Calendar Year 2017 Health Plan Data Request Methodology Documentation

State of South Carolina

Department of Health and Human Services

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I. BACKGROUND

Milliman, Inc. has been retained by the State of South Carolina, Department of Health and Human Services (SCDHHS) to provide actuarial and consulting services related to the Medicaid managed care program. We were requested to assist in the development of an encounter monitoring report that is utilized in the contract between SCDHHS and the managed care organizations, and which is evaluated on a quarterly basis throughout the calendar year.

For the second quarter analysis in 2017 (Q2 CY 2017), we request managed care organizations (MCOs) who participated in the South Carolina Medicaid managed care program at any time from January 1, 2017, to June 30, 2017, to complete and submit the financial data request that accompanies this instruction document and which is entitled *Q2 CY 2017 Quarterly Health Plan Data Request.xlsx*. The information reported through this data collection will be used to validate the consistency of plan reported information and to review emerging calendar year (CY) 2017 experience and trends.

This document outlines the instructions for MCOs to complete the requested information in the accompanying Excel data collection template. It is expected that each MCO will submit a completed data submission for Q2 CY 2017 to SCDHHS no later than **October 31, 2017**. The remainder of this document provides a description of the requested information and instructions for completing the submission.

II. REQUESTED INFORMATION

The Health Plan Data Request is intended to be utilized in the review and analysis of MCO detail encounter data, including both payment information and utilization metrics. The purposes of this request are to collect summary financial data from the MCOs for quarterly monitoring of the completeness and accuracy of MCO encounter data which has been submitted to and accepted by SCDHHS, and for review of emerging financial information for MCOs. The Health Plan Data Request is intended to expand upon and replace the current CRCS process. The data request encompasses monthly exposure, benefit expense, other claims, reserves, and revenue for the CY 2017 reporting period. Please note that the template also includes data elements that will only be required with the Q4 CY 2017 data submission to supplement the capitation rate-setting process; this additional data request includes non-covered services, reinsurance, subcapitated arrangements and claim detail, and non-benefit expense items.

A. GENERAL INSTRUCTIONS

MCO respondents should complete the data request using the following guidelines. Beginning with section II.B Attestation, detailed instructions are provided for each tab in the accompanying *Q2 CY 2017 Quarterly Health Plan Data Request.xlsx* template.

Incurred basis

All responses should be completed on the basis of incurred dates of service. For example, benefit expenses for January 2017 should be reported as the expenditures associated with services provided from January 1, 2017, through January 31, 2017.

Completeness

The Health Plan Data Request will continue to be monitored on a cumulative calendar year basis. The summarized data should include three months of paid claims run-out from the end of the reporting quarter. Additionally, the Health Plan Data Request includes an additional tab to report estimates for incurred but not reported (IBNR) claims.

Accuracy

SCDHHS and Milliman will rely on the accuracy and completeness of the submitted data based on the attestation of the MCO executive signing off on this request. We may follow up with individual MCOs on an as-needed basis to gain clarification or to request additional information at our discretion.

Rating hierarchy

The rate cells should be reported consistent with the financial models developed for the capitation rate setting. These rate cells include:

- TANF: 0-2 months old (AH3)
- TANF: 3-12 months old (AI3)
- TANF: Age 1-6 (AB3)
- TANF: Age 7-13 (AC3)
- TANF: Age 14-18 M (AD1)
- TANF: Age 14-18 F (AD2)
- TANF: Age 19-44 M (AE1)
- TANF: Age 19-44 F (AE2)
- TANF: Age 45+ (AF3)
- SSI – Children (SO3)
- SSI – Adults (SP3)
- OCWI (WG2)
- Foster Care Children (FG3)
- KICK (MG2/NG2)

The following provides further clarification on how newborns are assigned into the appropriate rate cells.

Infants are assigned to a rate cell based on their month of birth. For example, an infant born anytime in April 2016 will be assigned to:

- TANF: 0-2 months old in April, May and June 2016
- TANF: 3-12 months old in July through December 2016 and January through April 2017
- TANF: Age 1-6 starting in May 2017
- TANF: Age 7-13 starting in May 2023

For the older age rate cells, age is determined as the age at the beginning of the month. In this example, the child remains in the 1 – 6 year rate cell during their birthday month at age 7.

Categories of service

The category of service classifications were refined for the state fiscal year (SFY) 2018 capitation rate setting, and these classifications are also provided as appendices to this methodology report, in the form of Excel documents. We request the MCOs to implement this updated methodology for the CY 2017 Health Plan Data Request. Periodic updates to the service category logic may occur to reflect updates to procedure and diagnosis code listings, and in such cases, we will provide appropriate amendments to the Excel crosswalk addenda. In addition to the Excel addenda, Appendix 9 has been provided as supporting documentation in the development of the MCO-specific coding logic for category of service classifications. The supplemental SAS coding logic is intended to be used as a guide in developing the appropriate programming logic needed to stratify the claims into the defined categories of service. Please note that this is only intended as a guide in the development of each health plan's coding logic and should not be relied upon in the completion of the health plan data request. It is the responsibility of each health plan to validate the results and ensure any necessary changes are made to accommodate plan-specific differences in data elements/definitions. Please refer to the following instructions for category of service assignment:

Note: The use of the SAS coding logic and associated appendices (Service) is provided for informational purposes only and should be used at the user's own risk. Milliman makes no warranty with respect to the Service and the results derived from such user inputs. The information should be checked and independently verified by the user. The Service is intellectual property of Milliman and is intended to be used as a guide in developing the appropriate programming logic needed to complete the Health Plan Data Request for the South Carolina Medicaid managed care program. The enclosed documentation should not be used for any other purpose.

Maternity KICK Services. The assignment of services to the KICK rate cell corresponds with the data models developed for the capitation rate setting. The following service categories are included in the maternity KICK payment:

- Inpatient: Maternity Delivery
- Outpatient Hospital - Maternity
- Physician: Maternity Delivery
- Physician: Maternity Anesthesia
- Physician: Maternity Office Visits
- Physician: Maternity Radiology
- Physician: Maternity Non-Delivery

Appendices 1 and 2 contain detailed coding logic, including a complete listing of ICD-10 delivery diagnosis codes, to appropriately assign claims to the categories of service included in the KICK payment. The ICD-10 diagnosis code list provided in Appendix 2 has been expanded from the previous report to include the diagnosis code mapping for both outpatient hospital and physician services.

- Outpatient hospital: The outpatient diagnosis code list contains delivery diagnosis codes related to outpatient KICK services
- Physician: The physician diagnosis code list represents diagnosis codes related to antepartum visits as defined in the maternity KICK payment. The maternity physician diagnosis codes are provided by SCDHHS in the Physicians Provider Manual found on the SCDHHS website. Appendix 2 includes federal fiscal year 2017 updates to the physician ICD-10 code list recently published by SCDHHS (https://www.scdhhs.gov/provider-type/physicians-laboratories-and-other-medical-professionals-provider-manual-020105-edition)

This logic should be placed at the top of the hierarchy over all the following categories of service.

Inpatient Services. All plans' inpatient hospital claims are assigned a category of service using an APR DRG based on 3M DRG version 32 grouping software. The crosswalk detailing the APR DRG to inpatient category of service has been included in Appendix 3, as an Excel document to this letter. Utilization for all inpatient service categories should be reported as days. Inpatient hospital claims with a date of admission equal to the date of discharge should be recorded as one unit. Note that all claims containing a room and board revenue code (0100-0219) and not containing an APR DRG included in the Excel addendum are grouped in the "Other Inpatient" service category.

Outpatient Services. The methodology assigns all outpatient hospital claims to a subcategory based on the hierarchy below. The following hierarchy applies to each claim.

- Outpatient Surgery
- Outpatient Emergency Room
- Non-Surgery Other
- Observation Room
- Treatment, Therapy, and Testing
- Other Outpatient

The hospital outpatient category of service mapping hierarchy is based on the Hospital Services Provider Manual posted on the SCDHHS website. The hierarchy assigns an entire claim to a single subcategory following testing of associated revenue codes on the claim. An outpatient category of service mapping is provided in Appendix 4. Additional detail related to the specific mapping of revenue codes, outpatient surgery procedure codes, and treatment, therapy, and testing procedure codes has been provided in Appendices 6, 7, and 8, respectively, to supplement Appendix 4 and allow for more direct translation into the MCO coding logic to stratify outpatient claims into the appropriate category of service.

Physician and Ancillaries Services. The crosswalk detailing HCPCS/procedure codes to ancillaries and physician categories of service has been included as an Excel addendum to this report in Appendix 5. A complete list of service categories and their associated unit types is provided for reference in the "Service Categories" tab of the Health Plan Data Request.

Successful submission

A submission will be considered complete when all applicable sections of the data request have been completed. Partial submissions will not be accepted. To the extent a resubmission is required due to incompleteness or based on additional as-needed follow up, **an updated attestation must be completed.**

Notes

MCO respondents should provide additional information in the "Notes" tab of the data request as necessary. This may include discussion of specific anomalies, clarifying commentary, or general input from the MCO. SCDHHS may consider these comments during review of the encounter data monitoring report.

B. ATTESTATION

The MCO CFO, CEO, or other executive should complete the attestation indicating they believe the information provided is a complete and accurate representation of the members and services provided by the MCO within the MCO contracts. **Failure to complete the attestation will be considered a partial submission and will not be accepted by SCDHHS.**

C. EXPOSURE

Exposure information should be reported in the 'Exposure' tab of the health plan data request template. For the KICK rate cell, the exposure units should represent maternity delivery counts. For all other rate cells, the exposure counts should reflect member months. Maternity Delivery counts in the KICK rate cell represent the number of enrollees who have either a maternity delivery APR DRG of 540, 541, 542, or 560 or a physician maternity delivery claim (or both) during the experience period.

D. BENEFIT EXPENSE

MCOs are requested to provide utilization and expenditure information related to benefit expenses at the level of detail outlined in the 'Benefit Expense' tab of the health plan data request template.

Non-Subcapitated Encounters

For non-subcapitated experience, unit counts and payment amounts should be reported consistent with the category of service instructions.

Subcapitated Encounters

Subcapitated encounter claims are identified as those claims in the encounter data with a reimbursement indicator type of "C". For subcapitated experience, the monthly unit counts and the proxy payment amounts should be reported for each category of service. This proxy should be either a reasonable estimation calculated by the MCO or a default fee-for-service fee schedule amount.

Zero Dollar Paid Amounts

We will not count units for any non-subcapitated claims with zero dollar paid amounts in the encounter data.

E. OTHER CLAIMS

MCOs are requested to provide amounts for expenditures related to medical services not otherwise reported through the Benefit Expense section of this data request. These claim-related items are requested to be reported by rate cell, incurred month, and major service category. These items may include lump sum provider settlements not adjudicated through the encounter claims system, provider withholds paid, and provider bonus payments. Additional payment amounts not included in the previously defined columns should be reported in the "Other" column. Please provide additional documentation and discussion in the 'Notes' section of the template for any expenditures included in the "Other" column.

F. RESERVES

MCOs are requested to provide outstanding reserve amounts held for incurred but not reported claims and pending provider settlements. Milliman requests reserves to be reported at the rate cell level. If the MCO does not calculate reserves at the rate cell level, please allocate reserves to each rate cell and include detail in the 'Notes' tab of the methodology used to allocate the reserves.

G. REVENUE

MCOs are requested to provide revenue amounts for payments received related to capitation payments net of withholds for all rate cells, including the maternity case rate payments under the KICK rate cell. MCOs are also requested to provide estimates of premium receivable amounts and the amount of estimated withhold the MCO anticipates will be returned.

H. NON-COVERED SERVICES

MCOs are requested to provide incurred and paid expenditure amounts related to services provided that are not covered by the capitation rate. These types of services include, but are not limited to: waived member copays, non-state plan services (e.g. circumcisions), and state plan services not covered under the capitation rate (e.g. Hepatitis C drugs). Non-state plan services are requested to be reported by rate cell, incurred month, and major service category. Please note that this information is only required to be completed on an annual basis with the Q4 CY 2017 submission.

I. REINSURANCE

MCOs are requested to provide amounts paid for reinsurance premiums and amounts received in reinsurance recoveries. Please note that this information is only required to be completed on an annual basis with the Q4 CY 2017 submission.

J. SUBCAP

MCOs are requested to provide amounts paid under subcapitated arrangements by incurred month, vendor, service category detail (e.g Vision), and population. MCOs are also requested to indicate if the subcapitated vendor is a related entity.

The amounts reported for subcapitated proxy paid expenditures should be consistent with the amounts reported in the Benefit Expense section of this request.

Note, the subcapitated total paid amount is calculated as the sum of the proxy paid amount, administrative expense, and any residual gain or loss. Please note that this information is only required to be completed on an annual basis with the Q4 CY 2017 submission.

K. NON-BENEFIT EXPENSE

MCOs are requested to provide non-benefit expenses by category and population. Non-benefit expenses should be estimated for healthcare quality improvement, general administrative expenses, taxes, fees, and assessments, and other material non-benefit expenses. For purposes of completing this request, healthcare quality improvement expenses include care coordination, care management, disease management, and other categories of expenditures related to healthcare quality. Please report the care coordination and care management component of healthcare quality improvement expenses separate from all other quality improvement expenses. Please note that this information is only required to be completed on an annual basis with the Q4 CY 2017 submission.

III. SUMMARY EXHIBITS BY POPULATION

Summary exhibits by population have been included in the template as a data validation resource for the exposure and benefit expense submitted in the detailed tables. A summary by category of service is included for the TANF, SSI, OCWI, Foster, and KICK populations.

Upon completion of the health plan data request, please review the summary exhibits to ensure the data provided is consistent with internal financial reporting

IV. DATA TRANSMISSION AND ACCEPTANCE

We request that each MCO submit their completed data request for the Q2 CY 2017 analysis **no later than October 31, 2017**.

Upon receipt of the data files, we will review the contents of each submission for completeness. Any submissions determined by SCDHHS to be out of compliance with the original request shall be deemed incomplete and **will require resubmission with an updated attestation**.

We may follow up with individual MCOs on an as-needed basis to clarify and resolve potential issues related to data quality and completeness.

V. LIMITATIONS AND QUALIFICATIONS

The information contained in this letter has been prepared for SCDHHS, and its consultants and advisors. This letter may not be distributed to any other party without the prior consent of Milliman. It is our understanding that a copy of this report with the specific enclosure will be shared with each MCO participating in the South Carolina Medicaid managed care program. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for SCDHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the information presented

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and SCDHHS approved July 1, 2017.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

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