

Breen, Chandra F (DHS)

From: Palmer, Beryl F (DHS)
Sent: Wednesday, August 17, 2011 4:01 PM
To: (clay.hager [REDACTED]); (Franchesca.Shine [REDACTED]); (sean_burns [REDACTED]); Adrienne Stark; Alison Colton (Alison_E_Colton [REDACTED]); Amy Johnson; Barbara Johnston; Brett Skyles [REDACTED]; Brian Hicks; Brian Nasi (bnasi [REDACTED]); Bruce Wegner; Clelland, Jennifer J; Bjerke, Colleen; Cynthia Macdonald [REDACTED]; Frank Fernandez [REDACTED]; Ghita Worcester ([REDACTED]); Glenn Andis ([REDACTED]); Glenn Wong; Jamie Carsello ([REDACTED]); Jim Przybilla ([REDACTED]); Joann Durham ([REDACTED]); John Whittington ([REDACTED]); Jonathon Hodgson; Judy Knudson; Stone, Julie; Kristy Hayburn; Leota Lind; Mary Prentnieks ([REDACTED]); Metoxen, Sue; Metropolitan Health Plan; 'mlarson([REDACTED]); Natalie Madgy; Pat Higgins ([REDACTED]); Rob Sauer ([REDACTED]); Rob Smith ([REDACTED]); Robert Burkhardt; Sue Westrich; Swenson, Jay Zimmerman, Marie L (DHS); Peed, Karen (DHS); Breen, Chandra F (DHS); Parker, Pam J (DHS); Johnson, Heidi S (DHS); Olson, Pamela R (DHS); Paulsen, Nancy E (DHS); Schoenberger, Heather M (DHS); Tallaksen, Lillian M (DHS); Wernimont, Michelle (DHS)
Cc:
Subject: RE: Provider Payment Report
Attachments: 2011 Payment Data Reporting Instructions & Template - 8-17-11 FINAL.XLS
Importance: High

Sent on behalf of Chandra Breen

Good Afternoon – On August 12 an email was sent notifying MCOs that the submission of the provider payment report was being delayed. We also indicated that we would be sending you a final template. Attached you will find the final template. The only significant change is the elimination of the “frequency of claims” column under section 4. MCOS will not be required to report this information. The report is due no later than **October 3, 2011**. If you have any questions regarding this e-mail or the template, please contact Beryl Palmer.

Beryl Palmer
Contract Manager
Minnesota Department of Human Services
P.O. Box 64984
St. Paul, MN 55164-0984

Fax: [REDACTED]

Caution: This e-mail and attached documents, if any, may contain information that is protected by state or federal law. E-mail containing private or protected information should not be sent over a public (nonsecure) Internet unless it is encrypted pursuant to DHS standards. This e-mail should be forwarded only on a strictly need-to-know basis. If you are not the intended recipient, please: (1) notify the sender immediately, (2) do not forward the message, (3) do not print the message and (4) erase the message from your system.

From: Breen, Chandra F (DHS)
Sent: Friday, August 12, 2011 2:45 PM
To: (clay.hager [REDACTED]); (Franchesca.Shine [REDACTED]); (sean_burns [REDACTED]); Adrienne Stark; Alison Colton ([REDACTED]); Amy Johnson; Barbara Johnston; Brett Skyles ([REDACTED]); Brian Hicks; Brian Nasi ([REDACTED]); Bruce Wegner; Clelland, Jennifer J; Bjerke, Colleen; Cynthia Macdonald ([REDACTED]); Frank Fernandez ([REDACTED]); Ghita Worcester ([REDACTED]); Glenn Andis ([REDACTED]); Glenn Wong; Jamie Carsello ([REDACTED]); Jim Przybilla ([REDACTED]); Joann Durham ([REDACTED]); John Whittington ([REDACTED]); Jonathon Hodgson; Judy Knudson; Stone, Julie; Kristy Hayburn; Leota Lind; Mary Prentnieks ([REDACTED]); Metoxen, Sue; Metropolitan Health Plan; 'mlarson([REDACTED]); Natalie Madgy; Pat Higgins ([REDACTED]); Rob Sauer

([REDACTED]); Rob Smith ([REDACTED]); Robert Burkhardt; Sue Westrich; Swenson, Jay
Cc: Zimmerman, Marie L (DHS); Peed, Karen (DHS); Parker, Pam J (DHS); Johnson, Heidi S (DHS); Olson, Pamela R (DHS); Palmer, Beryl F (DHS); Paulsen, Nancy E (DHS); Schoenberger, Heather M (DHS); Tallaksen, Lillian M (DHS); Wernimont, Michelle (DHS)
Subject: Provider Payment Report
Importance: High

Good Afternoon – In the e-mail sent to the group on 6/30/2011 DHS indicated that due to the potential shutdown we would consider delaying the submission of the provider payment report. This is notification that the submission of the provider payment report is being delayed until October 3, 2011. We also indicated that we would be sending you a final template. We hope to have that completed and sent to the group no later than Wednesday, August 17th. If you have any questions regarding this e-mail please contact the MCO's contract manager.

Chandra Breen
Manager of Contract Management and Compliance
Minnesota Department of Human Services
P.O. Box 64984
St. Paul, MN 55164-0984

Fax: [REDACTED]

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**MANAGED CARE ORGANIZATION (MCO) PAYMENT DATA REPORTING
MINNESOTA HEALTH CARE PROGRAMS (MHCP)**

REPORTING INSTRUCTIONS - 2011

Section 1. AGGREGATE PAYMENT DATA

Instructions: For each provider type, service category and sub-category, provide the total paid amount (see definition below) by the managed care organization (MCO) for each program listed in section 1 for the defined reporting period. For Medicare integrated products, this is the amount paid by Medicaid (includes Medicaid only services and Medicare cost-sharing paid by Medicaid). The data submitted in the template should not include Medicare dollars. MCOs will need to allocate the Medicaid amount based on the same methodology used in data submission to the state's actuaries for basic care rate-setting. Please include as an attachment or footnote to section 1 a description of the methodology used to allocate the amount paid by Medicaid for Medicare integrated products. MCOs should include claims run out through May 31, 2011 for services provided January 1-December 31, 2010 for this section.

For IBNR, MCOs should use consistent factors with data submitted to the state's actuary for rate-setting purposes.

For total cost of care, sub-captated, and other similar arrangements, the MCO must allocate expenditures into the appropriate provider/service category. If the MCO is unable to allocate expenditures, please include the amounts in the "Alternative Payment Arrangements" category and provide a description of each arrangement included and what percentage each arrangement is of the total amount reported in this category.

Please insert data directly into the template in section 1. Please use **Attachment A** to as a reference for hierarchy in reporting payment data.

Definition of paid amount: paid amount means the amount the managed care organization (MCO) pays to a provider including sub-contracted services that are capitated. The paid amount excludes third-party liability and enrollee co-payments.

Definition of reporting period: reporting period means services provided from January 1 to December 31st of the most recent complete contract year.

Provider/Service Type	Category for MDH financial reporting	Definition
ADVANCED PRACTICE NURSE SERVICES	Other health professional services	
1. Primary Care Specialists (American Board of Specialists)		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.
Family Practice		
General Practice		
Internal Medicine		
Pediatrics		
OB/GYN		
2. All Other Non-Primary Care Specialists		
PHYSICIAN SERVICES	Physician services	
1. Primary Care Specialists (American Board of Specialists)		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.
Family Practice		
General Practice		
Internal Medicine		
Pediatrics		
OB/GYN		
2. Health Care Home Payments		
3. All Other Non-Primary Care Specialists		

MATERNITY CARE Physician services, Inpatient services

These are costs for all maternity care including prenatal visits, labor & delivery, through the first post-natal visit

1. Inpatient

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2. Outpatient (hospital)

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3. Professional & all other	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.
1. Inpatient 2. Outpatient (hospital) 3. Professional & all other CHIROPRACTIC SERVICES	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	LAB, DIAGNOSTIC, & RADIOLOGICAL SERVICES	Inpatient hospital services	These are costs for all laboratory and radiology services provided outside of an inpatient setting or ambulatory surgical center.
ACCESS SERVICES	DURABLE MEDICAL EQUIPMENT & MEDICAL SUPPLIES	Other health professional services Emergency Services	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	LAB, DIAGNOSTIC, & RADIOLOGICAL SERVICES	Emergency services	These are costs for interpreter services (language & hearing), access transportation which includes transit, taxi or volunteer transportation, common carrier, and community health workers.
1. Inpatient 2. Outpatient (hospital) 3. Professional & all other 4. Targeted Case Management (TCM)	MENTAL HEALTH SERVICES	Chemical Dependency and Mental Health	These are costs for all emergency and non-emergency transportation provided by an ambulance or a special transportation service (STS) provider.
OUTPATIENT HOSPITAL SERVICES (facility)	DURABLE MEDICAL EQUIPMENT & MEDICAL SUPPLIES	Outpatient services	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.
DHS - Managed Care Purchasing and Payment Policy Division	OUTPATIENT HOSPITAL SERVICES (facility)	Outpatient services	These are costs for those services offered by a hospital which are furnished to ambulatory patients not requiring

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MINNESOTA HEALTH CARE PROGRAMS (MHCP)**

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 Outpatient services

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.

PODIATRIC SERVICES Other health professional services

These are costs for all services provided by a licensed podiatrist.

PRESCRIPTION DRUGS & 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 PROFESSIONAL SERVICES 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.

VISION CARE SERVICES Other health professional 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.

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 FACILITIES 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.

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ELDERLY WAIVER (EW) SERVICES

N/A

These are costs for Elderly Waiver services. This should not include any state plan home care services.

MEDICARE COST-SHARING

N/A

These are expenses for Medicare cost-sharing paid by Medicaid for Part A and B services.

ALTERNATIVE PAYMENT ARRANGEMENTS

N/A

This includes expenses for sub-capitated, total cost of care, risk/gain sharing and other payment arrangements that cannot be allocated into the other service categories (please provide a description of these arrangements included in this category).

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EXPENSES NOT ITEMIZED ABOVE

Expenses not itemized above

This includes expense for services/payments that cannot be allocated into the other service categories including performance payments, administrative fee withhold, prepayment for appointment availability, and IBNR that cannot be allocated into one of the other service/provider category.

Section 2. PROVIDER RATE CHANGES

Instructions: MCOs are required to annually report to DHS information on how legislatively mandated provider rate increases or decreases were passed on to providers for the defined reporting period for the scope of provider types/service categories described in "1. Aggregate Payment Data." Please use Attachment B as a reference tool only for this section.

MCOs can enter information directly into the template under section 2.

Definition of reporting period: "Reporting Period" means payment for services provided from January 1 to December 31st for the most recent complete contract year. This covers legislatively mandated provider increases or decreases that were included in the MCO rates for the most recent completed contract year.

Section 3. RATE METHODOLOGIES

Instructions: MCOs are required to annually report to DHS information on the reimbursement rate methodology for the defined reporting period for the scope of provider types/service categories described in "1. Aggregate Payment Data." For the purposes of reporting under this section, some of the provider types are consolidated as follows: "Physician" - includes physician, ophthalmologists (under vision care), and podiatrists (under podiatry). MCOs can enter information directly into the template under section 3.

Definition of reporting period: "Reporting Period" means rates established for services provided from January 1 to December 31st for the most recent complete contract year.

Definition of reimbursement rate: "Reimbursement Rate" means the provider contracted rate prior to any exclusions including: third-party liability, enrollee co-payments, and provider withholds and incentives for the most recent complete contract year.

Section 4. AGGREGATE REIMBURSEMENT RATES

Instructions: MCOs are required to annually report to DHS an aggregate array of provider reimbursement rates for the defined reporting period for the scope of provider types/service categories described in "1. Aggregate Payment Data." For the purposes of reporting under this section, some of the provider types are consolidated as follows: "Physician" - includes physician, ophthalmologists (under vision care), and podiatrists (under podiatry).

Please insert data directly into the template in section 4.

Please use Attachment C for CPT, HCPC, Dental, and Revenue code references. Please exclude third party liability and Medicare covered services. For Medicare-integrated products, only include rates for Medicaid only services (e.g. dental, PCA, etc.)

Definition of reporting period: "Reporting Period" means rates established for services provided from January 1 to December 31st for the most recent complete contract year.

Definition of reimbursement rate: "Reimbursement Rate" means the provider contracted rate prior to any exclusions including: third-party liability, enrollee co-payments, and provider withholds and incentives for the most recent complete contract year.

REPORTING DUE DATE

This report, including the template and all attachments, is due to DHS on **October 3, 2011**. Reports should be submitted via the MCO's MN-ITS mailbox

QUESTIONS?

If you have questions regarding MCO Payment Data Reporting for Minnesota Health Care Programs, please contact **Beryl Palmer** at **651-431-2521** or **Beryl.Palmer@state.mn.us**.

DHS - Managed Care Purchasing and Payment Policy Division

MCO PAYMENT DATA REPORTING
 MINNESOTA HEALTH CARE PROGRAMS (MHCP)
 Section 1. AGGREGATE PAYMENT DATA - CY 2010
 Please use Attachment A for hierarchy

Provider/Service Type	MA-Families & Children	General Assistance Medical Care (GAMC)	MinnesotaCare Families & Children	MinnesotaCare Adults w/o Children	Minnesota Senior Care Plus (MSC+)	Minnesota Senior Health Options (MSHO)	Special Needs Basic Care (SNBC)
ADVANCED PRACTICE NURSE SERVICES							
1. Primary Care Specialists	\$	-	\$	-	\$	-	\$
Family Practice							
General Practice							
Internal Medicine							
Pediatrics							
OB/GYN							
2. All Other Non-Primary Care Specialists	\$	-	\$	-	\$	-	\$
PHYSICIAN SERVICES							
1. Primary Care Specialists	\$	-	\$	-	\$	-	\$
Family Practice							
General Practice							
Internal Medicine							
Pediatrics							
OB/GYN							
2. Health Care Home Payments	\$	-	\$	-	\$	-	\$
3. All Other Non-Primary Care Specialists	\$	-	\$	-	\$	-	\$
MATERNITY CARE							
1. Inpatient	\$	-	\$	-	\$	-	\$
2. Outpatient (hospital)	\$	-	\$	-	\$	-	\$
3. Professional & all other	\$	-	\$	-	\$	-	\$
CHEMICAL DEPENDENCY TREATMENT SERVICES							
1. Inpatient	\$	-	\$	-	\$	-	\$
2. Outpatient (hospital)	\$	-	\$	-	\$	-	\$
3. Professional & all other	\$	-	\$	-	\$	-	\$
CHIROPRACTIC SERVICES	\$	-	\$	-	\$	-	\$
DENTAL SERVICES	\$	-	\$	-	\$	-	\$
INPATIENT HOSPITAL SERVICES	\$	-	\$	-	\$	-	\$
ACCESS SERVICES	\$	-	\$	-	\$	-	\$

MCO PAYMENT DATA REPORTING
 MINNESOTA HEALTH CARE PROGRAMS (MHCP)
 Section 1. AGGREGATE PAYMENT DATA - CY 2010

Please use Attachment A for hierarchy

Provider/Service Type	MA-Families & Children	General Assistance Medical Care (GAMC)	MinnesotaCare Families & Children	MinnesotaCare Adults w/o Children	Minnesota Senior Care Plus (MSC+)	Minnesota Senior Health Options (MSHO)	Special Needs Basic Care (SNBC)
LAB, DIAGNOSTIC, & RADIOLOGICAL SERVICES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DURABLE MEDICAL EQUIPMENT & MEDICAL SUPPLIES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MEDICAL TRANSPORTATION	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MENTAL HEALTH SERVICES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
1. Inpatient	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
2. Outpatient (hospital)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
3. Professional & all other	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
4. Targeted Case Management (TCM)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
OUTPATIENT HOSPITAL SERVICES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
AMBULATORY SURGICAL CENTER	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MEDICAL EMERGENCIES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
PODIATRIC SERVICES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
PRESCRIPTION DRUGS & OTCs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
1. Brand-name	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
2. Generic	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
REHABILITATIVE & THERAPEUTIC SERVICES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
VISION CARE SERVICES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
HOME CARE SERVICES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
NURSING FACILITIES EXPENSES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
ELDERLY WAIVER SERVICES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MEDICARE COST-SHARING	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
ALTERNATIVE PAYMENT ARRANGEMENTS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
EXPENSES NOT ITEMIZED ABOVE	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
IBNR							

**MCO PAYMENT DATA REPORTING
MINNESOTA HEALTH CARE PROGRAMS (MHCP)
Section 2. PROVIDER RATE CHANGES - CY 2010**

Please provide a description for each legislatively mandated provider rate increase or decrease and how it was passed on to providers for calendar year 2010. Please include differences across programs.

Please see **Attachment B** for legislative exclusions.

Questions:

1. Please report how the provider rate changes were implemented (e.g. renegotiated fee schedule, deducted from claim, etc.) and what dates the changes were implemented.
2. Please report whether specific provider types, services or codes that were excluded from the reduction.
3. Please report whether the MCO used any surplus to avoid the reduction and how much.

Provider rate changes implemented beginning September 1, 2010:

1. MinnesotaCare adults without children at or above 75% FPG - 15%

2. Non-administrative services reduction (MA, MinnesotaCare) - 3%

Provider rate changes implemented beginning October 1, 2010:

1. Non-primary care physician & professional services (MA, MinnesotaCare) - 7%

2. Inpatient ratable reduction. The 2009 inpatient ratable reduction of 1.9% was extended through June 30, 2011.

4. PT, OT, & Speech services reduction (MA only) - ratable reduced from 6.5% to 4.5%

MCO PAYMENT DATA REPORTING
MINNESOTA HEALTH CARE PROGRAMS (MHCP)
Section 3. RATE METHODOLOGIES - CY 2010

Please provide a description of the MCO's rate methodologies for the provider types listed below. Please include differences across programs. Primary and non-primary care provider should be reported separately. Please be specific.

Questions:

1. Please report for each provider type listed below if the contracted rate is specifically tied to or based on the Minnesota Health Care Programs (MHCP) fee schedule. For Medicare-integrated products, this applies to Medicaid only services.
2. For each provider type, please compare the MCO's average contracted rate to the MHCP fee schedule. For example, "on average the MCO reimburses primary care physicians at 110% of the MHCP fee schedule."
3. Please explain how many and the type of alternative payment arrangements the MCO has such as total cost of care, risk-sharing, gain-sharing, or sub-capitation, etc. Please explain the providers and services included in these arrangements. What percentage of the MCO's non-administrative payments as reported under section 1 are represented by these arrangements.
4. Under Physician (#1), please report how many health care homes the MCO has included in its network. Please describe the HCH payment methodology if it differs from the state's methodology.

1. Physician

- A. Primary Care Providers
- B. Non-Primary Care Providers
- C. Health Care Homes

2. Advanced Practice Nurses

- A. Primary Care Providers
- B. Non-Primary Care Providers

3. Chiropractors

4. Providers of rehabilitative and therapeutic services

5. Inpatient Hospital

6. Outpatient Hospital (facility only)

7. Dentists, dental hygienists

8. Prescription drugs (pharmacies)

*Please report brand & generic separately

- A. Dispensing Fee - brand & generic
- B. Benchmark - brand & generic
- C. Benchmark adjustment factor (i.e. AWP-15% or 105% of WAC) - brand & generic

9. Home care providers

10. Chemical Dependency services (outpatient only)

11. Mental Health Services (outpatient only)

MCO PAYMENT DATA REPORTING
MINNESOTA HEALTH CARE PROGRAMS (MHCP)
Section 4. AGGREGATE REIMBURSEMENT RATES - CY 2010

Please provide the average reimbursement rates for the provider/service types listed below.
 Please see Attachment C for CPT, HCPC, Dental and Revenue code references.

Provider/Service Type	Average rate
1. Physician	
A. Primary Care Providers	
i. Clinic-based visits	
1. Level 1: minimal (new & established)	\$ -
2. Level 2: limited (new & established)	\$ -
3. Level 3: low severity (new & established)	\$ -
4. Level 4: moderate (new & established)	\$ -
5. Level 5: comprehensive (new & established)	\$ -
6. Medical home program, comprehensive care coordination and planning, initial	\$ -
7. Medical home program, comprehensive care coordination and planning, maintenance	\$ -
ii. Non clinic-based visits	
1. Inpatient	\$ -
2. Outpatient	\$ -
B. Non-Primary Care Providers	
i. Clinic-based visits	
1. Level 1: minimal (new & established)	\$ -
2. Level 2: limited (new & established)	\$ -
3. Level 3: low severity (new & established)	\$ -
4. Level 4: moderate (new & established)	\$ -
5. Level 5: comprehensive (new & established)	\$ -
ii. Non clinic-based visits	
1. Inpatient	\$ -
2. Outpatient	\$ -
2. Advanced Practice Nurses	
A. Primary Care Providers	
i. Clinic-based visits	
1. Level 1: minimal (new & established)	\$ -
2. Level 2: limited (new & established)	\$ -
3. Level 3: low severity (new & established)	\$ -
4. Level 4: moderate (new & established)	\$ -

MCO PAYMENT DATA REPORTING
MINNESOTA HEALTH CARE PROGRAMS (MHCP)
Section 4. AGGREGATE REIMBURSEMENT RATES - CY 2010

Please provide the average reimbursement rates for the provider/service types listed below.
Please see Attachment C for CPT, HCPC, Dental and Revenue code references.

Provider/Service Type	Average rate
5. Level 5: comprehensive (new & established)	
ii. Non clinic-based visits	
1. Inpatient	\$ -
2. Outpatient	\$ -
B. Non-Primary Care Providers	
i. Clinic-based visits	
1. Level 1: minimal (new & established)	\$ -
2. Level 2: limited (new & established)	\$ -
3. Level 3: low severity (new & established)	\$ -
4. Level 4: moderate (new & established)	\$ -
5. Level 5: comprehensive (new & established)	\$ -
ii. Non clinic-based visits	
1. Inpatient	\$ -
2. Outpatient	\$ -
3. Chiropractors	
A. Chiropractic manipulative treatment (CMT)	
i. one to two regions	\$ -
ii. three to four regions	\$ -
iii. five regions	\$ -
4. Providers of rehabilitative and therapeutic services (outpatient professional services)	
A. Speech-language pathology	
i. Medical evaluation of speech	\$ -
ii. SLP treatment sessions	\$ -
B. Physical Therapy	
i. PT evaluation, initial	\$ -
ii. PT re-evaluation, periodic	\$ -
iii. PT treatment session	\$ -
C. Occupational Therapy	
i. OT evaluation, initial	\$ -

MCO PAYMENT DATA REPORTING
MINNESOTA HEALTH CARE PROGRAMS (MHCP)
Section 4. AGGREGATE REIMBURSEMENT RATES - CY 2010

Please provide the average reimbursement rates for the provider/service types listed below.
 Please see Attachment C for CPT, HCPC, Dental and Revenue code references.

Provider/Service Type	Average rate
ii. OT re-evaluation, initial	\$ -
iii. OT treatment session	\$ -
5. Inpatient Hospital (rates should be reported per stay)	
A. Maternity	
i. vaginal birth - normal	\$ -
ii. C-section - normal	\$ -
iii. vaginal birth - complicated	\$ -
iv. C-section - complicated	\$ -
B. Chemical dependency	
i. hospital-based residential per diem	\$ -
ii. hospital-based room & board	\$ -
iii. hospital-based treatment	\$ -
iv. Global CD payment (please specify what is included)	\$ -
OR	
C. Mental Health	
i. children (0-21)	\$ -
ii. adults	\$ -
6. Outpatient Hospital (facility only)	
A. Emergency	
B. Non-emergency	\$ -
7. Dentists, dental hygienists	
A. Diagnostic	
B. Preventive	\$ -
C. Restorative	\$ -
D. Endodontics	\$ -
E. Orthodontics	\$ -
8. Prescription drugs (pharmacies)	
This section should provide average cost per script for each category	
A. Dispensing fee	\$ -
B. Brand ingredient reimbursement	\$ -
C. Generic ingredient reimbursement	\$ -

MCO PAYMENT DATA REPORTING
MINNESOTA HEALTH CARE PROGRAMS (MHCP)
Section 4. AGGREGATE REIMBURSEMENT RATES - CY 2010

Please provide the average reimbursement rates for the provider/service types listed below.
Please see Attachment C for CPT, HCPC, Dental and Revenue code references.

Provider/Service Type	Average rate
9. Home care providers	
A. Private Duty Nursing (RN/LPN) - 15 minute unit	
B. Skilled Nurse Visits - visit	\$ -
C. Home Health Aide (HHA) - visit	\$ -
D. PCA services - 15 minute unit	\$ -
E. PCA Assessment - visit	
10. Chemical Dependency services (non-hospital based)	
*Please provide the MCO contracted, not the host county rate (unless they are the same).	
A. Non-residential	
i. room & board only	\$ -
ii. treatment (medication assisted therapy)	\$ -
iii. treatment	\$ -
iv. Global CD payment (please specify what is included)	
OR	
11. Mental Health Services (outpatient only)	
A. Children's Mental Health Services	
i. Diagnostic assessment - 1 session	\$ -
ii. Interactive diagnostic assessment - 1 session	\$ -
iii. CTSS Individual psychotherapy - 30 minutes	\$ -
iv. CTSS Group psychotherapy - 1 session	\$ -
v. CTSS Family psychotherapy - 1 session	\$ -
B. Adult Mental Health Services	
i. Diagnostic assessment - 1 session	\$ -
ii. Interactive diagnostic assessment - 1 session	\$ -
iii. Individual psychotherapy - 20-30 minutes	\$ -
iv. Group psychotherapy - 1 session	\$ -
v. Family psychotherapy - 1 session	\$ -
vi. Basic Living and social skills - 15 minutes	\$ -

ATTACHMENT A

Hierarchy for Section 1: Aggregate Payment Data

A. Diagnosis

- 1 Maternity Care
- 2 Chemical Dependency
- 3 Mental Health Services

B. Practitioner Type

- 1 Chiropractic
- 2 Dental
- 3 Podiatric
- 4 Rehabilitative & Therapeutic
- 5 Vision Care
- 6 Home Care
- 7 Nursing Facility
- 8 Advanced Practice Nursing (APN)
- 9 Physician

C. Services

- 1 DME & Medical Supplies
- 2 Medical Transportation
- 3 Access Services
- 4 Lab, Diagnostic, Radiological (not inpatient or ASG)
- 5 Prescription Drugs (pharmacy, not physician-administered)
- 6 Inpatient Hospital Services
- 7 Medical Emergency Services
- 8 Outpatient Hospital
- 9 Ambulatory Surgical Center
- 10 Elderly waiver services
- 11 Medicare Cost Sharing
- 12 Alternative payment arrangements
- 13 Expenses not itemized above

ATTACHMENT B
2010 Legislative Session & Unallotment Ratable Reductions

	Physician & Professional Services Ratable Reduction MA & MinnesotaCare: 7.0% (non-primary)	Inpatient Services Ratable Reduction MA & MinnesotaCare: 1.9% (extension)
Categories of Service (COS)	043 (physician)* 055 (podiatry) 057 (chiropractic) 058 (audiology) 078 (vision) 079 (radiology) 090 (nurse midwife)* 091 (nurse practitioner services)* 092 (nutrition services)	001 (inpatient hospital general) 006 (inpatient hospital rehabilitation) 014 (inpatient hospital IMD) 015 (inpatient long term hospital) 073 (inpatient hospital neo-natal ICU)
Exclusions*	For COS 043, 090, and 091, exclude the following from physician and professional services reduction: 1) procedure codes 99000-99999 for treating provider types 20 (physician), 65 (nurse practitioner), 66 (nurse midwife), 68 (clinical nurse specialist), and 69 (physician's assistant) when the pay-to provider type is 54 (family planning agency), and 2) procedure codes 99201-99215, 99381-99412, when the treating provider specialty is 01 (general practice), 33 (geriatric nurse practitioner), 35 (family nurse practitioner), 43 (gerontology), 77 (family practice), or PR (primary care).	Excludes the following facilities: Indian Health Services (IHS)

ATTACHMENT B
2010 Legislative Session & Unallotment Ratable Reductions

	Physician & Professional Services Ratable Reduction MA & MinnesotaCare: 7.0% (non-primary)	Inpatient Services Ratable Reduction MA & MinnesotaCare: 1.9% (extension)
	3) 90281-90399, 90476-90749 (vaccines), 90465-90474 when provided with Mn Vaccines for Children, 96372-96379 when provided with Mn vaccines for Children (administration), A4641-A4642, A9500-A9700, C9113-C9253, J0120-J9999, Q0144-Q0181, Q4080-Q4099, Q9951-Q9967, S0012-S0197, S8085 (injections), S4989, S4993 (contraception) G9002 (coordinated care fee). <u>Excludes the following providers:</u> Federally Qualified Health Centers (FQHCs) Rural Health Centers (RHC) Indian Health Services (IHS) or 638	

ATTACHMENT C

Code reference for Section 4. Aggregate Reimbursement Rates

Provider/Service Type	Codes: CPT, HCPC, Revenue, Dental
1. Physician	
A. Primary Care Providers	
i. Clinic-based 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
6. Medical home program, comprehensive care coordination and planning, initial	S0280
7. Medical home program, comprehensive care coordination and planning, maintenance	S0281
ii. Non clinic-based visits	
1. Inpatient	99221-99233
2. Outpatient	99201-99215, 99381-99383
B. Non-Primary Care Providers	
i. Clinic-based 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
2. Advanced Practice Nurses	
A. Primary Care Providers	
i. Clinic-based 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 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

ATTACHMENT C

Code reference for Section 4. Aggregate Reimbursement Rates

Provider/Service Type	Codes: CPT, HCPC, Revenue, Dental
3. Chiropractors	
A. Chiropractic manipulative treatment (CMT)	
i. one to two regions	98940
ii. three to four regions	98941
iii. five regions	98942
4. Providers of rehabilitative and therapeutic services (outpatient professional services)	
A. Speech-language pathology	
i. Medical evaluation of speech	92506
ii. SLP treatment sessions	92507-92508, 92526, 92626-92627, 92630, 92633
B. Physical Therapy	
i. PT evaluation, initial	97001
ii. PT re-evaluation, periodic	97002
iii. PT treatment session	95851-95852
C. Occupational Therapy	
i. OT evaluation, initial	97003
ii. OT re-evaluation, initial	97004
iii. 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 residential per diem	0101
ii. hospital-based room & board	0118, 0128, 0138, 0148 or 0158
iii. hospital-based treatment	0944, or 0945; H2036
iv. Global CD payment (please specify what is included)	
C. Mental Health	
i. children (0-19)	
ii. adults	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
C. Restorative	D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2740, D2790, D2792, D2930, D2931, D2932
D. Endodontic	D3220, D3310, D3320, D3330
E. Orthodontics	D8010, D8020, D8030, D8040, D8050, D8060, D8070, D8080, D8090
8. Prescription drugs (pharmacies)	
This section should provide average cost for each category	
A. Dispensing fee	various
B. Brand ingredient reimbursement	various
C. Generic ingredient reimbursement	various
9. Home care providers	
A. Private Duty Nursing (RN/LPN) - 15 minute unit	T1002-T1003, modifiers TG, TT
B. Skilled Nurse Visits - visit	T1030
C. Home Health Aide (HHA) - visit	T1021
D. PCA services - 15 minute unit	T1019, modifiers TT, HQ, U6, UA
E. PCA Assessment - visit	T1001, modifiers TS, U6
10. Chemical Dependency services (non-hospital based)	
A. Non-residential (outpatient)	

ATTACHMENT C

Code reference for Section 4. Aggregate Reimbursement Rates

Provider/Service Type	Codes: CPT, HCPC, Revenue, Dental
i. room & board only	1003
ii. treatment (medication assisted therapy)	0944; H0020
iii. treatment	0944 or 0945; H2035
O iv. Global CD payment (please specify what is included)	
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
iv. CTSS Group psychotherapy - 1 session	90853 - modifier UA
v. CTSS Family psychotherapy - 1 session	90847 - 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
iv. Group psychotherapy - 1 session	90853
v. Family psychotherapy - 1 session	90847
vi. Basic Living and social skills - 15 minutes	H2017

**Minnesota Department of Health (MDH) Health Plan Financial and Statistical Reporting
Definitions - Section 7 Health Care Expenses**

Physician services expenses	These are costs for all services provided by or under the supervision of licensed medical doctors and doctors of osteopathy, including pharmaceuticals and supplies administered or dispensed from the physician office and billed directly through the physician. Physician services expenses should exclude the costs of mental health services and chemical dependency services.
Other health professional services expenses	These are costs for all services provided by health professionals other than physicians and dentists, including chiropractors, therapists, social workers, nurse practitioners, and medical dental services. Other health professional services should exclude the costs of mental health services and chemical dependency services.
Inpatient hospital services expenses	These are costs for those services furnished by a hospital for inpatient services, including inpatient hospice care. Inpatient hospital services expenses should exclude costs of mental health and chemical dependency services.
Outpatient services expenses	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. Outpatient services expenses should exclude the costs of mental health services and chemical dependency services.
Skilled nursing facilities expenses	These are costs for services furnished by a facility primarily engaged in providing 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 skilled nursing facilities. Skilled nursing facilities expenses should exclude costs of mental health and chemical dependency services.
Home health care expenses	These are costs for medical care services delivered in the home under the direction of a physician. This includes non-inpatient hospice care expenses.
Emergency services expenses	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.

**Minnesota Department of Health (MDH) Health Plan Financial and Statistical Reporting
Definitions - Section 7 Health Care Expenses**

<p>Pharmacy and other nondurable medical goods expenses</p>	<p>These are only costs paid by the health plan company to a pharmacist or medical supply company to provide pharmaceuticals and non-reusable supplies or pieces of equipment that are 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.</p>
<p>Durable medical goods expenses</p>	<p>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.</p>
<p>Chemical dependency and mental health expenses</p>	<p>These are costs related to chemical dependency services and mental health services expense, for inpatient and outpatient services, coded using the following codes or amended equivalent codes: ICD-9 diagnosis code ranges 303.00 to 305.92, 290 to 302.9, and 306 to 319; CPT codes 90801, 90841, 90843, 90844, 90844.22, 90846, 90847, 90847.22, 90849, 90853, 98900, 98902, 98910, 98912, 90801, 90841, 90843, 90844, 90844.22, 90846, 90847, 90847.22, 90849, 90853, 98900, 98902, 98910, and 98912.</p> <p>Do not include prescription drugs or supplies administered or dispensed that are billed directly through a hospital or health care provider. Expenses include all costs related to inpatient, outpatient, and other professional chemical dependency services and mental health services that are coded using codes from another coding system, where the commissioner determines that the codes indicate diagnoses or procedures comparable to or consistent with codes listed above. Health plan companies may use a nationally recognized standardized reporting system that captures chemical dependency or mental health inpatient, outpatient, and other professional services.</p>
<p>Dental services expenses</p>	<p>These are all costs, professional and other, provided under dental services contracts or riders.</p>
<p>Indirect health care expenses</p>	<p>These are costs for administrative parts of the business. Use the total from section 8 to allocate indirect health care expenditures across the product categories as outlined in the report. Do not include taxes and assessments in this line. Please note: The sum of indirect expenses across categories in section 7 should equal the total indirect health care expenses in section 8.</p>

**Minnesota Department of Health (MDH) Health Plan Financial and Statistical Reporting
Definitions - Section 7 Health Care Expenses**

Expenses not itemized above	These are all costs not itemized in the preceding categories. For coverage designed solely to provide payments on a per diem, fixed indemnity, or non-expense incurred basis, you may report total expenses in this line, rather than the categorized expenses (for example: fixed indemnity, capitated, stop-loss, and Medicare supplement payments that cannot be itemized).
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