

Medical Assistance Program  
Oversight Council  
January 11, 2013





# Today's Agenda

- Confirmation re Primary Care Rate Increases
- Hospital Payment Reform Overview
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Report
- Eligibility Reports

# Primary Care Rate Increases

- Effective January 1, 2013, ACA requires states to increase Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rate for 2013 and 2014 (financed with 100% federal funding)
- Final federal rule issued November 2, 2012



## Primary Care Rate Increases (cont.)

- services must be delivered by a physician who specializes in family medicine, general internal medicine, or pediatric medicine
- certain physician subspecialists who are board certified in those specialties or provide primary care within the overall scope of those categories also qualify for the enhanced payment



## Primary Care Rate Increases (cont.)

- higher payment will be made for primary care services rendered by practitioners (e.g. Advance Practice Registered Nurses, APRNs) working under the personal supervision of any qualifying physician

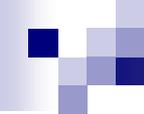
## Primary Care Rate Increases (cont.)

- the Department anticipates that it will take until at least July 1, 2013 to make all of the necessary changes to implement the rate increase, retroactive to January 1, 2013



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# Payment Reform - Background

In conjunction with the other health care reform strategies outlined in the November and December meetings of MAPOC, the Department is also embarking on a project to update and modernize its payment methodologies. Overall, the Department seeks to move toward **value-based purchasing**.

## Payment Reform – Background (cont.)

The Centers for Medicare and Medicaid Services (CMS) define **value-based purchasing** as a method that provides for:

*Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.*

## Payment Reform – Background (cont.)

Many elements are required in order to successfully implement a **value-based purchasing strategy**, including selection of performance measures and implementation of a means of sharing information with providers. A necessary first step for the Department, however, is updating its current payment mechanisms so that they are consistent with other major payers (Medicare, private payers).

## Payment Reform - Background (cont.)

Two key elements of updating and modernizing payment mechanisms include:

- reforming the means of making hospital payments
- conversion of medical codes from ICD-9 to ICD-10

# Hospital Payment Reform

- Hospital payment reform will:
  - align payments to the services that are provided
  - incent efficiency
  - enhance predictability and transparency of method
  - accommodate value-based payment mechanisms (pay-for-performance P4P, shared savings, episode bundling)
  - better align with methods used by private payers

## Hospital Payment Reform (cont.)

- Hospital payment reform will involve two elements:
  - conversion of inpatient method from the current Target Payment/Discharge approach to use of Diagnosis Related Groups (DRGs)
  - conversion of the outpatient method from the current mix of fixed fees and cost-to-charge ratios to Ambulatory Payment Classifications (APC)

## Hospital Payment Reform (cont.)

Inpatient payment should be converted from the current Target Payment/Discharge approach to use of Diagnosis Related Groups (DRGs) because:

- targets are based on 2007 data that is outmoded
- payment is premised on average acuity, and may be undercompensating the actual costs of care
- settlement is required almost two years subsequent to payment

## Hospital Payment Reform (cont.)

DRGs (a prospective payment based on age, principle and secondary diagnoses and in some cases surgical procedure performed) will:

- permit the Medicaid to establish “base rates” and “relative weights” for intensity of service; and
- outlier payments to accommodate higher acuity

## Hospital Payment Reform (cont.)

Outpatient payment should be converted from the current mix of fixed fees and cost-to-charge ratios to Ambulatory Payment Classifications (APC) because:

- the current method is based on Medicare Cost Reports that are perennially dated; and
- APCs (a prospective payment based on service(s) provided) will permit the Medicaid to establish “base rates” and “relative weights” for intensity of service

# Conversion of Medical Codes

Effective October 1, 2014, all providers that are HIPAA –covered entities will be required to convert from the current ICD-9 medical code set to the updated ICD-10 set. This change involves both modifications to code groupings (taxonomy) and doubling of the number of codes, representing a much higher degree of specificity.

ICD refers to the International Classification of Diseases, Tenth Revision, Procedure Coding System.



## Conversion of Medical Codes (cont.)

### **Example:**

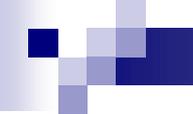
ICD-9 provided a code for a burn.

ICD-10 provides a series of codes for burns based on where the burn is located on the body and its degree of seriousness, among other factors.

# Conversion of Medical Codes (cont.)

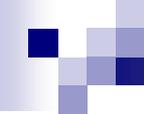
These codes are currently used by the Department in:

- Medicaid Management Information System (MMIS) processing, including how we configure:
  - coverage rules
  - reimbursement rules
  - prior authorizations
  
- Data Warehouse
  - queries
  - reports



# Payment Reform – Next Steps

Following reform of hospital payments and conversion of medical codes, the Department will evaluate use of payment mechanisms including pay-for-performance (P4P), episodes of care and shared savings.



# Today's Agenda

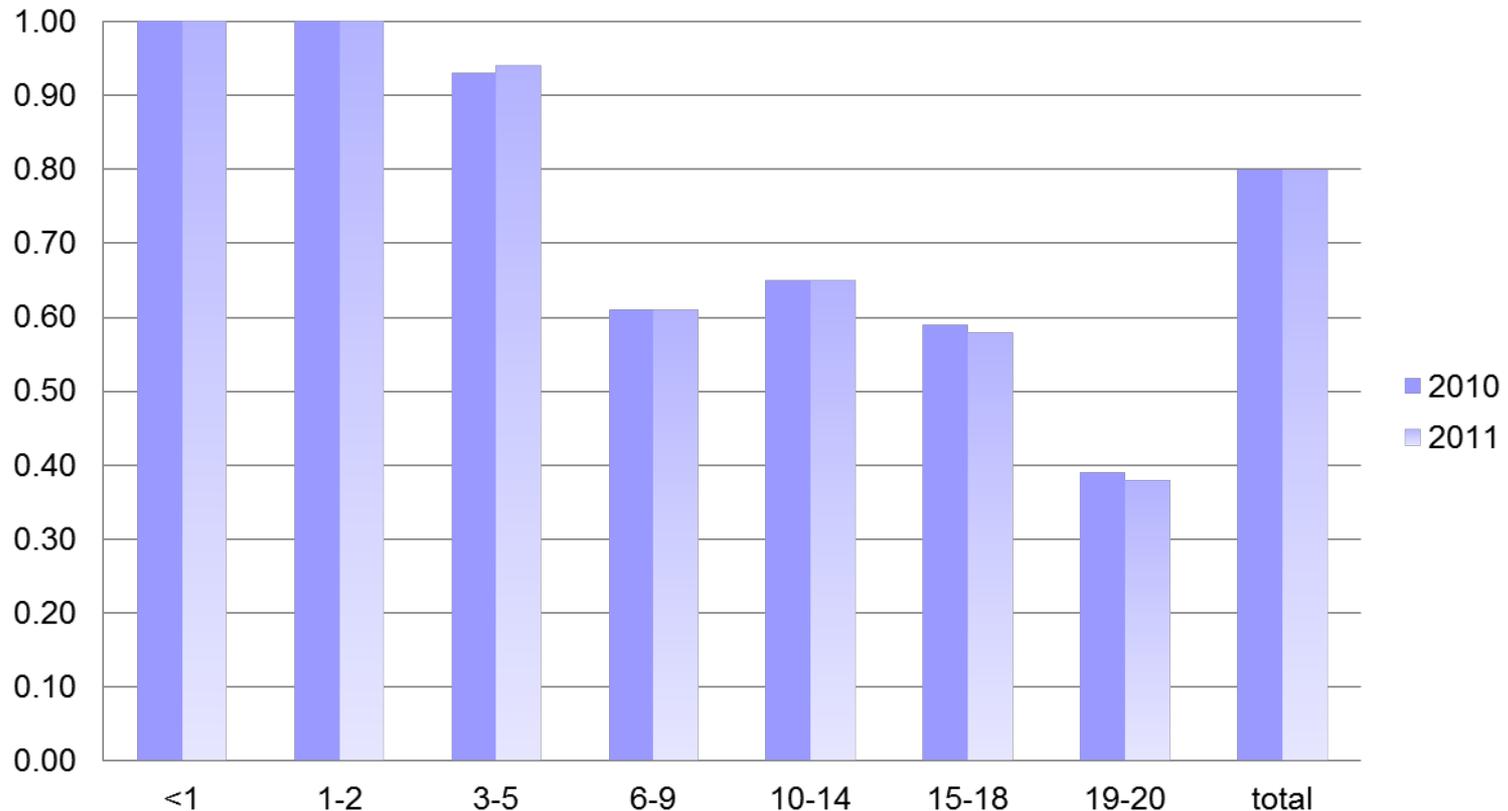
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# CMS 416 Report

- Annual Medicaid report based on the Federal Fiscal Year
- Redefined for the 2010 reporting year
- Changes include:
  - a redefinition of the eligible population
    - include CHIP members if the program is a Medicaid expansion program (not applicable to CT)
    - include services for only those children enrolled at least 90 continuous days
  - expanded dental measures

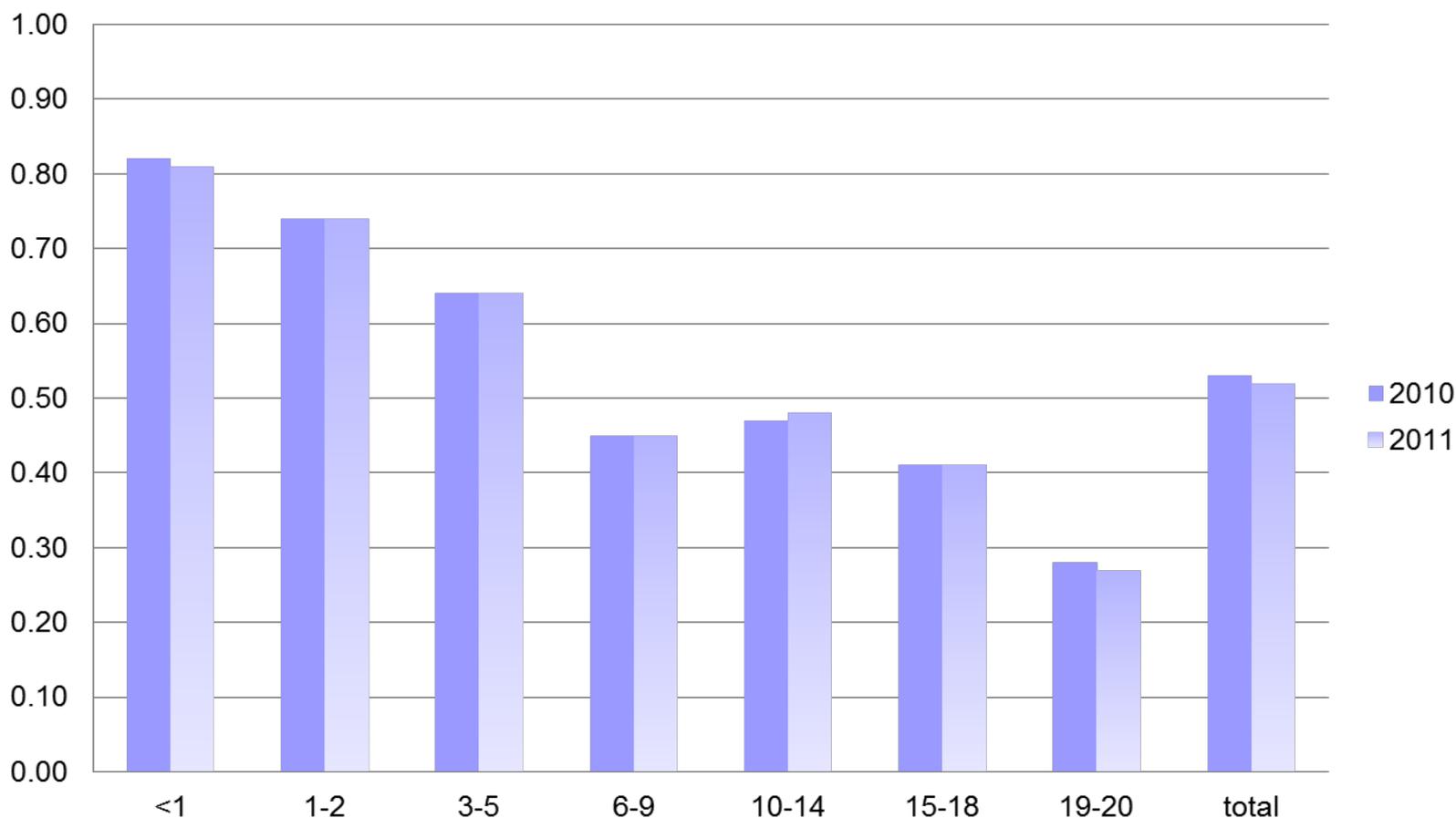
# Screening Ratio

The extent to which children received an initial or periodic screen per the state's periodicity schedule, prorated by the proportion of the year they were Medicaid eligible.



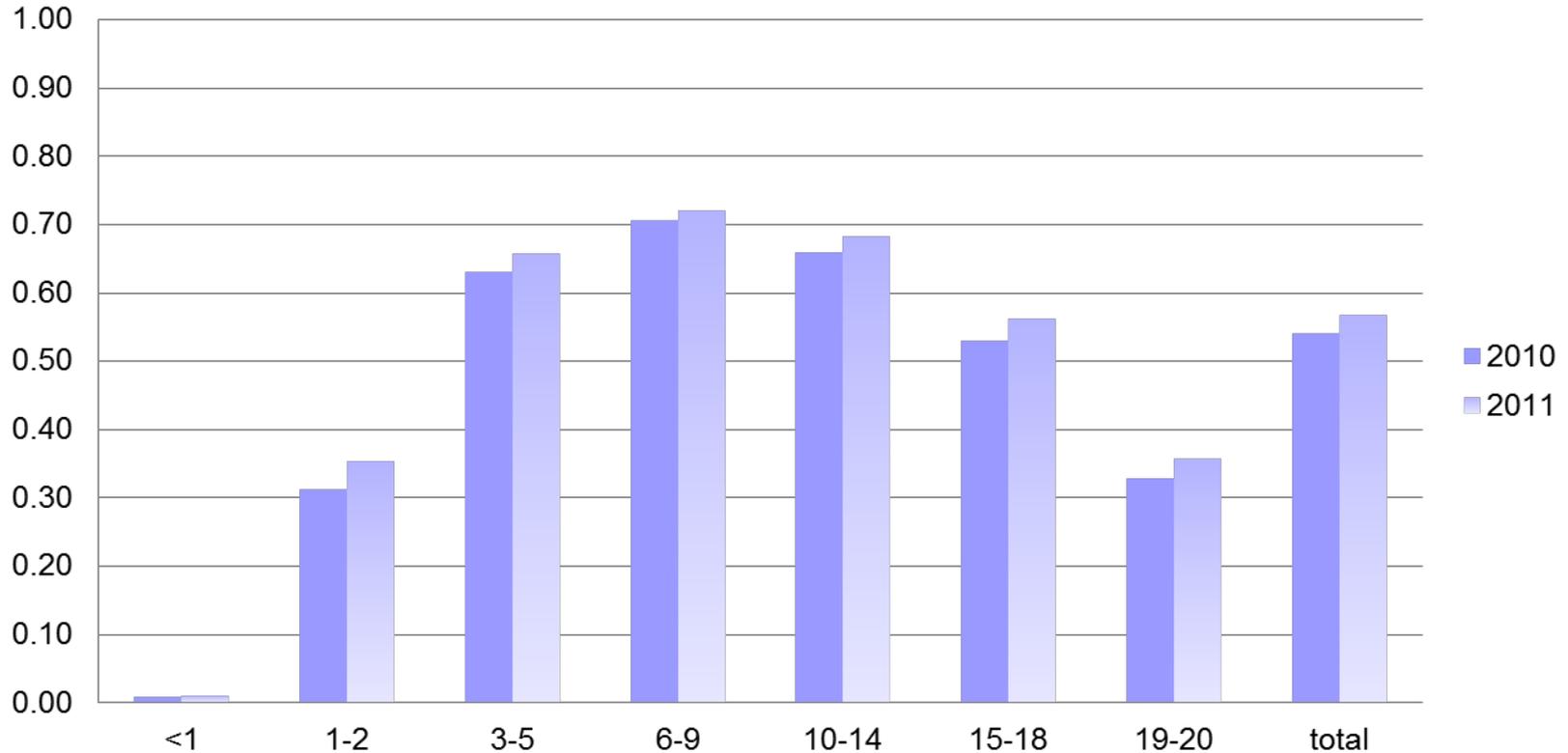
# Participation Ratio

The extent to which children received any initial or periodic screening service during the year.



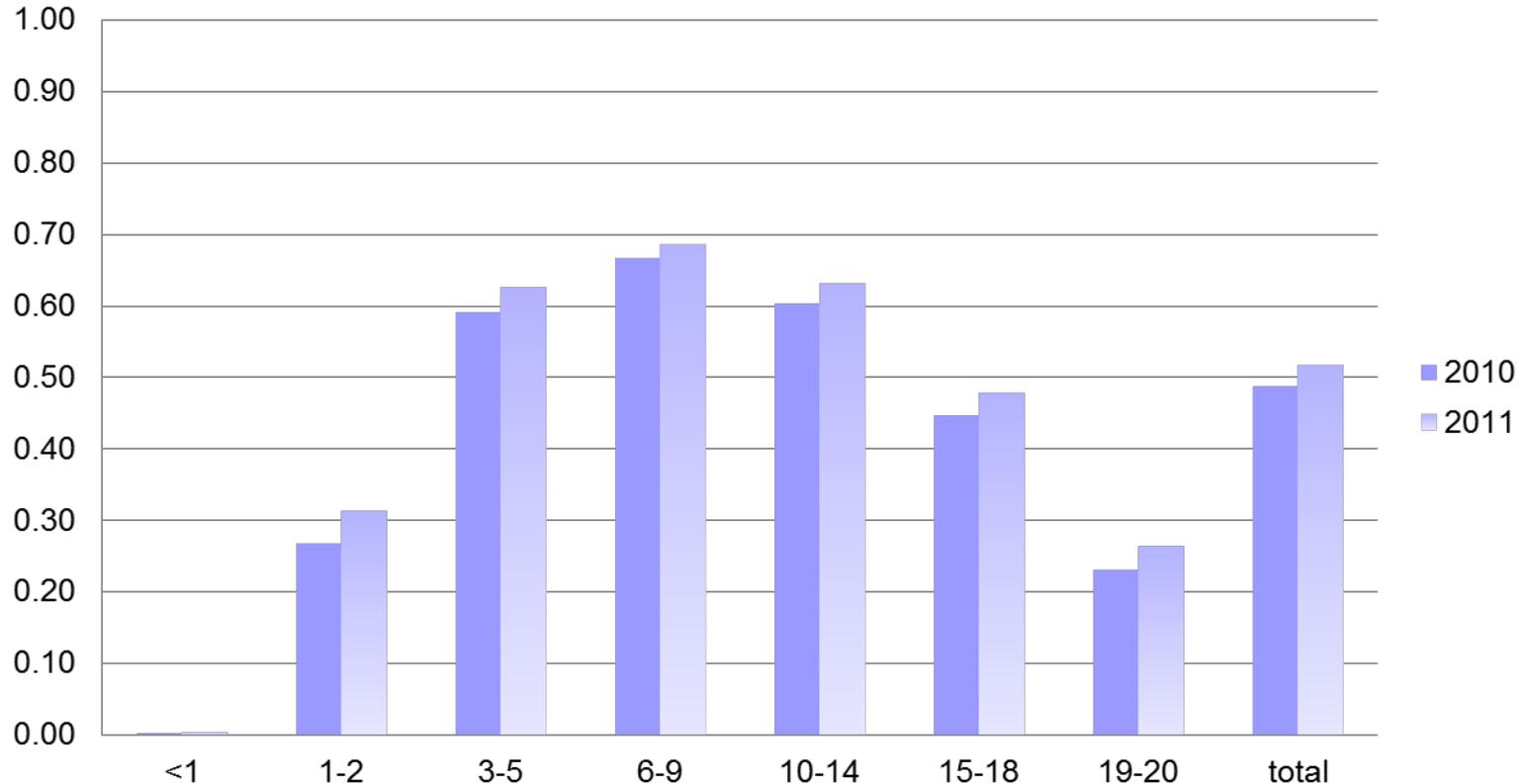
# Children who Received any Dental Services

The number of children who received at least one dental service by or under the supervision of a dentist.



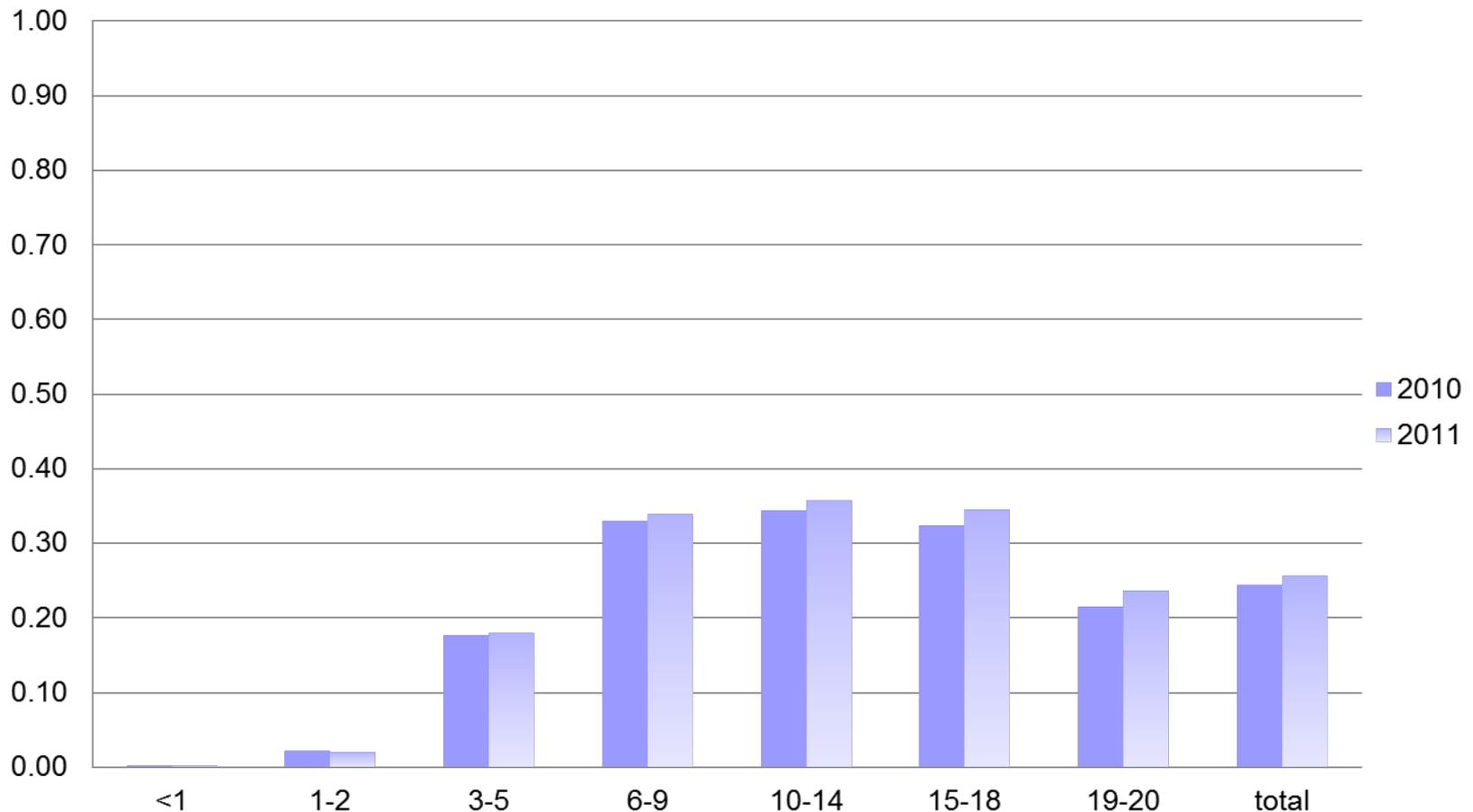
# Children who Received Preventive Dental Service

The number of children who received at least one preventive dental service by/under supervision of a dentist.



# Children who Received Dental Treatment

The number of children receiving at least one treatment service by or under the supervision of a dentist.





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**Questions or comments?**