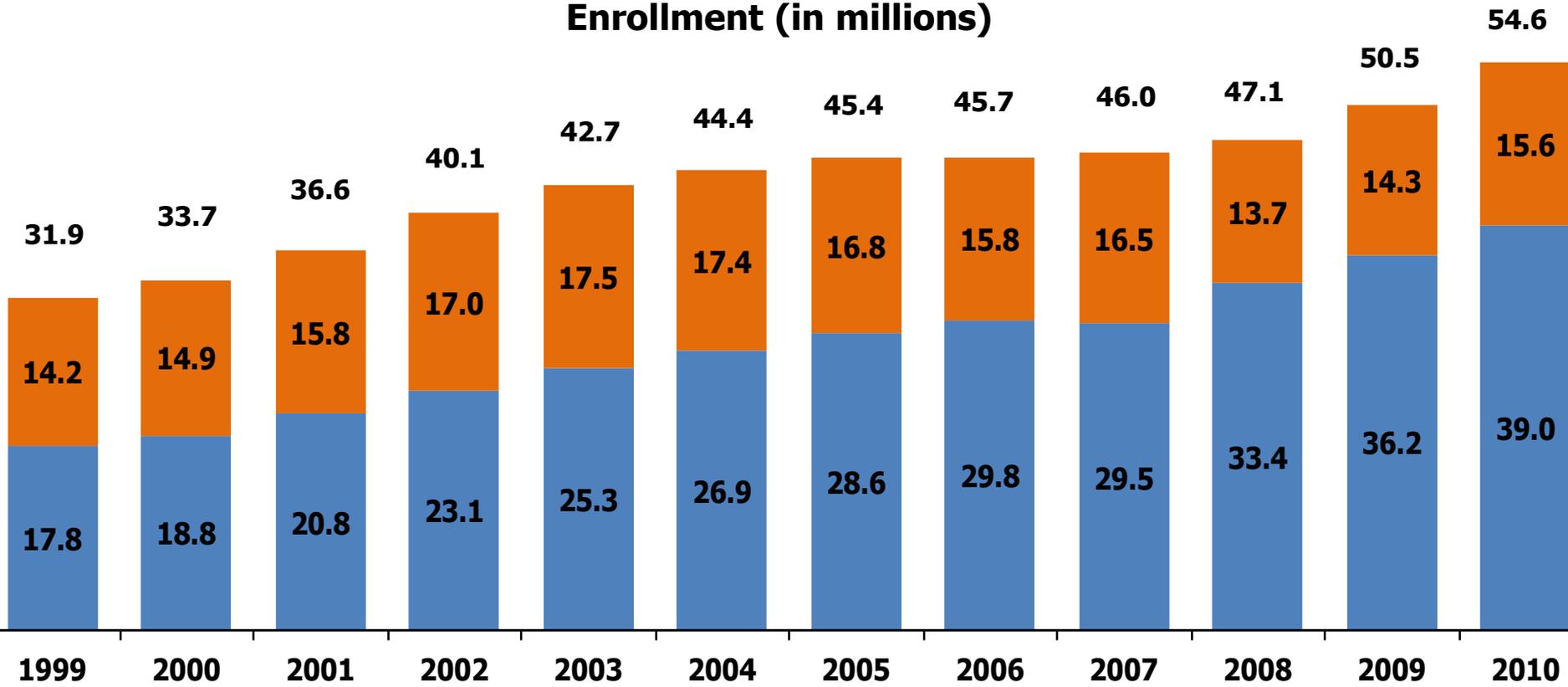
- Integrated Models for Medicare-Medicaid Enrollees 
- Carve-ins for drug coverage
- Pharmacy Benefit Managers (focus on specialty drugs) 
- Managed Care Organizations / Accountable Care Organizations / Specialty Plans 
- Medical Homes – blended payment featuring management fee, FFS, and shared savings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



Managed Care as a Policy Instrument

Medicaid Managed Care and Traditional Enrollment (1999-2010)

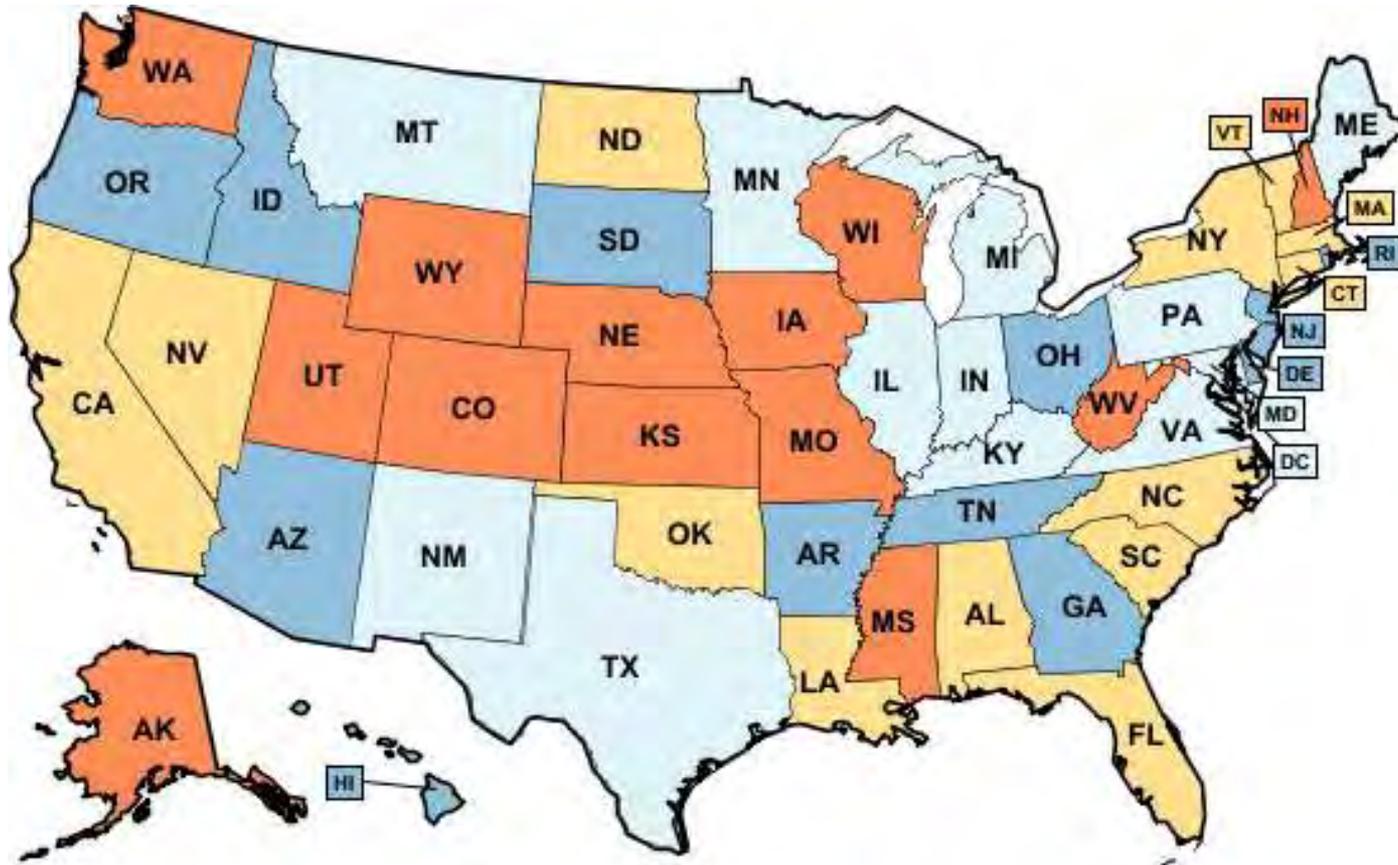
Enrollment (in millions)



- Number Enrolled in Traditional Medicaid Programs
- Number Enrolled in Medicaid Managed Care

Managed Care as a Policy Instrument

Medicaid Enrollment in Comprehensive MCOs (Oct 2010)



0.0% - 54.9%

66.3% - 75.9%

55.0% - 66.1%

76.4% - 100.0%

Managed Care as a Policy Instrument

Ohio Managed Care Activity

- Create a single point of care coordination: OH budget lays the groundwork for a new Integrated Care Delivery System (ICDS) for “dual eligibles” and people with severe and persistent mental illness
- Reform managed-care plans:
 - Consolidate the Aged, Blind and Disabled (ABD) and Covered Families and Children (CFC) managed care programs into a single program operated in three, not eight, districts
 - Shift to "pay for performance" to "reward value rather than volume" as a way to improve health and financial outcomes
 - Population includes approximately 1.6 million individuals enrolled in Ohio's CFC program and enrollment under the new contracts is expected to begin Jan. 1, 2013

Contract Management



Contract Management

A Good Foundation Helps

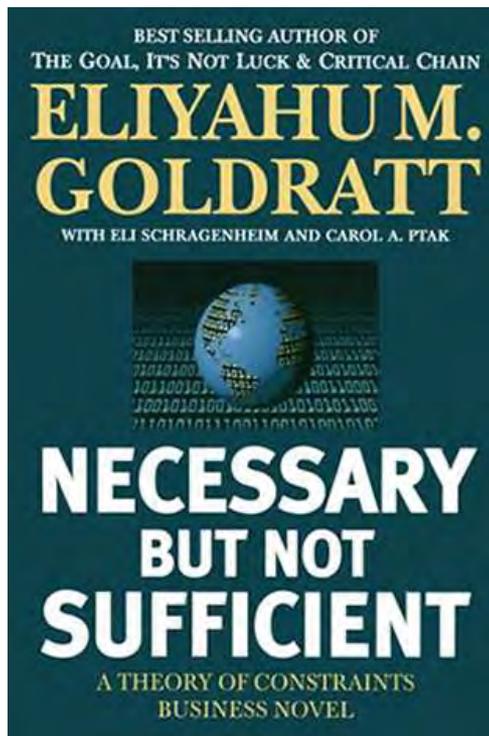
- Health services contractors (e.g., health plans) are used for the provision of Medicaid services on behalf of the State
- This is NOT the contracting experience we want



- 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

Contract Management

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



- **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
- **SMAAs need to understand both the ‘what’ and the ‘how’ contactors and trading partners are remediating ICD-10**

Contract Management



Policies, Procedures, & Plans



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]



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]



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]



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]

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]

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



Contract Management



Encounter Data

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
- SMAs 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



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.

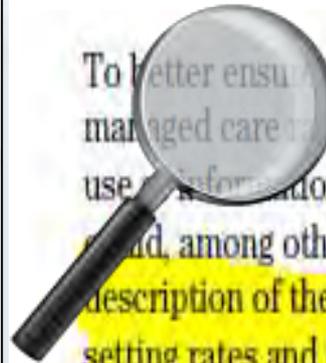
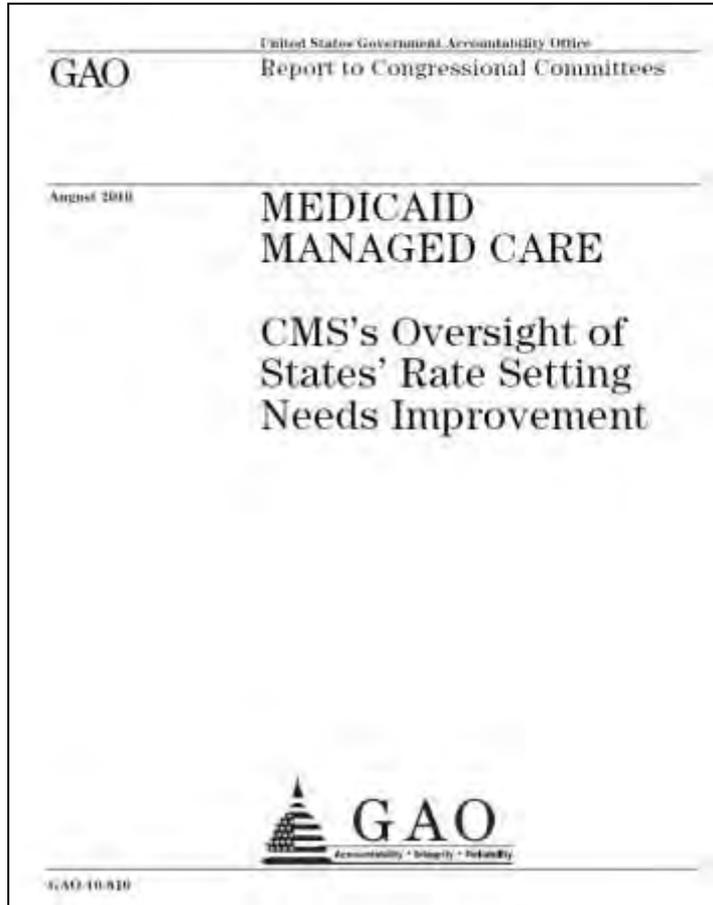
Encounter Data

Affordable Care Act (2010)

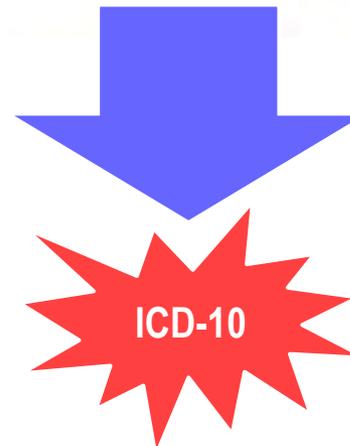
- **In 2007, HHS Office of Inspector General report found challenges with the reporting of encounter data**
 - 15 of 40 applicable States did not report encounters
- **Section 6402(c): Withholding of Federal matching payments for States that fail to report enrollee encounter data in the Medicaid Statistical 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!

Encounter Data

Other Recommendations



To better ensure the quality of the data states use in setting Medicaid managed care rates, we recommend that the Administrator of CMS make use of information on data quality in overseeing states' rate setting. CMS should, among other things, require states to provide CMS with a description of the actions taken to ensure the quality of the data used in setting rates and the results of those actions; consider relevant audits and studies of data quality done by others when reviewing rate setting; and conduct or require periodic audits or studies of the data states use to set rates.



Contract Management

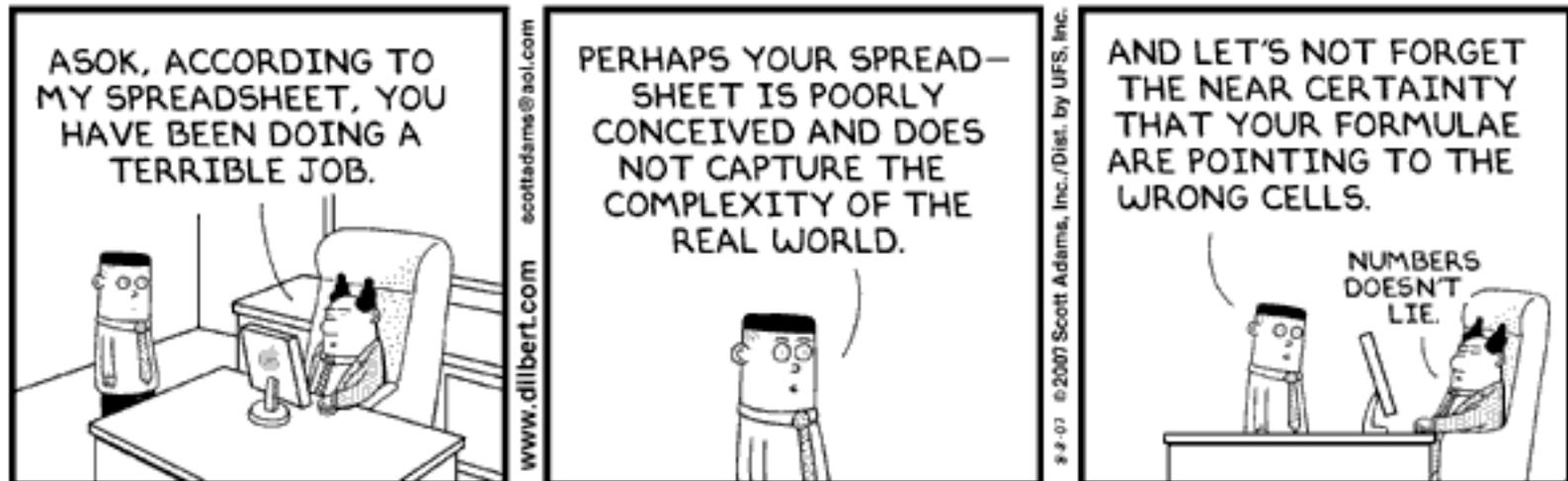


Performance Measurement

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



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



Performance Measurement

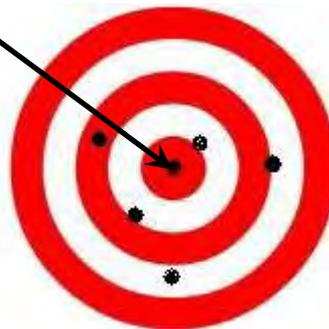
The Data Fog

- 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



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



Performance Measurement

- Added azilsartan to “Angiotensin II inhibitors” description in Table CDC-L.
- Added aliskiren, hydrochlorothiazide, amlodipine to the “Antihypertensive combinations” description in Table CDC-L.
- Clarified BP Control criteria for the Administrative Diabetes Care (CDC)
- Clarified that members who meet the Optional Exclusion criteria must be excluded from the denominator for all rates, if optional exclusions are applied.

■ 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.

- 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
- 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)

**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.

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”

BadgerCare Plus HMO Report Card Health Care Measures (2009 Data)

HMO	Asthma Care	Breast Cancer	Diabetes 1	Diabetes 2	Pap Tests	STD	Vaccines	Blood Lead*	Smoking*	Overall Grade
Abri Health Plan	C	B	D	D	B	A	C	A	D	C
Children's Community Health Plan	B	A	C	D	B	B	B	A	C	B
CompCare	C	B	B	C	B	D	B	A	A	B
Dean Health Plan	B	B	B	D	C	C	A	B	A	B
Group Health Cooperative - Eau Claire	C	B	A	B	B	D	A	B	A	B
Group Health Cooperative - South Central	A	B	C	D	A	A	A	C	A	B
Gunderson Lutheran Health Plan	N/A	N/A	C	C	A	C	N/A	N/A	A	B
Health Tradition Health Plan	N/A	N/A	N/A	N/A	N/A	N/A	C	A	N/A	B
Managed Health Services	B	C	C	D	A	B	D	B	D	C
MercyCare HMO	B	B	B	C	A	D	C	B	B	B
Network Health Plan	C	C	C	C	A	B	B	C	C	C
Physicians Plus	N/A	N/A	N/A	N/A	D	A	N/A	N/A	A	B
Security Health Plan	B	A	B	C	A	D	A	A	A	B
United Healthcare	B	B	C	D	A	B	B	B	C	B
Unity Health Plan	B	A	C	D	B	D	A	B	A	B
Wisconsin Medicaid Average	B	B	B	C	A	C	B	60.4% = B	58.8% = B	B
National Medicaid Average	88.6% = B	52.4% = B	80.6% = B	74.2% = B	65.8% = B	56.7% = B	74.3% = B	--	--	

Health Care grades show how each HMO compares to the **National Medicaid Average**.

* = National Medicaid Average is not available for this measure. Grades are based on how the HMOs compare to the Wisconsin Medicaid Average.

N/A = Complete data are not available for that measure.

Performance Measurement

Example – The Wisconsin Collaborative

TABLE 2: Group Means, HEDIS® Comprehensive Diabetes Care Measures (care provided in 1999-2009)

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
HbA1c Poor Control (>9.0%)*	---	---	---	---	22%	21%	21%	21%	21%	21%	22%
HbA1c Control (<8.0%)	---	---	---	---	---	---	---	---	---	70%	67%
HbA1c Good Control (<7.0%)	---	---	---	---	---	---	---	44%	48%	44%	47%
HbA1c Testing Performed	84%	88%	89%	90%	91%	92%	92%	92%	93%	93%	92%
Eye Exam Performed	63%	66%	63%	66%	63%▽	64%	69%	69%	67%	68%	68%
LDL-Cholesterol Screening Performed	70%	78%	81%	88%	90%	92%	94%	84%▽	85%	86%	87%
LDL-Cholesterol Control <100 mg/dL	---	---	---	---	---	47%	51%	48%▽	51%	51%	52%
Blood Pressure Control <140/90 mmHg	---	---	---	---	---	---	---	69%	70%	71%	72%
Blood Pressure Control <130/80 mmHg	---	---	---	---	---	---	---	38%	40%	41%	42%
Medical Attention for Nephropathy	---	---	---	---	---	---	---	85%	87%	88%	88%

Payment

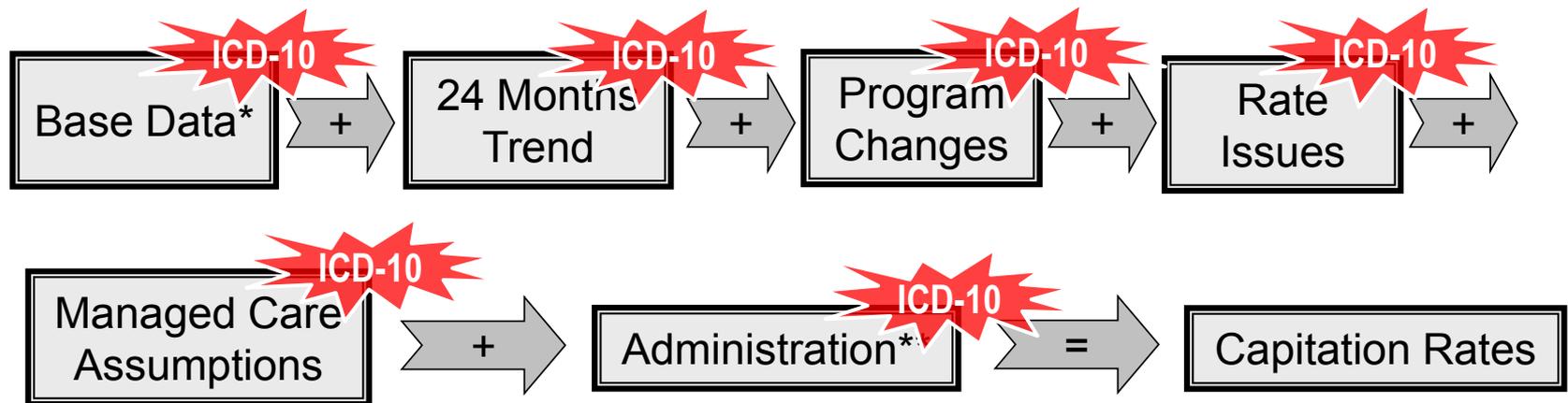


Rate Setting

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 completeness/assessments source will be reviewed and completion factors may be applied.

** Administration includes consideration for any assessments/taxes, as well

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  ICD-10
- Risk adjustment: age / gender only vs. adding diagnosis and/or pharmacy based tools  ICD-10
- Reinsurance (Commercial or State-sponsored)  ICD-10
- Medical Loss Ratios / Profit Caps / Risk Sharing  ICD-10
- Risk pools and Risk corridors  ICD-10
- Performance incentives and/or withholds  ICD-10

Payment



Risk Adjustment

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



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

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

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

Payment



Value-Based Purchasing

Value-Based Purchasing

Trend with Caution

- **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**

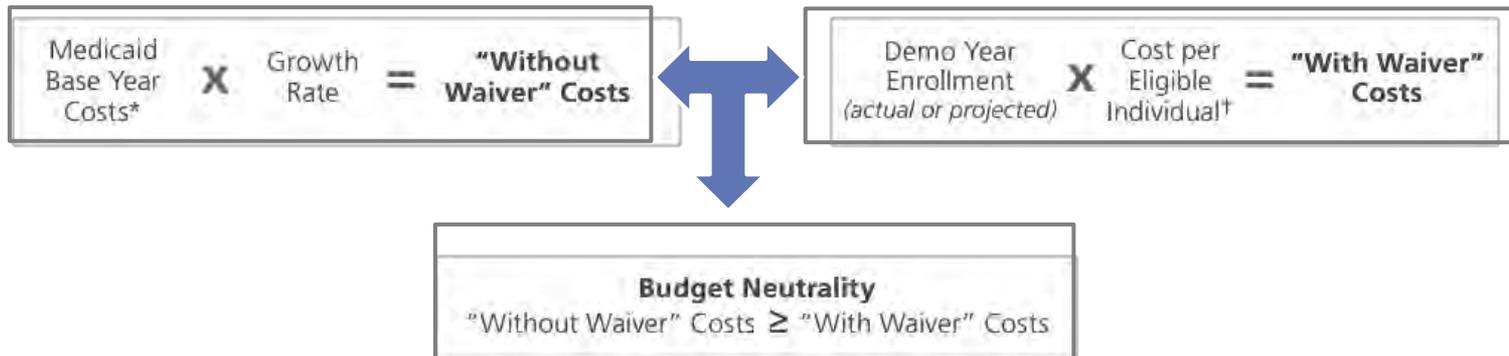


Budget Neutrality

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



- 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



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

Questions

