Reading the MCO Tea Leaves: What Is Your Data Telling You About Your Past, Present and Future?

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New LME-MCOs

- LME-MCOs will manage two new benefit plans, which requires them to expand business operations 4-6 times their current operations.
- LME-MCOs are being asked to take on primary responsibility for:
  - Taking on additional rules and requirements to manage Medicaid funds.
  - Adding new services that they must provide administratively, and through providers.
  - Providing *Utilization Management and Utilization Review* for Medicaid services.
  - Providing *Care Coordination* responsibilities for MH, SA and CAP consumers.
  - Expanding and managing a closed *Provider Network*.
  - An Expanded *Customer Services role* for both IPRS and Medicaid eligible consumers.
  - An Expanded role in coordination of care between *Physical and Behavioral Healthcare*.
  - Expanded *Quality Management* responsibilities.
  - Accepting *Financial Risk* of the expanded operations, and
  - Increased level of reporting and oversight.

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How do you get your arms around understanding the impact of all this on your organization ……?

- Look to the demonstration model…
  - Basic framework.
  - Examples of implementation
- Understand the unique characteristics of your own region.
- Combine the demonstration model with your own unique dynamics.

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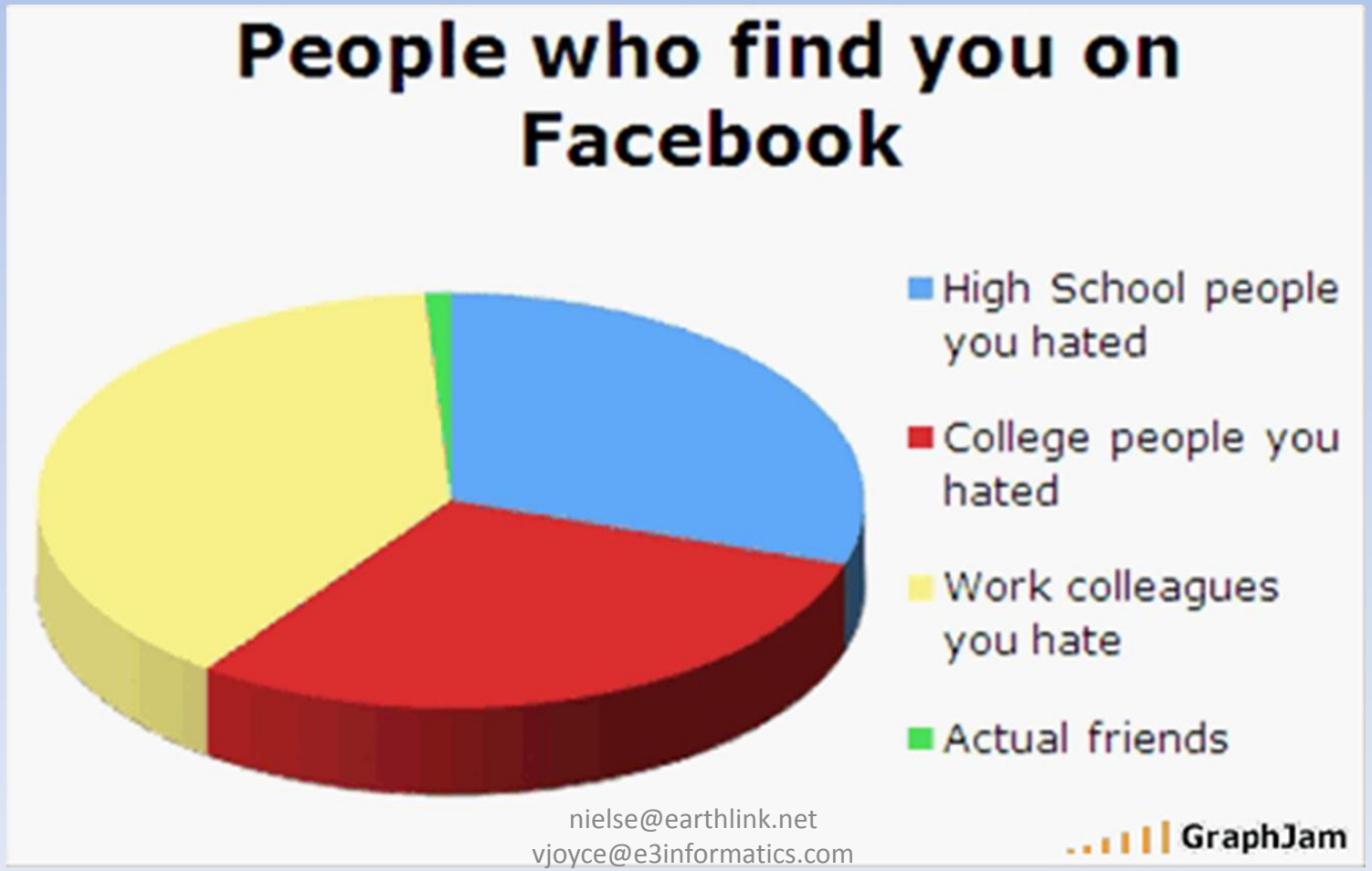
How do we understand the Characteristics of our own region?

- The problem of perceptions:



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What knowledge do we want to discover or validate about ***consumers***?

- How many consumers received both Medicaid and IPRS funded services?
- How many consumers were eligible for services?
- How many consumers are in which aid category?
- Which kind of services did they receive?
- How much service did they receive?
- Who provided the services?
- What did it costs?
- What was their diagnosis?
- Where did they live in the region?
- What is their age, sex, ethnicity?
- Where did they get received those services?
- What data is there relating to substance abuse services?

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Where do we get data to find out about consumers?

- Monthly Medicaid Paid Claims File
  - A goldmine of information, very detailed
  - Contains all behavioral healthcare claims paid for consumers in your catchment area
  - Fixed-field file structure that is easily imported into Access, SQL, Oracle
  - SA claim records are de-identified, so they are not as useful as MH and DD claim records
  - Automatically placed in LME download directory each month

Where do we get data to find out about consumers?

- IPRS Claims
  - IPRS claims data must be extracted from your own LME claims adjudication system
  - Try to develop a unique consumer ID so a consumer's total claim history can be analyzed – IPRS and Medicaid
  - IPRS is a primary source of information for SA claims
  - To get data similar to Medicaid paid claims, you will need to query consumer and provider demographics, as well as IPRS claims data

Where do we get data to find out about consumers?

- Medicaid Global Eligibility File
  - File of eligible members' current and historical Medicaid coverage
  - Separate record for every eligibility renewal or change
  - Contains base Medicaid ID and up to 6 additional
  - Contains Medicaid type information (TANF, MAFCN, MADCY, etc.)
  - Contains CAP indicators
  - Contains TPL and Medicare indicators
  - Fixed-field file structure
  - Determines number of PMPMs you receive

Where do we get data to find out about consumers?

- Medicaid Paid Claims Consumer Data Fields
  - First name, last name, middle initial
  - Submitted Medicaid ID, Base Medicaid ID
  - Date of birth, gender, race, ethnicity
  - County of Medicaid eligibility
  - Disability
  - Primary diagnosis and up to two additional diagnoses (specific to the claim)
  - Medicaid type
  - CAP Indicator

Where do we get data to find out about consumers?

- Global Eligibility File Data Fields
  - Last name, first name, middle initial
  - Address
  - Date of birth
  - SSN
  - County of eligibility
  - Base Medicaid numbers and alternates
  - Case head and authorized person data
  - Medicaid types and coverage periods
  - CAP, TPL, Medicare and PACE indicators

How do we organize consumer data into usable reports?

- Should import data into a suitable relational database
  - SQL
  - Oracle
  - Must be able to query large amounts of data
  - Some fields are codes, need crosswalks for definitions
- Summary Reports by counts and costs
  - By disability
  - By age group
  - By ethnicity

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How do we organize consumer data into usable reports?

- Summary Reports by counts and costs
  - By diagnostic range
  - By county
  - By type of Medicaid coverage
  - By Category of Aid (must be calculated from type of Medicaid. See your Data Book.)
  - Highest cost consumers
  - Total catchment area counts and costs

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Providers Must Be Data Savvy

- Can you quantify?
  - Consumers by demographics?
  - Consumers by county?
  - Consumers by diagnoses?
  - Consumers by funding source?
  - Consumers by costs???
- Effective and efficient providers need practice management software
  - Accessible and accurate reports
  - Electronic claims

Consumer related reports

- Data Elements to Consider:
  - First Name, Last Name
  - Consumer address/County
  - Medicaid/ID
  - Medicaid Category of Aid/CAP indicator
  - Disability
  - Diagnosis
  - Age
  - Sex
  - Race/Ethnicity
  - Service provider
  - Billing provider
  - Date of service
  - Service Address/County
  - Procedure Code
  - Units of service
  - Amount of Claim
  - Date of payment
  - Funding Source

Consumer related reports

Report Formats:

- Category of Aid by Month
  (Data: Month of eligibility)
- Consumer by DX by Amount of Services
  (Sort by Highest Cost Consumers)
  - By type of services
- Number of consumer served/number of consumer consumers eligible
  (Penetration Rate)
  - By sub groups Age, Sex, Race/Ethnicity/County
- Number of consumers served:
  - By County
  - By Diagnosis
  - By Provider

Data can be annoying, or helpful depending on our attitude

What knowledge do we want to discover or validate about ***Providers?***

- How many Medicaid and IPRS providers in our region?
- Which providers billed directly to Medicaid?
- Where are your providers located?
  - In your region vs. Out of your region
  - Service location vs. Billing location
- How many consumers do they serve and what is the funding mix?
- What is the diagnosis of the consumers they serve?
- What kind of services do they bill for?
- How much service was delivered ?
- What is their annual revenue from services in your region?
- Which services in your service array are being delivered and how much?
- What new services will you be required to manage; ie. ED?
- Who is providing those services now?

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Where do we get data to find out about Providers?

- Monthly Medicaid Paid Claims File
  - Includes behavioral healthcare claims paid to every provider who billed for your consumers
  - Will include providers who are new to you
    - Psychiatrists who have direct billed Medicaid
    - Licensed psychologists who have direct billed Medicaid
    - Licensed therapists who have direct billed Medicaid
  - Will include providers you endorsed, but they only billed Medicaid and not IPRS

Where do we get data to find out about Providers?

- Monthly Medicaid Paid Claims File
  - Will include out of catchment area providers
    - Emergencies
    - Services not available in your area
    - <=40 miles out of State
  - Will include inpatient providers!
    - Private hospitals
    - State hospitals
    - ICF/MR
    - PRTF

Where do we get data to find out about Providers?

- Monthly Medicaid Paid Claims File
  - Will include detailed information on services provided
    - Procedure codes, modifiers and descriptions
    - From date of service/to date of service (be careful with inpatient date spans)
    - Units of service
    - Paid claim amounts (after coordination of benefits)
    - Category of Service (must be calculated. See your Data Book for parameters.)

Where do we get data to find out about Providers?

- Monthly Medicaid Paid Claims File
  - Will include detailed information on services provided
    - Emergency room visits
    - Emergency room ancillary services!!!
    - Inpatient service billed with DRGs
    - CAP waiver supplies
- Combine with IPRS data from your own claims adjudication system

Where do we get data to find out about Providers?

- Medicaid Paid Claims Provider Data Fields
  - Name and Medicaid Provider Number
  - NPI and taxonomy code
  - City, County and State
  - Provider type (Hospital, Physician group, etc.)
  - Provider specialty (Mental health multi-specialty, licensed psychologist, etc.)
  - Billing provider (company or group)
  - Attending provider (individual practitioner)
  - Some information on referring provider

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Where do we get data to find out about Providers?

- Medicaid Paid Claims Service Data Fields
  - Procedure Codes and modifiers
  - Diagnosis
  - Units
  - Paid amount
  - Service date(s) and paid date
  - DRGs, if applicable
  - State ICN (important for linking multiple services billed on one claim)
  - State COS (this is NOT the waiver Category of Service, but it is used in determining the waiver Category of Service)

How do we organize Provider data into usable reports?

- Summary Reports by counts and costs
  - By county
  - In catchment area vs. out of catchment area
  - Cumulative counts and costs
- Real value is in combining provider data with consumer data and service data
  - Who did providers serve?
  - What services did they provide?
  - What was the cost?

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How do we organize Provider data into usable reports?

- Paid claims data will allow you to analyze the services rendered to consumers by providers:
  - By disability
  - By age group
  - By ethnicity
  - By diagnostic range
  - By county (including out of county)
  - By type of Medicaid coverage
  - By Category of Aid
  - By Category of Service
  - By COST!
  - Any combination

Provider related reports

- Data Elements to Consider:
  - Consumer Name
  - Consumer address/County
  - Medicaid/ID
  - Medicaid Category of Aid/CAP indicator
  - Disability
  - Diagnosis
  - Age
  - Sex
  - Race/Ethnicity
  - Service provider
  - Billing provider
  - Date of service
  - Service Address/County
  - Procedure Code
  - Units of service
  - Amount of Claim
  - Date of payment
  - Funding Source

Provider related reports

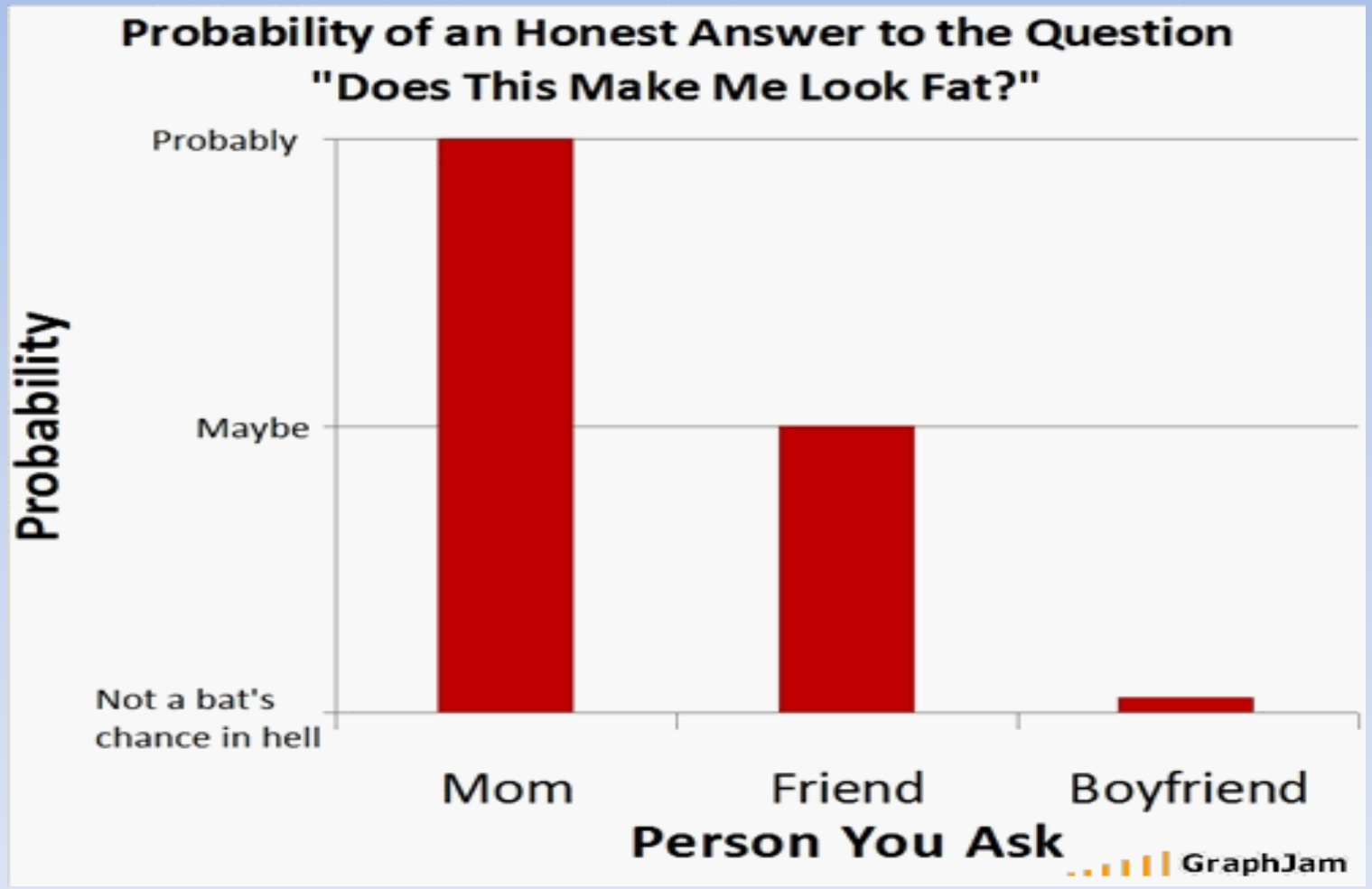
- Report Formats:

- Provider by Diagnosis by number of persons served
- Provider by Service code by Amount of Services paid

  (Sort by Highest amount of payment)

  Who has what percent of market share by service category?
- Billing Provider by Attending provider
- Service Code by provider
  - Which provider is providing what services to how many consumers and at what cost.

Statistics may give us data we don't want to look at…..



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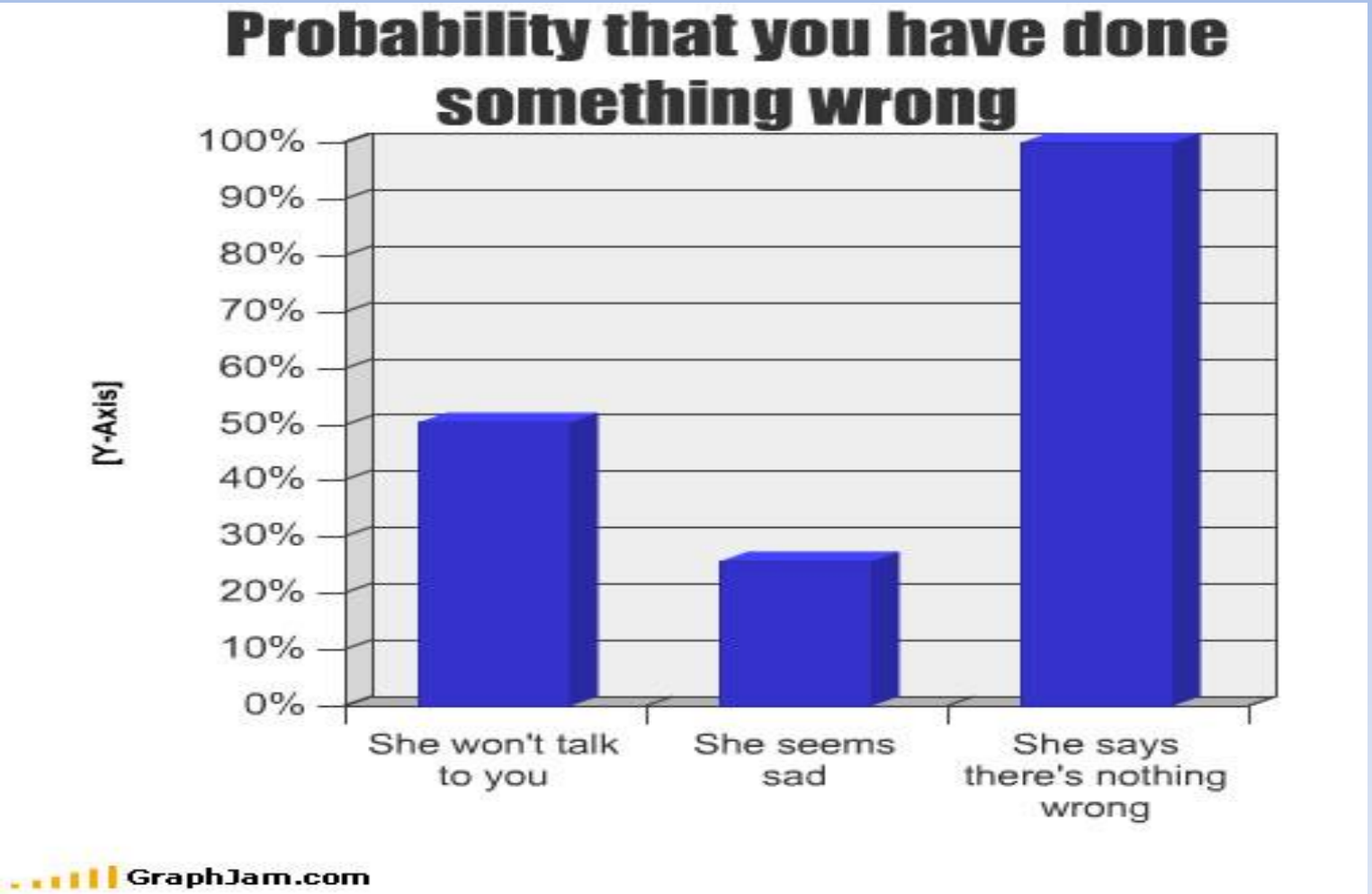
But, it can give us some good feedback!



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What knowledge do we want to discover or validate about ***Care Coordination?***

- How many consumers received Care Coordination, by diagnosis?
- The State Medicaid Program and the CAP-MR program are two different data basis. What are issues in combining the data?
  - What data will need to be filtered out?
- How much care coordination was provided by consumer? Who provided that service?
- What type of services did CAP consumers receive?
- What type of service codes have changed with the change from a billed service to and administrative service?
- What are the Wavier supplies provided and can this be use to indicate level of need?

Where do we get data to find out about Care Management?

- Analyze claims data for consumers who received case management
  - T1017:HE
  - T1017:HI
  - H0032
- Analyze claims data for high cost consumers
- Analyze claims data for recidivism, lengths of stay
- Analyze claims data for increases in level of care (indicated by consumer service mix over time)

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Where do we get data to find out about Care Management?

- Analyze claims data for consumers who had multiple episodes of crisis services or inpatient services
  - Emergency room visits
  - Facility based and mobile crisis stabilization
  - Hospital inpatient
  - PRTF
  - Level 3 and 4 residential

Where do we get data to find out about Care Management?

- Analyze claims data for consumers who have high use of CAP waiver supplies
  - Feeding tubes
  - Nutrition aids
  - Home modifications
  - Vehicle modifications

How do we organize Care Management data into usable reports?

- Look at Care Management trends
  - By diagnoses
  - By disability
  - By Medicaid type
  - By Category of Aid
  - By county
  - By combinations with other services

Care Coordination related reports

- Data Elements to Consider:
  - Consumer Name
  - Consumer address/County
  - Medicaid/ID
  - Medicaid Category of Aid/CAP indicator
  - Disability
  - Diagnosis
  - Age
  - Sex
  - Race/Ethnicity
  - Service provider
  - Billing provider
  - Date of service
  - Service Address/County
  - Procedure Code
  - Units of service
  - Amount of Claim
  - Date of payment
  - Funding Source
  - Annual treatment plans

Care Coordination related reports

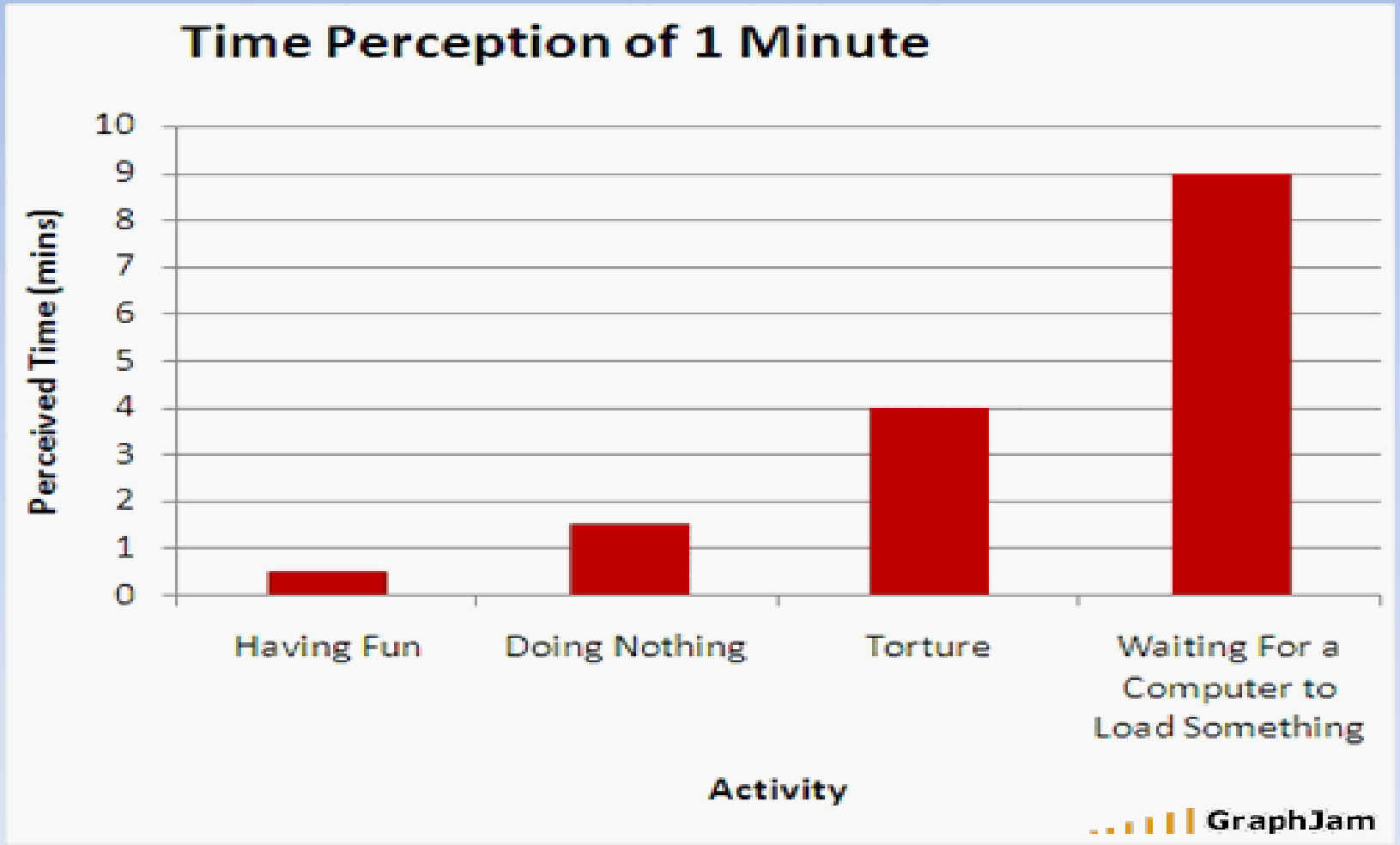
Report Formats:

- Comparison of Plan of treatment (annual budget) current year vs. previous year. (Service mix, Units, Cost)
- Comparison of Plan of treatment utilization. (Individual budget vs. Utilization)
- Provider by Service code by Amount of Services paid

  (Sort by Highest amount of payment)

  Who has what percent of market share by service category?
- CAP Services by Provider
  - Which provider is providing what services to how many consumers and at what cost.

“The Speed of Thought” by Bill Gates



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What knowledge do we want to discover or validate about ***Service Utilization Management***?

- How many authorizations were issued for both Medicaid and IPRS services, by diagnosis, by consumer, by provider?
- What service was authorized?
- How much service was authorized?
- How much was those service authorizations used, by diagnosis?
- What kind of services were authorized?
- What kind of services were not authorized, but available in the service array?

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Where do we get data to find out about Service Authorizations?

- Medicaid paid claims files contain no information regarding authorizations
- We can analyze service trends and assume services were properly authorized
- But we have no information on the number of authorized units used or unused
- Will be imperative to develop utilization management reports going forward (should already be in place for IPRS)

How do we organize Authorization data into usable reports?

- Going forward
  - Look at authorized units vs. used units trends
  - Start building authorized unit to used unit ratios
    - By disability
    - By diagnosis range
    - By age
    - By Category of Aid
    - By Category of Service
    - By Provider
  - Compare authorization trends to budget

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Service Authorization related reports

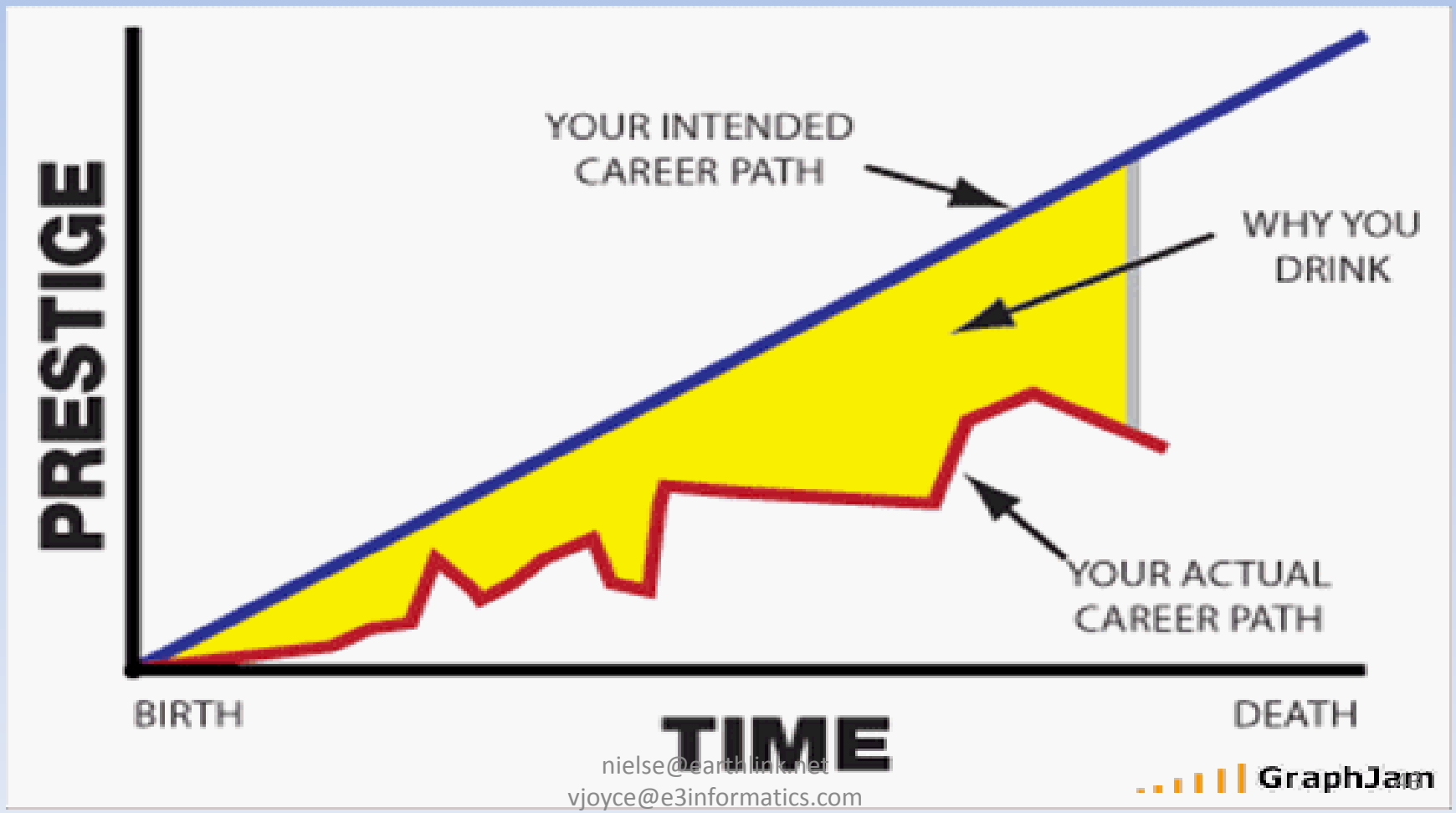
- Data Elements to Consider:
  - Consumer Name
  - Consumer address
  - Medicaid/ID
  - Disability
  - Diagnosis
  - Age
  - Sex
  - Race/Ethnicity
  - Service date range for the authorization
  - Service provider
  - Service Address/County
  - Procedure Codes authorized
  - Units of service authorized
  - Cost of services authorized
  - Date of Authorization submitted
  - Date of Authorized approved
  - Number and reason for authorization denials
  - Data and status of appeals

Utilization Management related reports

Authorizations by diagnosis by consumer vs. Service utilization by diagnosis by consumer

- Service authorization by service code. Trending data.
- Service authorization by provider
- Service authorization by consumer
- Service authorization compared to annual budget

Using Data will allow us to see the gaps between our perceptions and reality.



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What knowledge do we want to discover or validate about *Financial issues*?

- How many claims were made per month?
- What is the dollar value of those claims?
- What is our region's IBNR patterns by major service categories?
- What is our *spending tends* by major service category?
- What data can we used to base our initial budget estimated on?
- How does our historical data compare to the capitation payment rates and overall amount?
- What is the ratio of our service dollar revenue to our actual service cost?
- What is the ratio of our Administrative dollar revenue to our actual administrative cost?

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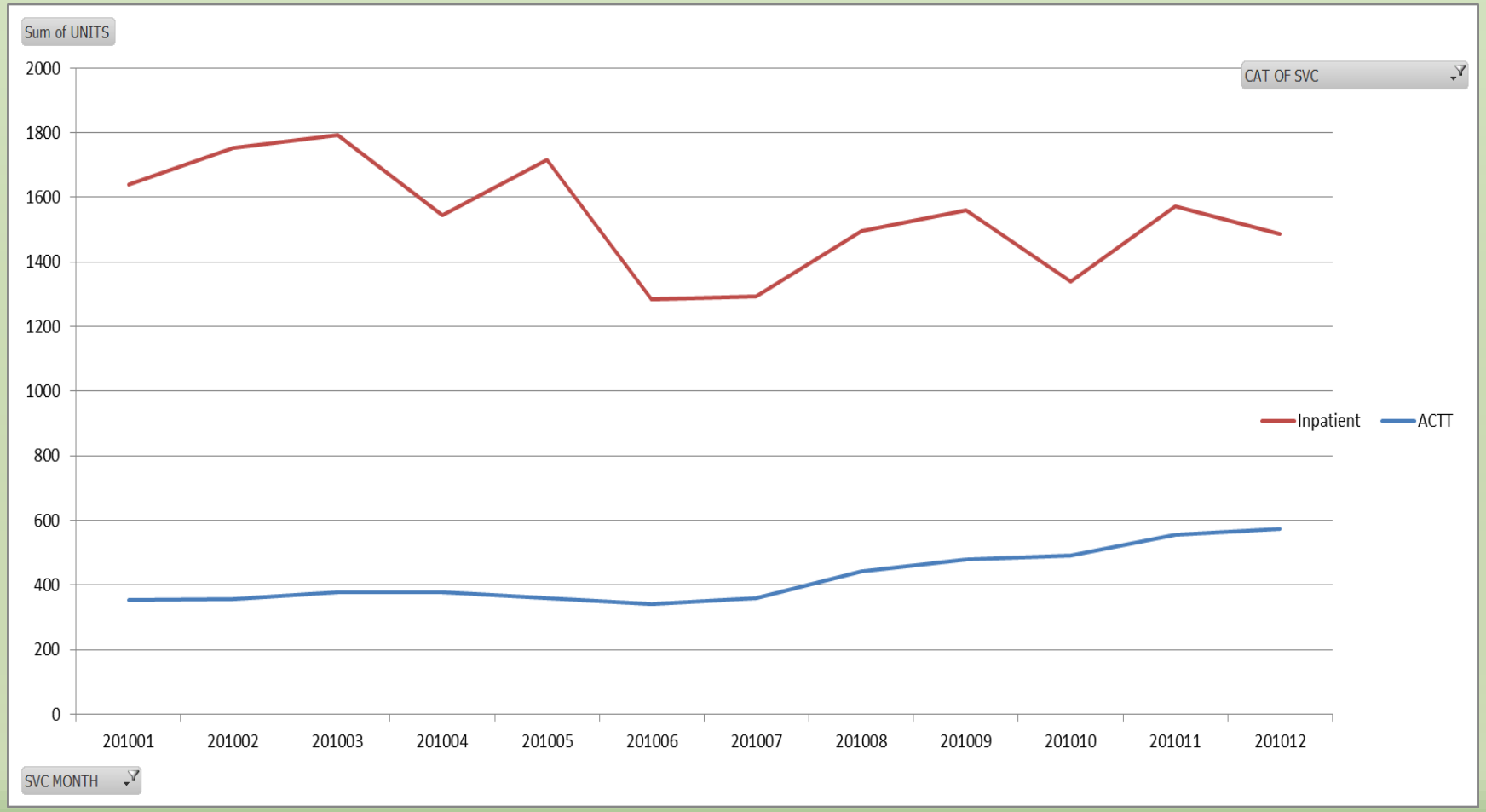
Where do we get data to find out about financial issues?

- Historical claim volume and spending trends can be easily calculated from paid claims data
  - By units, dollars
  - By provider
  - By consumer demographics and diagnostics
  - By Category of Aid
  - By Category of Service

Where do we get data to find out about financial issues?



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Where do we get data to find out about financial issues?

- Historical IBNR can be calculated from paid claims data
  - Convert service dates to service months
  - Convert paid dates to paid months
  - Construct IBNR triangles with a pivot table or a crosstab query using:
    - Service month
    - Paid month
    - Sum of paid amount, sum of units

Where do we get data to find out about financial issues?

CATOFSVC	(All)											
IBNR	**Service Month**											
Paid Month	**201005**	**201006**	**201007**	**201008**	**201009**	**201010**	**201011**	**201012**	**201101**	**201102**	**201103**	**201104**
201005	14579											
201006	57936	32332										
201007	6567	67717	19759									
201008	2204	13879	77639	32195								
201009	1176	2174	12215	61909	22866							
201010	1117	1922	2978	14988	69563	35133						
201011	791	1199	1612	2199	8480	49540	13970					
201012	786	1570	1322	1980	4081	17191	72528	24455				
201101	417	1051	765	1220	1199	2635	12601	63279	27786			
201102	301	426	1043	1364	1529	1954	2827	7510	50877	22586		
201103	438	905	1398	973	679	974	1356	2069	9166	65297	26168	
201104	320	505	635	1706	553	789	898	1200	2756	7766	72445	15621
Grand Total	**86632**	**123680**	**119366**	**118534**	**108950**	**108216**	**104180**	**98513**	**90585**	**95649**	**98613**	**15621**

Where do we get data to find out about financial issues?

- Total PMPM is based on Medicaid paid claims data and Global Eligibility
  - Based on services delivered to your eligible members
    - Qualifying Categories of Service in your Data Book
    - Some services/paid claims are excluded
  - Based on number of eligibles in your catchment area
    - Qualifying Categories of Aid in your Data Book
    - Some Medicaid types are excluded

Where do we get data to find out about financial issues?

- 3 important files for reconciling member eligibility and PMPM
  - Global Eligibility File
    - Daily additions and changes to member eligibility
    - Flat file
  - 834 Enrollment and Maintenance File
    - Monthly file, final snapshot of additions and changes
    - Standard EDI transaction
  - 820 Premium Payment File
    - PMPM – member eligibility, category of aid
    - Standard EDI file

Where do we get data to find out about financial issues?

- Key data matches for reconciliation
  - Base Medicaid ID
  - Medicaid type/category of aid
  - Coverage date range
  - PMPM vs. expected PMPM
- Identify Discrepancies
  - In one file and not another
  - Coverage or dollars do not match
- Identify retro actions
  - Positive dollars
  - Negative dollars

Where do we get data to find out about financial issues?

- Paid claims data can be analyzed for signs of fraud and abuse
  - Trends over time within a provider organization
  - Trends across provider organizations during same time
  - Excess units during a 24 hour period
  - Excess units over weekends and holidays
  - Comparatively high use of authorized units

How do we organize data into usable financial reports?

- Analyze IBNR
  - By Category of Service
  - By service date ranges
  - By paid date ranges
- Compare service trends to actual budgets
  - Authorizations
  - Actual service delivery
- Reconcile member eligibility and PMPM
- Fraud and abuse
  - Trends
  - Comparisons

Financial Management related reports

- Data Elements to Consider:
  - Consumer Name
  - Consumer address/County
  - Medicaid/ID
  - Medicaid Category of Aid/CAP indicator
  - Disability
  - Diagnosis
  - Age
  - Sex
  - Race/Ethnicity
  - Service provider
  - Billing provider
  - Date of service
  - Service Address/County
  - Procedure Code
  - Units of service
  - Amount of Claim
  - Date of payment
  - Funding Source
  - Annual treatment plans

Financial Management related reports

- Authorizations by diagnosis by consumer vs. Service utilization by diagnosis by consumer
- Service authorization by service code. Trending data.
- Service authorization and utilization by provider
- Service authorization and utilization by consumer
- Service Category budgets compared to Actual Service Costs. Trend projections for the rest of the year.

Looking forward…..

- Look for mission critical data
  - Are we focusing on the right priority?
  - What cost must are services are higher risk than others?
  - What costs are more controllable than others?
  - Establishing bases lines for quality improvement.
- Build monthly dashboard reports on mission critical issues
  - Penetration rates
  - Service Expense Ratio
  - Administrative Cost Ratio
  - Authorization Utilization ratio

Looking forward…..

- Build monthly dashboard reports on mission critical issues
  - Budget to *Actual* comparisons by service category
  - Utilization trends of Best Practice services
  - Utilization of ED facilities vs. Community based crises
  - Quality indicators (usually non-financial data base)
    - Timeliness to services
    - Grievance and Appeals monitoring
  - Timeliness of claims payment and Service Authorizations
  - Claims and Authorization denials

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Thank You for Your Participation!

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