Provider Payment and Reimbursement Rates

Health Care Administration

Managed Care & Payment Policy

January 2011

Legislative Report

Minnesota Department of **Human Services**

Cost of Report

Pursuant to Minnesota Statutes, §3.195 the total cost of preparation of this report is $13,600.21.

Three staff persons from the Managed Care Purchasing and Payment Policy Division participated in the development of this report. It is estimated that 284 combined hours of time was spent in gathering the information, drafting and reviewing the report. The cost of salaries, including fringe benefits is $13,552.21, and non-salary administrative costs such as printing, and supplies incurred in development and preparation of this report is $48.00.

Copy costs are 25 cents per page. Eight copies of this twenty four-page report were prepared at 25 cents per page, a cost of $48.00.

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INTRODUCTION

Legislative Mandate

Minnesota Statutes §256B.69, subdivision 9b, paragraph (d) requires the Minnesota Department of Human Services (DHS) to provide an annual report to the Legislature on managed care organizations' (MCOs) aggregate provider payment and reimbursement rate data. MCOs are both health maintenance organizations and county-based purchasing plans contracted to provide health care services to enrollees of Minnesota Health Care Programs (MHCP). This includes Medical Assistance (MA), MinnesotaCare, and General Assistance Medical Care (GAMC). The MCOs under contract are Blue Plus, HealthPartners, Itasca Medical Care (IMCare), Medica, Metropolitan Health Plan (MHP), PrimeWest, South Country Health Alliance (SCHA), and UCare[1]. This is the first report provided to the Legislature under this requirement.

The impetus for this legislative mandate was an evaluation report by the Office of the Legislative Auditor (OLA) titled *Financial Management of Health Care Programs*. The report made several recommendations to the legislature regarding the need for increased financial oversight of MCOs and, specifically, provider payments by MCOs under contract with the state. The report recommended that the legislature classify information provided to DHS on a health plan's provider contracts and contract-related payment rates as nonpublic data.

The 2008 legislation requires DHS to collect provider payment data from MCOs and classify the data as nonpublic. In 2009, the law was further amended to include additional reporting by MCOs to DHS and an annual report by DHS to the Legislature. Additional information required from MCOs by the 2009 legislation includes: aggregate provider payment categorized by primary and non-primary care providers; information on how MCOs pass through rate increases and decreases; and specific information regarding the MCOs' provider rate methodologies. DHS is required to include in this report aggregate payments made to physicians, physician-extenders, and hospitals, and to array aggregate reimbursement rates by MCO by primary care and non-primary care categories.

Report Background and Implementation

This report was prepared by the Managed Care Purchasing and Payment Policy Division of DHS which has the contract procurement, management, compliance, and rate setting responsibilities for contracted MCOs. Preparations for this report began in early fall of 2009 for implementation in calendar year 2010. As required by statute, DHS consulted with MCOs and provider groups regarding the form and manner of the data collection. This included a workgroup of MCO administrative and data staff that met during 2009 and into 2010 on the specifications for the first phase of the provider payment data collection. DHS also met with provider organizations, such

[1] DHS' contract with First Plan Blue ended in calendar year 2009. No data is reported for First Plan because the reporting requirement is in the calendar year 2010 managed care contracts.

as the Minnesota Medical Association (MMA) and the Minnesota Hospital Association (MHA), to provide input on the proposed implementation of the data collection.

This new reporting requirement for MCOs will be accomplished in two phases. Phase I requires MCOs to submit provider payment data for the most recent completed contract year by provider type and service categories for each MHCP managed care product, information on passing through rate increases and decreases, rate methodologies, and an array of provider contracted rates. The first phase requires MCOs to submit this data manually to DHS, similar to the financial data submission required by the Minnesota Department of Health (MDH). The format of this submission was the product of the MCO administrative and technical payment data work group. The workgroup agreed upon the provider types, service categories, and related definitions as reported in Appendix 1.

Phase II will require MCOs to report provider payment data on individual encounter claims. The second phase will be implemented January through April of 2011. Some data will still be collected manually by DHS, e.g. provider payments outside the claims process, Medicare cost-sharing, rate methodologies, etc.; however, the majority of data will be submitted via encounter claims. This will support more consistent MCO data collection and allow DHS to perform more in-depth analyses. In future reports, DHS will use individual-level data received on encounter claims to produce aggregate reports.

PROVIDER PAYMENT DATA

Report overview

The data submitted by the MCOs to DHS consisted of four major sections as outlined in statute: 1) aggregate provider payment data; 2) how MCOs pass through legislatively mandated provider rate increases and decreases; 3) information on the MCOs' provider rate methodologies; and 4) an aggregate array of provider reimbursement rates. As required by statute, DHS has included in this report payments to physicians, physician extenders, hospitals, and other provider types and array aggregate provider reimbursement rates by MCO, by primary care and non-primary care categories.

This legislative report includes the data required to be reported to the legislature as described above and a high-level discussion of the nonpublic data submitted to DHS. All of the MCO-specific data submitted to DHS under the reporting requirement is classified as nonpublic data under Minnesota Statutes §13.02. For this first report, the reporting period is calendar year 2009, the most recently completed contract year for which all data was available. Managed care products include: MA Families and Children, GAMC, MinnesotaCare, Minnesota SeniorCare Plus (MSC+), Minnesota Senior Health Options (MSHO), Minnesota Disability Health Options (MnDHO), and Special Needs Basic Care (SNBC).

For Phase I of this reporting requirement, DHS focused the scope of the data submission to basic care services. These services generally consist of medical services, medical facility fees, access services, and home care services for all MHCP enrollees in managed care. The rates set by DHS and paid to the MCOs for these services (referred to as basic care rates) are determined separately from long-term care services such as elderly waiver (EW) services. Home and community-based waiver services were not included in the first phase but will be collected on encounter claims as part of the second phase of this reporting requirement beginning April 1, 2011.

It is also important to note that this report does not include payments made for Medicare covered services for dual eligible enrollees in the Medicare integrated products MSHO and SNBC. MCOs are only required to submit payment data for Medicaid covered services and Medicare cost-sharing paid by Medicaid.

Section 1 – Aggregate provider payment data

MCOs are required to submit aggregate provider payments separated by inpatient and outpatient services and by primary care and non-primary care categories. In consultation with the MCO workgroup, DHS defined service categories[2] similar to those used in annual health plan financial reporting to the Minnesota Department of Health (MDH), for the *Health Plan Financial and Statistical Report* as a base to improve consistency in reporting. These categories are used by MDH to collect expenditure data. DHS further expanded the categories to include other service categories and provider types similar to the MHCP fee-for-service (FFS) program.

Since the legislation focused on MCOs reporting primary care and non-primary care categories separately, DHS used the following primary care specialties for physician and advanced practice nurse (APN) services to define the primary care category.

- Family Medicine
- General Medicine
- Internal Medicine
- Obstetrics and Gynecology (OB/GYN)
- Pediatric (non-subspecialty)

Primary care specialties were established by using the *American Board of Specialties* recognized specialties and subspecialties. Provider types, services categories and definitions are reported in Appendix 1. All other provider specialties were categorized as non-primary care.

[2] See Minnesota Department of Health, Health Plan Financial and Statistical Report, Formset & Instructions, Section 7: Health Care Expenses. http://www.health.state.mn.us/divs/hpsc/dap/cdireports/grppurch/index.html

Aggregate provider payment data is reported in Tables 1-8 by MCO, service or provider type, and managed care product. Payments for certain services or provider categories may appear low or vary significantly for products for dual eligible enrollees (MSC+, MSHO, SNBC) because those services are typically covered by Medicare Part A, B and D (e.g. physician services, inpatient, outpatient, prescription drugs, etc.) and allocation of Medicaid dollars vis-à-vis Medicare may differ across MCOs. Dual eligible enrollees make up 100 percent of the MSHO[3] program, 80 percent of MSC+, and 60 percent of SNBC and MnDHO. The MSC+ product is not integrated with Medicare.

The data reported in Tables 1-8 represent MCO payments for services provided January 1 through December 31, 2009 to MHCP enrollees in managed care. As mentioned above, these payments are for state plan services included in the basic care rate and exclude payments for home and community-based waiver services. Payments for services can vary greatly across MCOs and across programs. Factors that contribute to that variation include:

- *Population demographics and health risk.* Age, gender, institutional status, dual eligibility status, and health risk are all factors that cause variation in what MCOs spend on medical services comparatively. For example, an MCO may have high prevalence of mental health diagnoses in its enrolled population compared to other MCOs, resulting in higher spending on mental health services.
- *Program enrollment.* MCOs with higher enrollment are more likely to have higher spending across the board than MCOs with lower enrollment. Average monthly enrollment figures by MCO and by program are provided for reference in Tables 1-8.
- *Service area/geographic location.* MCO costs and types of services available can vary by geographic region. For example, Personal Care Assistance (PCA) services are more widely available in the metro area versus non-metro, therefore an MCO primarily serving the metro area may have higher PCA spending than an MCO primarily serving the non-metro area.
- *Payment type or arrangement.* MCOs employ a variety of payment arrangements with contracted providers. Varying arrangements may result in a service category dollars being higher or lower for one more or MCOs relative to all MCOs. For example, some MCOs may bundle professional or technical services with its outpatient facility rate versus other MCOs that do not. An MCO may have gain or risk-sharing arrangements that are allocated across certain service categories or that are reported under "expenses not itemized above."

[3] In calendar year 2009 there was a small percentage of non-dual eligibles in MSHO. Beginning in calendar year 2010, all MSHO enrollees are dual eligibles.

Table 1 – Medical Assistance (MA) Families & Children

Aggregate Provider Payments

Calendar Year 2009

	Blue Plus	HealthPartners	IMCare	Medica	MHP	PrimeWest	SCHA	UCare
Average Monthly Enrollment	**58,494**	**34,603**	**3,541**	**90,212**	**12,524**	**14,107**	**23,446**	**67,394**
Advanced Practice Nurses	$1,225,309	$4,619,816	$288,915	$5,926,026	$3,165,626	$43,811	$280,907	$3,897,650
APN – primary care	24,709	4,619,816	219,576	4,891,905	68,806	------	------	1,933,167
APN – non primary care	1,200,600	------	69,340	1,034,121	3,096,821	------	------	1,964,483
Physician services	29,151,979	24,917,094	3,135,077	50,453,050	8,394,111	6,745,218	8,616,961	32,632,921
Physician – primary care	16,314,536	9,659,580	2,368,923	27,281,349	3,762,516	3,642,024	8,616,961	16,653,947
Physician – non primary care	12,837,443	15,257,514	766,124	23,171,701	4,631,595	3,103,195	------	15,978,974
Maternity Care	32,847,534	11,857,447	1,716,936	72,547,021	3,979,298	8,625,417	3,533,807	27,359,435
Chiropractic	730,746	191,786	56,387	610,303	14,586	250,523	307,662	583,604
Rehabilitative & therapeutic	4,501,822	621,623	46,913	2,031,819	151,245	77,833	861,395	1,425,147
Other professional services-vision, podiatric, lab & radiology	22,469,331	11,357,368	131,776	44,886,357	2,878,260	5,148,388	10,576,391	19,024,445
DME & supplies	4,778,434	654,376	239,273	4,698,654	825,099	278,603	1,750,713	5,277,685
Chemical Dependency	6,397,352	3,897,504	311,819	12,529,207	496,302	2,203,559	1,844,107	3,470,817
Mental Health	21,117,369	11,234,067	1,866,603	45,118,095	3,168,435	5,667,614	9,124,318	16,744,901
Access Services	3,461,484	1,157,234	10,622	9,137,493	834,377	6,257	250,256	13,262,921
Medical Transportation	1,973,774	1,926,064	98,023	2,438,621	475,685	470,912	1,035,380	2,411,455
Medical Emergencies	8,227,607	10,068,734	926,255	6,805,309	3,127,358	1,376,451	4,157,939	14,209,205
Dental	9,146,426	10,151,046	916,426	17,249,356	1,879,393	2,832,660	5,650,250	15,273,383
Outpatient (facility)/ASC	19,539,747	10,189,467	1,500,757	16,346,700	4,804,896	3,709,869	9,307,601	11,568,556
Inpatient Hospital	43,640,622	33,228,355	630,477	35,405,059	9,823,082	3,111,250	17,098,579	51,855,025
Prescription drugs	24,023,707	12,879,376	2,166,183	40,721,044	3,924,431	6,719,959	10,582,016	23,452,190
Home Care	3,841,575	598,903	24,819	6,089,283	823,042	730,712	1,361,513	6,193,992
Nursing Facility Expenses	49,960	451,180	0	50,270	5,100	0	0	13,906
Medicare cost-sharing	------	------	------	------	------	------	------	------
Other expenses	1,749,951	0	0	11,486,566	1,481,387	196,456	6,504,866	3,171,044
Total Basic Care	**$238,874,729**	**$150,001,440**	**$14,067,261**	**$384,530,233**	**$50,251,713**	**$48,195,492**	**$92,844,661**	**$251,828,282**

Table 1

Notes:

- MCOs with missing payment information for Advanced Practice Nurse services (APN) were unable to differentiate primary care and non-primary care specialties in their claims data.
- Other expenses category includes: provider adjustments, performance payments alternate payment mechanisms such as risk/gain-sharing or total cost of care arrangement, and other services that could not be allocated into one of the available service categories. Some MCOs may have allocated some services listed here in another service category.
- Data listed in these tables does not include any MCO administrative expenses.
- Factors that may contribute to variation across service or provider categories and across MCOs listed on page 4 should be viewed in conjunction with this table. This includes: population demographics and health risk, program enrollment, service area/geographic location, and provider payment type or arrangement.

Table 2 – General Assistance Medical Care (GAMC)
Aggregate Provider Payments
Calendar Year 2009

	Blue Plus	HealthPartners	IMCare	Medica	MHP	PrimeWest	SCHA	UCare
Average Monthly Enrollment	**2,198**	**3,442**	**188**	**5,955**	**1,589**	**490**	**840**	**4,386**
Advanced Practice Nurses	$77,234	$606,682	$77,452	$489,127	$409,991	$33,844	$15,036	$143,176
APN – primary care	975	606,682	58,864	305,883	901	------	------	68,517
APN – non primary care	76,259	------	18,589	409,091	409,091	------	------	74,659
Physician services	3,097,402	5,787,571	393,736	8,246,001	1,936,165	620,463	365,575	4,900,957
Physician – primary care	1,081,333	1,048,581	299,239	2,055,566	453,556	138,091	365,575	1,363,109
Physician – non primary care	2,016,069	4,738,990	94,497	6,190,434	1,482,608	482,372	------	3,537,849
Maternity Care	62,403	29,857	1,230	252,243	2,074		7,305	133,723
Chiropractic	44,859	47,899	5,949	96,303	13,693	12,370	9,895	38,061
Rehabilitative & therapeutic	772,915	247,347	9,141	480,171	123,152	8,718	195,931	351,050
Other professional services-vision, podiatric, lab & radiology	2,827,135	3,055,126	22,967	9,762,065	1,092,0702	572,466	1,342,450	3,937,272
DME & supplies	534,200	252,101	23,256	932,369	294,655	31,293	272,707	1,208,292
Chemical Dependency	5,981,675	6,427,036	293,162	18,114,361	1,880,657	1,073,351	894,007	5,610,845
Mental Health	4,282,957	5,592,349	245,409	14,362,557	1,605,282	503,041	1,804,925	7,465,489
Access Services	517,112	126,033	57	122,702	178,391	18	132,644	2,506,265
Medical Transportation	401,351	962,169	38,023	648,567	316,526	84,593	157,856	982,555
Medical Emergencies	732,003	3,092,638	125,088	1,049,955	1,191,928	82,914	363,005	3,556,698
Dental	751,636	2,296,024	95,947	2,246,373	479,873	225,636	384,605	1,990,240
Outpatient (facility)/ASC	2,726,877	3,251,312	224,342	4,206,307	1,141,034	414,739	1,056,097	3,001,533
Inpatient Hospital	5,620,957	11,467,728	369,573	10,084,208	591,974	807,874	1,765,206	12,317,148
Prescription drugs	4,791,541	5,752,114	716,945	13,027,063	2,960,871	1,261,897	2,342,845	8,657,785
Home Care	94,424	311	0	50,378	5,271	1,387	806	20,953
Nursing Facility Expenses	7,396	208,353	0	15,797	3,172	14,458	379	27,463
Medicare cost-sharing	------	------	------	------	------	------	------	------
Other expenses	169,506	0	0	1,393,318	177,520	15,014	1,127,245	153,734
Total Basic Care	**$33,493,583**	**$49,202,650**	**$2,642,277**	**$85,579,865**	**$24,232,931**	**$5,764,076**	**$12,238,519**	**$57,003,239**

Table 2

Notes:

- MCOs with missing payment information for Advanced Practice Nurse services (APN) were unable to differentiate primary care and non-primary care specialties in their claims data.
- Other expenses category includes: provider adjustments, performance payments alternate payment mechanisms such as risk/gain-sharing or total cost of care arrangement, and other services that could not be allocated into one of the available service categories. Some MCOs may have allocated some services listed here in another service category.
- Data listed in these tables does not include any MCO administrative expenses.
- Factors that may contribute to variation across service or provider categories and across MCOs listed on page 4 should be viewed in conjunction with this table. This includes: population demographics and health risk, program enrollment, service area/geographic location, and provider payment type or arrangement.

Table 3 – MinnesotaCare Families with Children
Aggregate Provider Payments
Calendar Year 2009

	Blue Plus	HealthPartners	IMCare	Medica	MHP	PrimeWest	SCHA	UCare
Average Monthly Enrollment	**28,153**	**7,234**	**847**	**17,309**	**716**	**621**	**606**	**10,477**
Advanced Practice Nurses	$444,446	$692,583	$33,064	$740,490	$332,718	$26,954	$6,365	$299,312
APN – primary care	7,212	692,583	25,128	538,102	6,892	------	------	193,969
APN – non primary care	437,234	------	7,935	202,388	325,826	------	------	105,343
Physician services	12,599,243	5,015,820	731,071	9,300,175	1,472,700	448,348	83,177	4,726,921
Physician – primary care	5,783,739	1,436,023	554,420	4,238,327	365,638	136,409	83,177	2,012,323
Physician – non primary care	6,815,504	3,579,797	176,651	5,061,848	1,107,062	311,939	------	2,714,598
Maternity Care	4,665,162	781,080	131,594	3,739,498	32,648	96,645	41,179	1,283,314
Chiropractic	734,952	116,343	23,323	288,620	558	29,824	4,891	92,605
Rehabilitative & therapeutic	2,432,120	194,674	13,082	534,747	7,728	12,002	31,565	234,025
Other professional services-vision, podiatric, lab & radiology	11,852,763	2,788,169	42,817	8,329,272	74,732	350,366	340,454	3,757,198
DME & supplies	2,277,448	134,209	50,286	941,402	28,612	23,024	65,029	1,029,413
Chemical Dependency	1,820,237	515,727	62,107	1,518,243	4,025	87,148	35,518	407,309
Mental Health	5,426,703	1,639,179	154,310	5,943,782	140,697	236,566	143,746	1,951,166
Access Services	77,769	200,156	0	225,851	5,752	257	2,702	231,439
Medical Transportation	594,792	189,493	1,885	266,934	5,212	13,376	11,092	212,110
Medical Emergencies	2,424,128	1,232,168	122,026	537,124	52,424	43,209	79,856	1,585,502
Dental	5,838,588	2,944,957	241,165	5,171,034	183,710	434,775	186,797	3,415,761
Outpatient (facility)/ASC	11,885,120	2,538,935	374,607	3,262,255	79,239	229,348	366,692	2,486,696
Inpatient Hospital	13,360,897	2,814,179	210,730	5,502,725	94,870	222,766	308,184	4,633,826
Prescription drugs	14,094,822	3,566,909	585,379	9,219,150	119,798	978,638	367,568	5,869,962
Home Care	619,444	91,488	55	165,355	5,527	1,024	4,088	273,445
Nursing Facility Expenses	431	58,140	0	2,466	0	0	0	45,343
Medicare cost-sharing	------	------	------	------	------	------	------	------
Other expenses	477,005	0	0	2,180,371	37,418	10,324	292,928	252,744
Total Basic Care	**$91,626,070**	**$25,514,209**	**$2,777,501**	**$57,869,494**	**$2,678,369**	**$3,244,594**	**$2,371,831**	**$32,788,091**

Table 3

Notes:

- MCOs with missing payment information for Advanced Practice Nurse services (APN) were unable to differentiate primary care and non-primary care specialties in their claims data.
- Other expenses category includes: provider adjustments, performance payments alternate payment mechanisms such as risk/gain-sharing or total cost of care arrangement, and other services that could not be allocated into one of the available service categories. Some MCOs may have allocated some services listed here in another service category.
- Data listed in these tables does not include any MCO administrative expenses.
- Factors that may contribute to variation across service or provider categories and across MCOs listed on page 4 should be viewed in conjunction with this table. This includes: population demographics and health risk, program enrollment, service area/geographic location, and provider payment type or arrangement.

Table 4 – MinnesotaCare Adults without Children
Aggregate Provider Payments
Calendar Year 2009

	Blue Plus	HealthPartners	IMCare	Medica	MHP	PrimeWest	SCHA	UCare
Average Monthly Enrollment	**15,805**	**7,076**	**655**	**12,774**	**1,305**	**1,148**	**1,752**	**9,805**
Advanced Practice Nurses	$446,388	$1,069,838	$70,545	$919,124	$1,791	$48,130	$24,949	$275,220
APN – primary care	4,424	1,069,838	53,614	620,145	------	------	------	147,643
APN – non primary care	441,964	------	16,931	298,979	1,791	------	------	127,577
Physician services	14,516,886	9,507,344	1,099,452	14,146,235	9,983	862,403	520,038	7,939,501
Physician – primary care	5,625,895	1,839,863	835,584	4,005,586	1,648	264,695	520,038	1,944,401
Physician – non primary care	8,890,991	7,667,481	263,868	10,140,649	8,335	597,708	------	5,995,099
Maternity Care	547,154	90,946	0	357,872	24,254	12,952	4,349	212,387
Chiropractic	437,718	121,618	18,844	272,240	14,737	34,900	24,432	85,010
Rehabilitative & therapeutic	2,556,726	363,317	26,966	767,511	76,512	22,822	156,622	453,560
Other professional services-vision, podiatric, lab & radiology	14,180,238	5,102,969	41,945	14,544,187	929,441	867,735	1,683,038	7,143,764
DME & supplies	2,323,767	358,210	84,070	1,380,250	176,209	52,626	297,809	2,336,676
Chemical Dependency	5,891,622	3,325,647	190,816	7,663,629	379,303	956,614	933,206	2,600,723
Mental Health	6,073,375	2,468,811	159,054	8,461,788	705,815	459,980	837,841	3,340,732
Access Services	74,784	197,313	0	166,700	19,589	0	0	367,454
Medical Transportation	913,021	618,793	41,926	578,766	98,386	80,709	123,239	667,723
Medical Emergencies	2,278,131	2,434,943	185,739	736,185	472,859	107,569	363,307	3,260,942
Dental	4,460,637	4,713,421	307,035	3,813,778	384,729	237,257	933,157	4,407,660
Outpatient (facility)/ASC	14,770,839	4,729,463	696,901	6,014,366	814,803	651,422	1,576,103	5,507,330
Inpatient Hospital	9,757,589	4,285,903	400,879	5,812,273	226,523	581,295	1,327,713	5,336,373
Prescription drugs	18,454,252	7,766,536	982,997	17,812,346	1,895,980	974,895	1,836,213	12,747,885
Home Care	350,531	1,629	4,739	342,962	34,503	15,405	3,597	134,968
Nursing Facility Expenses	31,977	166,020	628	58,477	0	4,472	0	45,529
Medicare cost-sharing	------	------	------	------	------	------	------	------
Other expenses	611,068	0	0	1,774,557	182,688	21,084	1,189,533	492,926
Total Basic Care	**$98,676,703**	**$47,322,721**	**$4,312,536**	**$85,623,246**	**$6,448,106**	**$5,992,270**	**$11,835,146**	**$57,356,363**

Table 4

Notes:

- MCOs with missing payment information for Advanced Practice Nurse services (APN) were unable to differentiate primary care and non-primary care specialties in their claims data.
- Other expenses category includes: provider adjustments, performance payments alternate payment mechanisms such as risk/gain-sharing or total cost of care arrangement, and other services that could not be allocated into one of the available service categories. Some MCOs may have allocated some services listed here in another service category.
- Data listed in these tables does not include any MCO administrative expenses.
- Factors that may contribute to variation across service or provider categories and across MCOs listed on page 4 should be viewed in conjunction with this table. This includes: population demographics and health risk, program enrollment, service area/geographic location, and provider payment type or arrangement.

Table 5 – MA Minnesota Senior Care Plus (MSC+)
Aggregate Provider Payments
Calendar Year 2009

	Blue Plus	HealthPartners	IMCare	Medica	MHP	PrimeWest	SCHA	UCare
Average Monthly Enrollment	**2,085**	**1,298**	**146**	**3,379**	**652**	**1,050**	**956**	**1,417**
Advanced Practice Nurses	$674,733	$77,771	$9,322	$22,241	$63,929	------	$996	$19,968
APN – primary care	85	77,771	7,084	14,043	130	------	------	7,605
APN – non primary care	674,649	------	2,237	8,198	63,799	------	------	12,363
Physician services	804,340	1,914,799	88,846	512,796	142,667	381,684	11,645	397,547
Physician – primary care	190,995	202,656	67,523	166,886	45,138	44,791	11,645	127,129
Physician – non primary care	613,345	1,712,142	21,323	345,910	97,529	336,893	------	270,419
Maternity Care	5,653	0	0	0	0	0	0	0
Chiropractic	7,341	1,456	456	6,107	1,414	6,580	12,937	1,555
Rehabilitative & therapeutic	297,973	137,553	1,683	223,929	1,019	72,409	12,263	36,362
Other professional services-vision, podiatric, lab & radiology	412,510	493,698	2,953	585,769	91,076	29,945	48,030	288,377
DME & supplies	1,023,583	183,923	7,382	75,667	44,870	3,697	71,079	761,893
Chemical Dependency	57,400	14,226	12,992	191,990	325	445	3,836	30,285
Mental Health	777,914	1,716,017	77,492	386,990	83,256	263,735	253,568	326,176
Access Services	936,522	328,964	443	1,725,466	258,387	202,523	61,116	878,965
Medical Transportation	154,800	223,795	3,985	59,531	8,524	5,567	290,398	366,648
Medical Emergencies	59,745	138,724	38,399	10,340	8,438	0	5,274	64,837
Dental	297,490	472,544	38,184	932,151	1,480	168,909	173,647	359,233
Outpatient (facility)/ASC	708,018	2,064,546	68,349	649,647	81,254	0	35,475	156,514
Inpatient Hospital	1,139,435	1,276,424	79,593	567,186	171,373	0	98,249	883,236
Prescription drugs	331,940	510,146	90,711	870,574	295,519	110,992	91,026	409,863
Home Care	4,681,123	2,231,930	595,648	15,233,846	2,317,379	2,066,077	1,782,280	6,950,207
Nursing Facility Expenses	1,022,433	745,512	67,479	1,528,002	34,239	589,460	988,872	580,260
Medicare cost-sharing	------	566,899	196,874	10,480,052	1,972,241	2,128,618	2,185,612	1,629,494
Other expenses	105,557	0	0	399,198	118,033	19,094	123,684	103,447
Total Basic Care	**$13,498,510**	**$13,098,926**	**$1,380,791**	**$34,461,482**	**$5,695,423**	**$6,049,735**	**$6,249,987**	**$14,244,867**

Table 5

Notes:

- MCOs with missing payment information for Advanced Practice Nurse services (APN) were unable to differentiate primary care and non-primary care specialties in their claims data.
- Other expenses category includes: provider adjustments, performance payments alternate payment mechanisms such as risk/gain-sharing or total cost of care arrangement, and other services that could not be allocated into one of the available service categories. Some MCOs may have allocated some services listed here in another service category.
- Data listed in these tables does not include any MCO administrative expenses
- Data listed in these tables does not include payments for all services rendered for special needs population products (i.e. MSC+, MSHO, MnDHO, and SNBC).
- For MSC+, MSHO, SNBC, and MnDHO data may be under or over reported for some MCOs due to or data limitations and/or in categories where services are covered by both Medicare and Medicaid.
- For Medicare-integrated products, MCOs may use different methodologies for allocating Medicaid –only dollars across service and provider categories where Medicare is the primary coverage; therefore some service categories may not be comparable across MCOs.
- For seniors, MCOs are only required to cover 180 days of nursing home care.
- Factors that may contribute to variation across service or provider categories and across MCOs listed on page 4 should be viewed in conjunction with this table. This includes: population demographics and health risk, program enrollment, service area/geographic location, and provider payment type or arrangement.

Table 6 – MA Minnesota Senior Health Options (MSHO)
Aggregate Provider Payments
Calendar Year 2009

	Blue Plus	HealthPartners	IMCare	Medica*	MHP	PrimeWest	SCHA	UCare
Average Monthly Enrollment	**10,045**	**2,780**	**472**	**8,821**	**773**	**2,059**	**1,865**	**9,123**
Advanced Practice Nurses	$329,703	$160,950	$217,350		$33,837		$27	$73,990
APN – primary care	------	160,950	165,186		15	------	------	$16,451
APN – non primary care	329,703	------	52,164		33,823	------	------	57,539
Physician services	264,871	513,736	71,686		77,025	894,318	2,134	2,288,811
Physician – primary care	144,832	102,823	54,481		28,540	8,602	2,134	1,598,913
Physician – non primary care	120,039	410,913	17,205		48,485	885,716	------	689,898
Maternity Care	0	0	0		0	0	0	89
Chiropractic	562	3,727	1,445		6,865	0	33,806	10,576
Rehabilitative & therapeutic	840,876	270,136	1,081		24,295	125,344	20,854	281,044
Other professional services-vision, podiatric, lab & radiology	273,198	154,648	6,848		28,807	195,280	148,354	1,697,158
DME & supplies	4,253,863	44,237	271,948		1,485	19,545	148,133	2,700,355
Chemical Dependency	29,473	19,791	18,164		3,259	743	5,201	24,352
Mental Health	2,840,230	467,791	34,829		506,241	281,070	801,488	907,735
Access Services	2,782,964	772,091	17,717		357,436	379,826	97,687	5,222,578
Medical Transportation	15,460	457,137	3,081		7,065	43,830	377,142	1,456,649
Medical Emergencies	9,671	15,135	33,671		12,968	0	0	264,666
Dental	1,248,506	1,184,655	76,662		145,991	306,530	272,634	2,153,980
Outpatient (facility)/ASC	139,012	509,864	456,937		44,666	490	0	585,116
Inpatient Hospital	339,096	504,492	76,712		15,133	0	0	2,569,383
Prescription drugs	1,503,777	573,959	10,885		71,790	300,645	345,569	2,699,332
Home Care	23,025,385	12,114,864	900,587		3,385,582	2,338,727	2,175,047	43,127,233
Nursing Facility Expenses	9,253,767	2,152,702	300,970		330,235	6,125,353	5,809,259	7,442,791
Medicare cost-sharing	22,998,726	6,168,628	623,434		1,295,854	3,377,505	3,318,851	17,519,089
Other expenses	0	0	0		236,498	70,133	52,820	237,119
Total Basic Care	**$70,149,140**	**$26,088,544**	**$3,124,007**		**$6,584,762**	**$14,459,339**	**$13,609,006**	**$91,262,046**

Table 6

Notes:

- MCOs with missing payment information for Advanced Practice Nurse services (APN) were unable to differentiate primary care and non-primary care specialties in their claims data.
- Other expenses category includes: provider adjustments, performance payments alternate payment mechanisms such as risk/gain-sharing or total cost of care arrangement, and other services that could not be allocated into one of the available service categories. Some MCOs may have allocated some services listed here in another service category.
- Data listed in these tables does not include any MCO administrative expenses
- Data listed in these tables does not include payments for all services rendered for special needs population products (i.e. MSC+, MSHO, MnDHO, and SNBC).
- For MSC+, MSHO, SNBC, and MnDHO data may be under or over reported for some MCOs due to or data limitations and/or in categories where services are covered by both Medicare and Medicaid.
- For Medicare-integrated products, MCOs may use different methodologies for allocating Medicaid –only dollars across service and provider categories where Medicare is the primary coverage; therefore some service categories may not be comparable across MCOs.
- For seniors, MCOs are only required to cover 180 days of nursing home care.
- Factors that may contribute to variation across service or provider categories and across MCOs listed on page 4 should be viewed in conjunction with this table. This includes: population demographics and health risk, program enrollment, service area/geographic location, and provider payment type or arrangement.
- *Data are excluded for Medica due to data complications encountered in separating out Medicaid-only dollars. DHS will submit a supplemental table to this report once the data are received.

Table 7 – MA Special Needs Basic Care (SNBC)
Aggregate Provider Payments
Calendar Year 2009

	Blue Plus	HealthPartners	IMCare	Medica*	MHP	PrimeWest	SCHA	UCare
Average Monthly Enrollment	**1,334**	-----	-----	**853**	**139**	**254**	**774**	**151**
Advanced Practice Nurses	$42,841	-----	-----		$36,237	$3,762	$1,783	$9,615
APN – primary care	------	-----	-----		------	------	------	5,493
APN – non primary care	42,841	-----	-----		36,237	------	------	4,122
Physician services	897,778	-----	-----		173,629	565,004	35,083	99,745
Physician – primary care	374,767	-----	-----		37,544	39,442	35,083	43,769
Physician – non primary care	523,011	-----	-----		136,085	616,562	------	55,976
Maternity Care	9,065	-----	-----		11,525	0	0	0
Chiropractic	16,287	-----	-----		3,699	0	18,270	593
Rehabilitative & therapeutic	372,782	-----	-----		42,711	11,214	24,876	5,772
Other professional services-vision, podiatric, lab & radiology	973,803	-----	-----		72,120	131,317	187,613	99,223
DME & supplies	600,522	-----	-----		33,199	24,436	111,566	42,204
Chemical Dependency	156,170	-----	-----		12,086	49,020	28,612	36,123
Mental Health	1,467,873	-----	-----		439,074	1,071,025	1,973,417	181,846
Access Services	540,643	-----	-----		76,145	53,278	109,525	108,894
Medical Transportation	206,855	-----	-----		23,260	26,253	215,010	38,876
Medical Emergencies	200,976	-----	-----		93,939	13,779	31,219	58,046
Dental	418,563	-----	-----		176,962	30,008	456,256	81,826
Outpatient (facility)/ASC	873,222	-----	-----		61,749	139,798	207,102	60,931
Inpatient Hospital	3,390,099	-----	-----		41,886	123,997	338,815	82,327
Prescription drugs	2,421,608	-----	-----		546,444	741,576	599,638	235,391
Home Care	720,627	-----	-----		23,958	125,072	287,269	32,449
Nursing Facility Expenses	162,766	-----	-----		6,287	100,955	336,056	2,912
Medicare cost-sharing	2,060,707	-----	-----		146,246	616,562	1,436,522	181,201
Other expenses	3,339	-----	-----		208,513	15,813	174,521	90
Total Basic Care	**$15,536,526**	-----	-----		**$2,229,670**	**$3,842,869**	**$6,573,153**	**$1,358,064**

Table 7

Notes:

- MCOs with missing payment information for Advanced Practice Nurse services (APN) were unable to differentiate primary care and non-primary care specialties in their claims data.
- Other expenses category includes: provider adjustments, performance payments alternate payment mechanisms such as risk/gain-sharing or total cost of care arrangement, and other services that could not be allocated into one of the available service categories. Some MCOs may have allocated some services listed here in another service category.
- Data listed in these tables does not include any MCO administrative expenses
- Data listed in these tables does not include payments for all services rendered for special needs population products (i.e. MSC+, MSHO, MnDHO, and SNBC).
- For MSC+, MSHO, SNBC, and MnDHO data may be under or over reported for some MCOs due to or data limitations and/or in categories where services are covered by both Medicare and Medicaid.
- For Medicare-integrated products, MCOs may use different methodologies for allocating Medicaid –only dollars across service and provider categories where Medicare is the primary coverage; therefore some service categories may not be comparable across MCOs.
- For SNBC, MCOs are only required to cover 100 days of nursing home care.
- Factors that may contribute to variation across service or provider categories and across MCOs listed on page 4 should be viewed in conjunction with this table. This includes: population demographics and health risk, program enrollment, service area/geographic location, and provider payment type or arrangement.
- *Data are excluded for Medica due to data complications encountered in separating out Medicaid-only dollars. DHS will submit a supplemental table to this report once the data are received.
- HealthPartners and IMCare do not have a SNBC contract with DHS.

Table 8 – MA Minnesota Disability Health Options (MnDHO)
Aggregate Provider Payments
Calendar Year 2009

	Blue Plus	HealthPartners	IMCare	Medica	MHP	PrimeWest	SCHA	UCare
Average Monthly Enrollment	-----	-----	-----	-----	-----	-----	-----	**1,288**
Advanced Practice Nurses	-----	-----	-----	-----	-----	-----	-----	$64,285
APN – primary care	-----	-----	-----	-----	-----	-----	-----	11,319
APN – non primary care	-----	-----	-----	-----	-----	-----	-----	52,966
Physician services	-----	-----	-----	-----	-----	-----	-----	1,175,148
Physician – primary care	-----	-----	-----	-----	-----	-----	-----	292,817
Physician – non primary care	-----	-----	-----	-----	-----	-----	-----	882,331
Maternity Care	-----	-----	-----	-----	-----	-----	-----	8,813
Chiropractic	-----	-----	-----	-----	-----	-----	-----	5,398
Rehabilitative & therapeutic	-----	-----	-----	-----	-----	-----	-----	697,867
Other professional services-vision, podiatric, lab & radiology	-----	-----	-----	-----	-----	-----	-----	983,092
DME & supplies	-----	-----	-----	-----	-----	-----	-----	2,069,949
Chemical Dependency	-----	-----	-----	-----	-----	-----	-----	261,642
Mental Health	-----	-----	-----	-----	-----	-----	-----	1,164,309
Access Services	-----	-----	-----	-----	-----	-----	-----	1,383,377
Medical Transportation	-----	-----	-----	-----	-----	-----	-----	2,278,781
Medical Emergencies	-----	-----	-----	-----	-----	-----	-----	378,324
Dental	-----	-----	-----	-----	-----	-----	-----	843,844
Outpatient (facility)/ASC	-----	-----	-----	-----	-----	-----	-----	938,914
Inpatient Hospital	-----	-----	-----	-----	-----	-----	-----	4,553,603
Prescription drugs	-----	-----	-----	-----	-----	-----	-----	2,995,146
Home Care	-----	-----	-----	-----	-----	-----	-----	22,229,334
Nursing Facility Expenses	-----	-----	-----	-----	-----	-----	-----	891,466
Medicare cost-sharing	-----	-----	-----	-----	-----	-----	-----	2,890,518
Other expenses	-----	-----	-----	-----	-----	-----	-----	445,453
Total Basic Care	-----	-----	-----	-----	-----	-----	-----	**$46,259,263**

Table 8

Notes:

- MCOs with missing payment information for Advanced Practice Nurse services (APN) were unable to differentiate primary care and non-primary care specialties in their claims data.
- Other expenses category includes: provider adjustments, performance payments alternate payment mechanisms such as risk/gain-sharing or total cost of care arrangement, and other services that could not be allocated into one of the available service categories. Some MCOs may have allocated some services listed here in another service category.
- Data listed in these tables does not include any MCO administrative expenses
- Data listed in these tables does not include payments for all services rendered for special needs population products (i.e. MSC+, MSHO, MnDHO, and SNBC).
- For MSC+, MSHO, SNBC, and MnDHO data may be under or over reported for some MCOs due to or data limitations and/or in categories where services are covered by both Medicare and Medicaid.
- For Medicare-integrated products, MCOs may use different methodologies for allocating Medicaid –only dollars across service and provider categories where Medicare is the primary coverage; therefore some service categories may not be comparable across MCOs.
- For MnDHO, MCOs are only required to cover 180 days of nursing home care.
- Factors that may contribute to variation across service or provider categories and across MCOs listed on page 4 should be viewed in conjunction with this table. This includes: population demographics and health risk, program enrollment, service area/geographic location, and provider payment type or arrangement.
- UCare is the only MCO that has contracted for MnDHO with DHS.

Section 2 – Legislative provider rate changes

MCOs are required to submit information on how they pass through legislatively mandated provider rate increases or decreases. Since the reporting period is for calendar year 2009, DHS required MCOs to submit information based on provider rate changes that occurred in that contract year. The following includes legislatively mandated provider rate changes[4] during calendar year 2009, the effective date for managed care payments, and discussion of how the MCOs implemented the changes.

- Inpatient 1% reduction - effective 1/1/2009
- Physician services (non-primary care) 6.5% reduction - effective 10/1/2009
- Basic care services 4.5% reduction- effective 10/1/2009
- Home care services 2.58% reduction - effective 10/1/2009

In general, the MCOs followed MHCP FFS policy regarding specific services and codes to be included or excluded from the rate reductions. This happened automatically for some providers in an MCO's network if the provider contracted rate is based on the MHCP fee schedule; in this case, the MCO would reduce the claim before it is paid. This process is similar to DHS implementation of FFS rate reductions. Other MCOs amended provider contracts for the effective dates listed above or upon their renewal.

Section 3 – Provider rate methodologies

The legislative mandate also requires MCOs to report specific information on provider rate methodologies to DHS. For the major service categories or provider types requested by DHS and listed in Table 9, most MCOs reported using a methodology similar to MHCP FFS rates or using the FFS rates as a base for reimbursement (MHCP FFS rate methodologies differ depending on the type of service). Other common rate methodologies reported by MCOs include: a percent discount from their standard commercial rate, capitation, cost-based, Medicare, and a percent discount from billed charges. It is important to note that for all service categories or a provider type listed below, if the MCO did not report using the MHCP fee schedule as a basis or was unable to report their rates as compared to the MCHP fee schedule, those MCO rates are not reflected in the reported low to high rate ranges.

The data reported in Table 9 represents reimbursement rates paid for Medicaid services. It does not include Medicare rates paid for services provided to dual eligible enrollees.

[4] For the physician and professional services and basic care rate reductions, the reduction to Medical Assistance (MA) and General Assistance Medical Care (GAMC) was 6.5% and 4.5% respectively and For MinnesotaCare, 5.0% and 3.0% respectively. The difference in rate reductions across program is due to the Governor's unallotments.

Table 9 – MCO Provider Rate Methodologies

Calendar Year 2009

Provider/Service Category	MCO Rate Methodologies
Physician & Advanced Practice Nurse (APN) Services	Physician and APN services for most MCOs are based on relative value units (RVUs) or Resource Based Relative Value Scale (RBRVS) methodology. Reported MCO rates range from: Low:100% MHCP fee schedule for both primary care and non-primary care providers; and High: 122% MHCP fee schedule for primary care providers and 118% for non-primary care providers. Most MCOs reported reimbursement rates below 110% of the MHCP fee schedule. Some MCOs pay a small per member per month case management fee to their primary care providers. Some MCOs pay a higher percent for specific codes such as office visits (i.e. evaluation & management) and Child & Teen Check-ups (C&TC).
Chiropractic services	Some MCOs reported using the MHCP fee schedule for chiropractic services. Reported MCO rates range from: Low: 100% MHCP fee schedule; and High: 107% MHCP fee schedule. Some MCO reported using an RVU method, cost-based method, capitated arrangements, or pay a percent of their standard commercial rates.
Providers of rehabilitative & therapeutic services (PT, OT, Speech)	Rehabilitative & therapeutic services are generally based on RVUs payment methodology and/or the MHCP fee schedule. Reported MCO rates range from: Low: 100% MHCP fee schedule; and High: 118% MHCP fee schedule. Most MCOs reported reimbursement rates below 110% of the MHCP fee schedule.
Outpatient Hospital Services (facility)	MCOs use Medicare's Ambulatory Payment Classification (APC) methodology or a percent of billed charges for outpatient facility services. The MHCP fee schedule uses APC methodology. Reported MCO rates range from: Low: 100% MHCP fee schedule; and High: 110% MHCP fee schedule. Some MCOs reported paying differently for emergency versus non-emergency services or for critical access hospitals.
Inpatient Hospital Services	Most MCOs use Diagnostic Related Groups (DRGs) for inpatient hospital services. The MHCP fee schedule uses DRG methodology. Reported MCO rates range from: Low: 100% MHCP fee schedule; and High: 110% of MHCP fee schedule. MCOs that did not report they use MHCP as a basis for their rates may pay higher or lower than the MHCP fee schedule.
Dental Services	MCOs reported using the MHCP fee schedule as a base for their dental rates. Reported MCO rates range from: Low: 100% of MHCP fee schedule; and High: 140% of MHCP fee schedule. Some MCOs reported paying some provider higher rates for higher needs populations, such as SNBC, or for specialty providers.
Prescription Drugs	For both brand-name prescription drugs, most MCOs reported using the Average Wholesale Price (AWP) as the benchmark for reimbursement rates and Maximum Allowable Cost (MAC) for generics. Reported MCO rates range from: Low: AWP-18% for brand, AWP-72.9% for generic; and High: AWP-7% for brand, AWP-58% for generic. Most MCOs averaged between 12-16% discounts from AWP.
Mental Health Services - outpatient	Most MCOs reported using the MHCP fee schedule as the base for outpatient mental health services provider reimbursement. Reported MCO rates range from: Low: 100% MHCP fee schedule; and High: 115% MHCP fee schedule. Some MCOs reported using a percent of their standard commercial rate or a cost-based method for mental health services.
Chemical Dependency Services - outpatient	Most MCOs reported using the MHCP fee schedule as the base for chemical dependency non-residential provider reimbursement. Reported MCO rates range from: Low: 100% of MHCP fee schedule; and High: 130% of MHCP fee schedule. Some MCOs reported using a percent of their standard commercial rate for chemical dependency services.
Home Care Services – PCA, PDN, home health aide, skilled nurse visits	Most MCOs reported using the MHCP fee schedule as the base for home care provider reimbursement. Reported MCO rates range from: Low: 100% of MHCP fee schedule; and High: 110% of MHCP fee schedule. Some MCOs reported using a percent of billed charges for certain home care providers or providers outside of the metro area.

Section 4 – Aggregate provider reimbursement rates

The statute requires DHS to report an aggregate array of reimbursement rates by MCO broken down into primary and non-primary care categories. Primary care versus non-primary care is defined for this purpose in section 1. MCOs submitted average reimbursement rates across all provider contracts and across all public programs for the services or provider types similar to section 1. Each category includes a series of common procedures for services or provider types listed in Appendix 2. It is important to note that the rates reported in Table 10 are aggregated across the procedure codes listed in Appendix 2 and across all programs. Many factors can impact the reported average provider contracted rate, including but not limited to:

- *Program type.* Many MCOs' reimbursement rates differ by program because the populations in the programs are unique (e.g. MA families with children versus MA seniors, Medicare-integrated versus non-integrated) and because DHS sets rates separately for each program (i.e. base rates are different for MA versus MinnesotaCare families with children).
- *Population demographics and health status.* MCO reimbursement rates may differ depending on the case mix (population characteristics and health risk) and the MCO's enrollment or population size of the public programs they serve. For example, an MCO may have a higher percent of senior enrollment compared to its other public program enrollment and compared to other MCOs. This may result in higher or lower reimbursement rates for certain services based on the needs of the populations they serve.
- *Geographic location/provider access.* MCOs' reimbursement may vary based on provider costs in the metro versus non-metro and may be higher in some areas or by service type in order to ensure access to care for MCHP enrollees. For example, an MCO's rate may be higher for dental services in greater Minnesota versus the metro area and the majority of the MCO's service area may be outside the metro area; therefore that MCO's average rate for dental services may be higher compared to other MCOs.
- *Payment type or payment arrangement.* MCOs may reimburse providers differently across service categories, provider types and populations. MCOs pay bundled rates, have gain or risk-sharing contracts, and pay provider incentives or withholds. These varying arrangements may result in over or under reporting of reimbursement rates in certain categories in Table 10. The reporting reflects a standard FFS payment arrangement.

Table 10 - Average Provider Reimbursement Rates by MCO

Calendar Year 2009

Service	Blue Plus	HealthPartners	IMCare	Medica	MHP	PrimeWest	SCHA	UCare
Physician								
Primary Care								
Office visit-minimal (low)	$ 13.28	$ 16.65	$ 13.30	$ 16.22	$ 15.06	$ 19.19	$ 17.57	$ 20.01
Office visit-low severity(med)	$ 26.51	$ 30.28	$ 26.58	$ 35.62	$ 33.39	$ 30.30	$ 33.41	$ 37.64
Office visit-comprehensive(high)	$ 72.17	$ 85.75	$ -	$ 85.93	$ 82.47	$ 81.99	$ 88.87	$ 90.28
Non-clinic outpatient visit	$ 32.77	$ 41.55	$ 13.30	$ 78.43	$ 53.71	$ 21.58	$ 37.86	$ 34.57
Non-clinic inpatient visit	$ 63.55	$ 60.67	$ 32.39	$ 77.75	$ 72.09	$ 71.38	$ 78.46	$ 74.68
Non-Primary Care								
Office visit-minimal (low)	$ 12.92	$ 24.73	$ 11.56	$ 18.94	$ 19.54	$ 25.27	$ 27.42	$ 22.15
Office visit-low severity(med)	$ 28.10	$ 29.66	$ 23.11	$ 41.16	$ 33.83	$ 29.83	$ 33.89	$ 32.39
Office visit-comprehensive(high)	$ 73.85	$ 72.31	$ -	$ 90.32	$ 75.35	$ 79.37	$ 99.17	$ 84.83
Non-clinic outpatient visit	$ 46.69	$ 40.77	$ 11.56	$ 76.32	$ 50.11	$ 31.05	$ 37.10	$ 33.79
Non-clinic inpatient visit	$ 53.11	$ 93.40	$ 28.16	$ 78.06	$ 58.05	$ 70.57	$ 71.61	$ 70.61
Advanced Practice Nurse (APN)								
Primary Care								
Office visit-minimal (low)	$ 19.55	$ 16.65	$ 13.30	$ 16.26	$ 19.87	$ 25.12	$ 25.91	$ 22.35
Office visit-low severity(med)	$ 26.47	$ 30.28	$ 26.58	$ 30.90	$ 30.14	$ 29.73	$ 32.63	$ 33.45
Office visit-comprehensive(high)	$ 72.89	$ 85.75	$ -	$ 73.38	$ 80.32	$ 79.58	$ -	$ 85.94
Non-clinic outpatient visit	$ 32.17	$ 41.55	$ 13.30	$ 69.24	$ 33.73	$ 27.23	$ 42.24	$ 30.96
Non-clinic inpatient visit	$ 62.99	$ 60.67	$ 32.39	$ 56.89	$ 93.32	$ 68.80	$ 57.88	$ 69.10
Non-Primary Care								
Office visit-minimal (low)	$ -	$ 24.73	$ 11.56	$ 19.88	$ 19.52	$ -	$ 15.98	$ 21.85
Office visit-low severity(med)	$ -	$ 29.66	$ 23.11	$ 32.76	$ 32.22	$ -	$ 35.15	$ 33.68
Office visit-comprehensive(high)	$ -	$ 72.31	$ -	$ 89.51	$ 79.75	$ -	$ -	$ 91.14
Non-clinic outpatient visit	$ -	$ 40.77	$ 11.56	$ 74.75	$ 55.56	$ -	$ 56.77	$ 34.36
Non-clinic inpatient visit	$ -	$ 93.40	$ 28.16	$ 52.78	$ 93.40	$ -	$ 58.89	$ 66.05
Chiropractic								
Chiropractic manipulative treatment-One to two regions	$ 16.48	$ 30.65	$ 15.41	$ 19.87	$ 16.75	$ 17.44	$ -	$ -
Rehabilitative & therapeutic								
Speech therapy - treatment	$ 56.17	$ 46.64	$ 49.45	$ 69.41	$ 60.35	$ 55.44	$ 53.22	$ 86.32
Physical therapy - treatment	$ 21.71	$ 22.91	$ 18.66	$ 18.50	$ 34.86	$ -	$ 28.41	$ 20.64
Occupational therapy - treatment	$ 21.75	$ 22.91	$ 22.49	$ -	$ 34.86	$ -	$ 21.64	$ 24.00

Table 10 - Average Provider Reimbursement Rates by MCO, Continued

Calendar Year 2009

Service	Blue Plus	HealthPartners	IMCare	Medica	MHP	PrimeWest	SCHA	UCare
Inpatient								
Vaginal birth - normal	$ 3,468.27	$ 3,380.69	$ 2,830.56	$ 3,071.21	$ 3,210.30	$ 3,400.92	$2,995.33	$ 2,948.34
C-section - normal	$ 6,221.24	$ 5,506.96	$ 4,716.21	$ 4,353.63	$ 4,242.15	$ 5,581.90	$5,263.68	$ 5,283.95
Vaginal birth - complicated	$ 4,482.95	$ 4,585.77	$ 3,546.46	$ 4,044.43	$ 4,023.30	$ 3,709.90	$3,871.05	$ 3,477.11
C-Section - complicated	$ 7,012.33	$ 7,420.61	$ 6,054.55	$ 6,359.27	$ 4,759.88	$ 5,881.01	$6,566.36	$ 7,579.44
Mental Health (ages 19<)	$ 2,473.07	$ 5,517.00	$ 5,251.26	$ 8,996.85	$ 5,209.86	$ 6,234.56	$ 955.96	$ 8,294.52
Mental Health (ages 19>)	$ 2,469.81	$ 4,424.19	$ 5,270.48	$ 6,750.01	$ 5,729.27	$ 2,003.89	$ 920.58	$ 6,531.87
Chemical Dependency Treatment	$ 1,774.51	$ 115.69	$ 27.43	$ 3,606.16	$ -	$ -	$15,102.06	$ 3,727.99
Outpatient (facility)								
Emergency	$ 43.99	$ 152.96	$ 26.99	$ 256.60	$ 172.56	$ 122.23	$ 210.38	$ 151.87
Non-Emergency	$ 36.23	$ 97.83	$ 13.30	$ 69.10	$ 72.03	$ 26.47	$ 69.52	$ 60.59
Dental								
Diagnostic	$ 25.91	$ 42.00	$ 30.95	$ 39.42	$ 26.79	$ 26.48	$ 20.41	$ 23.26
Preventive	$ 50.05	$ 39.00	$ 55.99	$ 36.98	$ 52.04	$ 24.78	$ 18.54	$ 22.26
Home Care								
Private Duty Nursing (PDN)	$ 6.37	$ 7.26	$ 6.30	$ 10.84	$ -	$ -	$ 7.74	$ 7.80
Personal Care Assistance (PCA)	$ 3.81	$ 3.96	$ 3.96	$ 6.36	$ 4.06	$ 6.42	$ 5.01	$ 4.03
Mental Health (outpatient)								
Children's								
Diagnostic assessment	$ 215.50	$ 97.54	$ 139.11	$ 140.60	$ 115.34	$ 108.87	$ 140.53	$ 135.95
Interactive assessment	$ 148.17	$ 148.17	$ 170.40	$ 191.11	$ 178.57	$ 157.85	$ 163.03	$ 177.54
Individual psychotherapy	$ 37.47	$ 35.91	$ 53.13	$ 44.02	$ 33.20	$ 42.90	$ 42.36	$ 42.90
Adult								
Diagnostic assessment	$ 131.67	$ 97.54	$ 139.11	$ 134.90	$ 106.94	$ 108.85	$ 143.55	$ 131.37
Interactive assessment	$ 148.17	$ 148.17	$ 170.40	$ 198.19	$ 135.21	$ -	$ 142.52	$ 138.06
Individual psychotherapy	$ 37.47	$ 35.91	$ 41.30	$ 49.41	$ 44.05	$ 46.44	$ 48.41	$ 45.32
Chemical Dependency (outpatient)								
Residential treatment	$ 100.06	$ 89.42	$ 353.38	$ 2,106.22	$ 1,136.51	$ 1,140.34	$ 516.79	$ 97.30
Non-residential treatment	$ 44.78	$ 31.88	$ 27.43	$ 27.88	$ 114.49	$ 295.04	$ 148.81	$ 32.60

Table 10

Notes:

- MCOs with missing rate information for Advanced Practice Nurse (APN) services were unable to identify primary care versus non-primary care specialties in their claims data.
- MCOs with missing rate information for chiropractic services have capitated arrangements.
- MCOs with missing rate information in other categories did not have sufficient claims under the required procedure codes listed in Appendix 2 for the reporting period and/or the primary coverage was Medicare.
- The data listed in table 10 represents the average rate reported by MCOs aggregated across and programs and procedures codes listed in Appendix 2.
- The data listed in table 10 does not include data or information on the volume of services (i.e. utilization) for each service category reported.
- Factors that may contribute to variation across service or provider categories and across MCOs listed on page 15 should be viewed in conjunction with this table. This includes: program type, population demographics and health risk, geographic location/provider access, and provider payment type or arrangement.

CONCLUSION

This report is intended to provide information and data to the legislature on payments made to providers by MCOs under contract with DHS to provide services to MHCP enrollees. The information in this report provides a general overview of detailed provider payment and rate methodology data defined as nonpublic and aggregate provider payments and reimbursement rate data separated into primary care and non-primary care categories as required by statute. It is important to note that this reporting requirement is specific to MCO provider payments and does not include MCO administrative dollars or discussion of MCO surplus or loss as required by other health plan financial reporting[5].

Overall, the data submitted by the MCOs to DHS under this reporting requirement were generally consistent with some outliers and missing or incomplete data. Since this was the first year MCOs were required to submit this data to DHS, some issues were to be expected. Three to five years of data collection is necessary to improve consistency in the data submission and allow appropriate analyses of trends.

As noted earlier, the data in this report is from the first phase of the MCO provider payment data reporting requirement. Implementation of the second phase will be from January 1 through April 1, 2011. The second phase requires MCOs to start including provider payment and reimbursement rate data on the individual encounter claims already submitted to DHS on a monthly basis. Collecting data at the individual claim level will yield additional information to support improved oversight and accountability of the dollars MCOs pay to providers for services provided to MHCP enrollees.

[5] Data reported by MCOs under this requirement may differ from MCO financial reporting required by MDH or Commerce due to the timing of data submission (i.e. claims run out date) and other factors.

APPENDIX 1 - Provider Type and Service Category Definitions

Section 1: Aggregate Provider Payments

Provider/Service Type	Category for MDH financial reporting	Definition
ADVANCED PRACTICE NURSE SERVICES **1. Primary Care Specialties** **(American Board of Specialties)** Family Practice General Practice Internal Medicine Pediatrics OBGYN **2. All Other Non-Primary Care Specialties**	Other health professional services	These are costs for all services provided by licensed nurse practitioners, nurse anesthetists, nurse midwives, clinical nurse specialist, and public health nurses. Advanced practice nurse services expenses should exclude the costs of maternity care, mental health services, and chemical dependency services.
PHYSICIAN SERVICES **1. Primary Care Specialties** **(American Board of Specialties)** Family Practice General Practice Internal Medicine Pediatrics OBGYN **2. All Other Non-Primary Care Specialties**	Physician services	These are costs for all services provided by or under the supervision of licensed medical doctors by a physician assistant and doctors of osteopathy, including pharmaceuticals and supplies administered or dispensed from the physician office and billed directly through the physician and health care home services. Physician services expenses should exclude the costs of maternity care, mental health services and chemical dependency services. Costs should be allocated to a physician's primary specialty if they are credentialed in multiple specialties.
MATERNITY CARE	Physician services, Inpatient services	These are costs for all maternity care including prenatal visits, labor & delivery, through the first post-natal visit.
CHEMICAL DEPENDENCY TREATMENT SERVICES	Chemical Dependency and Mental Health	These are costs related to chemical dependency services, including inpatient and outpatient services, using the following chemical health diagnosis codes starting with 291, 292, & 303-305.
CHIROPRACTIC SERVICES	Other health professional services	These are costs for all services provided by a licensed chiropractor.
DENTAL SERVICES	Dental services	These are all costs, professional and other, provided under dental services contracts or riders. This includes services provided by a licensed dentist and dental hygienist.
INPATIENT HOSPITAL SERVICES	Inpatient hospital services	These are costs for those services furnished by a hospital for inpatient services, including inpatient hospice care. Inpatient hospital services expenses should exclude costs where the primary diagnosis codes are mental health and chemical dependency related. This excludes costs for maternity care.
ACCESS SERVICES	N/A	These are costs for interpreter services (language & hearing), access transportation which includes transit, taxi or volunteer transportation, common carrier, and community health workers.
OTHER PROFESSIONAL SERVICES	Other health professional services Emergency Services	Lab, Diagnostic, & Radiological services: These are costs for all laboratory and radiology services provided outside of an inpatient setting or ambulatory surgical center. Podiatric services: These are costs for all services provided by a licensed podiatrist. Vision care services: These are costs for all services provided by a licensed ophthalmologist, optometrist, and optician. This does not include the cost of eyewear or contact lenses.

Provider/Service Type	Category for MDH financial reporting	Definition
DURABLE MEDICAL EQUIPMENT & MEDICAL SUPPLIES	Durable medical goods	These are costs for such items as wheel chairs, eyewear, hearing aids, surgical appliances, bulk and cylinder oxygen, equipment rental, and other devices or equipment that can withstand repeated use; prosthetic and orthotic devices; and medical supplies including non-reusable supplies or pieces of equipment that are used to treat a health condition.
MEDICAL TRANSPORTATION	Emergency services	These are costs for all emergency and non-emergency transportation provided by an ambulance or a special transportation service (STS) provider.
MENTAL HEALTH SERVICES	Chemical Dependency and Mental Health	These are costs related to mental health services, including inpatient and outpatient services, using mental health diagnosis codes starting with 290, 293-302, & 306-316.
OUTPATIENT HOSPITAL SERVICES (facility) **AMBULATORY SURGICAL CENTER (ASC)**	Outpatient services	Outpatient hospital (facility): These are costs for those services offered by a hospital which are furnished to ambulatory patients not requiring emergency care and for which there is not a room and board charge, this includes triage and stabilization care. Outpatient services expenses should exclude the costs of maternity, mental health services and chemical dependency services. This category excludes lab, diagnostic, and radiological services. Ambulatory Surgical Center (ASC): These are costs for services provide at a free-standing or hospital based ambulatory surgical center, including lab, diagnostic, and radiological services. This category excludes professional services, mental health and chemical dependency services.
MEDICAL EMERGENCY SERVICES	Emergency services	These are costs for medical care provided in the emergency room of a hospital. This includes the room, board and any services such as x-ray and laboratory services billed by the facility. It does not include expenditures for physician services.
PRESCRIPTION DRUGS **OVER-THE-COUNTER (OTCs)**	Pharmacy and other nondurable medical goods	These are only costs paid by the health plan company to a pharmacist to provide pharmaceuticals used to treat a health condition. These data do not include the cost of pharmaceuticals and other nondurable medical goods administered or dispensed which are billed directly through a hospital or health care provider. Expenditures provided in this section should be net of pharmaceutical rebates.
REHABILITATIVE & THERAPEUTIC	Other health professional services	These are costs for all services provided by a licensed physical therapist, speech therapist, occupational therapist, audiologist, and respiratory therapist outside of an inpatient setting.
HOME CARE SERVICES	N/A	These are costs for the following non-waiver home care services: skilled nurse visits, private duty nursing, home health aide, personal care assistance, and qualified supervision of personal care services.
NURSING FACILITY EXPENSES	Skilled nursing facility expenses	These are costs for services furnished by a Medicare or Medicaid certified facility primarily engaged in providing nursing care and skilled nursing care and related services for patients who require medical or nursing care or rehabilitation services. These expenses should include room and board incurred at nursing facilities. Nursing facilities expenses should exclude costs of mental health and chemical dependency services. This should include Medicare coinsurance paid by Medicaid.

Provider/Service Type	Category for MDH financial reporting	Definition
MEDICARE COST-SHARING	N/A	These are expenses for Medicare cost-sharing paid by Medicaid for Part A and B services.
EXPENSES NOT ITEMIZED ABOVE	Expenses not itemized above	This includes expense for capitated and total cost of care arrangement that cannot be allocated into the other service categories (please provide a description of these arrangements included in this category), performance payments, administrative fee withhold, prepayment for appointment availability, and IBNR that cannot be allocated into one of the other service/provider category.

APPENDIX 2 – Procedure Codes

Section 1: Aggregate Provider Reimbursement Rates

Provider/Service Type	Procedure Code (CPT, HCPC, Dental, Revenue)
1. Physician/Advanced Practice Nurses (APNs)	
A. Primary Care Providers	
i. Clinic-based office visits	
1. Level 1: minimal (new & established)	99201, 99211
2. Level 2: limited (new & established)	99202, 99212
3. Level 3: low severity (new & established)	99203, 99213
4. Level 4: moderate (new & established)	99204, 99214
5. Level 5: comprehensive (new & established)	99205, 99215
ii. Non clinic-based visits	
1. Inpatient	99221-99233
2. Outpatient	99201-99215, 99381-99383
B. Non-Primary Care Providers	
i. Clinic-based office visits	
1. Level 1: minimal (new & established)	99201, 99211
2. Level 2: limited (new & established)	99202, 99212
3. Level 3: low severity (new & established)	99203, 99213
4. Level 4: moderate (new & established)	99204, 99214
5. Level 5: comprehensive (new & established)	99205, 99215
ii. Non clinic-based visits	
1. Inpatient	99221-99233
2. Outpatient	99201-99215, 99381-99383
3. Chiropractors	
A. Chiropractic manipulative treatment (CMT)	
i. one to two regions	98940
4. Providers of rehabilitative and therapeutic services (outpatient professional services)	
A. Speech-language pathology	
i. SLP treatment sessions	92507-92508, 92526, 92626-92627, 92630, 92633
B. Physical Therapy	
i. PT treatment session	95851-95852
C. Occupational Therapy	
i. OT treatment session	95851-95852
5. Inpatient Hospital	
A. Maternity	
i. vaginal birth - normal	DRG - 373
ii. C-section - normal	DRG - 371
iii. vaginal birth - complicated	DRG - 372
iv. C-section - complicated	DRG - 370
B. Chemical dependency	
i. hospital-based treatment	0944, or 0945; H2036

Provider/Service Type	Procedure Code (CPT, HCPC, Dental, Revenue)
C. Mental Health	diagnosis codes starting with 290, 293-302, & 306-316.
6. Outpatient Hospital (facility only)	
A. Emergency	99281-99285
B. Non-emergency	99201-99215, 99381-99383
7. Dentists, dental hygienists	
A. Diagnostic	D0120, D0140, D0145, D0150, D0210, D0220, D0230, D0272, D0274, D0330
B. Preventive	D1110, D1120, D1203, D1204, D1206, D1330, D1351, D1510, D1515
9. Home care providers	
A. Private Duty Nursing (RN/LPN) - 15 minute unit	T1002-T1003, modifiers TG, TT
B. PCA services - 15 minute unit	T1019, modifiers TT, HQ, U6, UA
10. Chemical Dependency services (non-hospital based)	
A. Residential	
i. treatment	0944 or 0945; H2036
B. Non-residential (outpatient)	
i. treatment	0944 or 0945; H2035
11. Mental Health Services (outpatient only)	
A. Children's Mental Health Services	
i. Diagnostic assessment - 1 session	90801
ii. Interactive diagnostic assessment - 1 session	90802
iii. CTSS Individual psychotherapy - 30 minutes	90804- modifier UA
B. Adult Mental Health Services	
i. Diagnostic assessment - 1 session	90801
ii. Interactive diagnostic assessment - 1 session	90802
iii. Individual psychotherapy - 20-30 minutes	90804