

Exploratory Analysis of Medicaid Claims and Encounter Data

Background

- The Florida Agency for Health Care Administration (Agency) administers the Florida Medicaid program.
- This includes making fee-for-service (FFS) payments to health care providers who submit FFS claims to the Agency detailing the services provided to Medicaid recipients who are not enrolled in capitated managed care organizations (MCOs).
- The Agency also makes fixed monthly capitation payments to MCOs who arrange for the health care needs of their enrolled recipients. MCOs submit, to the Agency, encounters that reflect services provided to recipients.
- Both FFS claims and MCO encounters provide demographic and medical information about Medicaid recipients, about the services provided, and about the payments made related to the services rendered by health care providers.
- Claims and encounters are used primarily for rate setting, risk modeling and budgeting, service delivery model reviews, measuring quality of services provided, and health plan performance.

Data Specifications

- The majority of reports in this presentation utilize a combination of both FFS claims and MCO encounters to provide an overview of the Medicaid program as a whole for selected populations and county groupings.
- All data is for dates of service that occurred during SFY 2009-10. County groupings are based on the Medicaid recipient's county of residence, regardless of where services were provided.
- The population includes either managed care enrolled recipients or managed care eligible recipients.
- County groupings are as follows, with the reform county bolded in each group:

Large Urban <i>850,000 to 2.5 million</i>	Medium Urban <i>850,000 to 920,000</i>	Large Rural <i>170,000 to 191,000</i>	Medium Rural <i>67,000 to 75,000</i>	Small Rural <i>24,000 to 29,000</i>
Broward Dade Hillsborough Orange Palm Beach	Duval Pinellas	Clay Hernando Okaloosa St. Johns	Columbia Nassau Putnam	Baker Bradford Hardee Washington

Types of Analyses

- Analyses include utilization measures and MCO overall plan performance for routine and preventive care.
- Utilization measures look at the continuum of care in each county. They specifically examine the utilization of primary care services, as well as hospital services in two areas: (1) emergency department (ED) visits; and (2) hospitalizations for Ambulatory Sensitive Conditions (ASCs). Taken together, these utilization measures can provide a general indication of access to and use of primary care services within a given county, as well as illustrating to some extent the effectiveness of that care. These analyses utilize specification criteria from nationally recognized entities and models.
- This report also depicts one measure of overall MCO performance, namely a History and Physical performed within 180 days of enrollment in a plan (H&P 180).
- The History and Physical measure is based solely on encounter data (i.e., relate to MCOs only - no FFS data). The utilization analyses are based on both FFS claims and MCO encounter data.
- In all these analyses, there are no controls for demographics (e.g., race, gender, age) and no attempt was made to identify the general level of health of a recipient. Any of these factors could significantly change the need for and intensity of care.

Primary Care Utilization

- The analysis of primary care utilization looks at the average number of visits to a primary care provider (PCP) per year, per 1,000 Medicaid recipients in each county. PCP visits are based on procedure codes that have been identified within Medicaid as primary care visits. The measures by themselves do not differentiate between visits that are urgent or routine and make no assumptions regarding the appropriateness of the visit.
- PCP office visits encompass Evaluation and Management (E&M) Medical Services. These include approximately 143 CPT codes ranging from 99201 through 99480 and several HCPCS codes.

Emergency Department (ED) Utilization

- The ED analysis looks at recipients' utilization of the hospital emergency department. In the overall analysis, all ED visits are summed and reported per 1,000 county enrollees.
- The criteria used for the ED reported utilization is based on an algorithm developed by the New York University Center for Health and Public Service Research to help classify ED utilization. The algorithm was developed with the advice of a panel of ED and primary care physicians, and it is based on an examination of a sample of almost 6,000 full ED records. Data abstracted from these records included the initial complaint, presenting symptoms, vital signs, medical history, age, gender, diagnoses, procedures performed, and resources used in the ED.
- ED results reported in the charts are based on the following categories:

Emergency Department Categories				
<i>Non-emergent</i>	<i>Emergent / Primary Care Treatable</i>	<i>Emergent Preventable / Avoidable</i>	<i>Emergent Not Preventable / Avoidable</i>	<i>Other (alcohol, injury, psychological, substance abuse)</i>

Preventable Hospitalizations

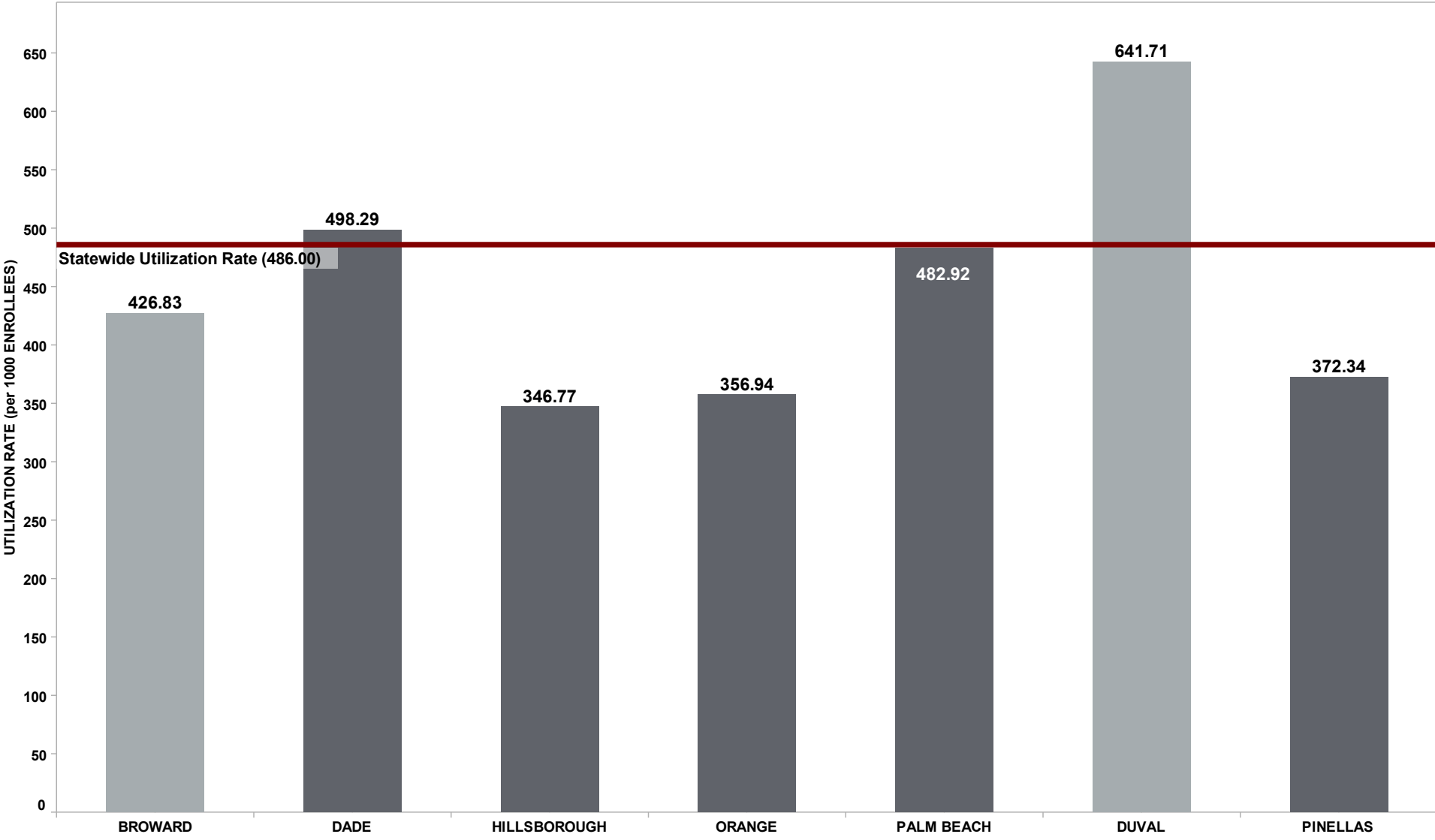
- The federal Agency for Healthcare Research and Quality (AHRQ) has developed measures known as the Prevention Quality Indicators (PQIs) to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care and appropriate treatment can potentially prevent the need for hospitalization or for which early intervention can prevent complications or a more severe manifestation of a disease.
- Ambulatory Sensitive Conditions (ASCs) are a component of hospital service utilization analyses.
- Results reported in the charts are based on the following categories from the AHRQ model:

AHRQ Preventable Quality Indicator (PQI) Categories			
<ul style="list-style-type: none"> ✓ <i>Angina without Procedure</i> ✓ <i>Asthma in Younger Adults</i> ✓ <i>Bacterial Pneumonia</i> ✓ <i>Congestive Heart Failure (CHF)</i> 	<ul style="list-style-type: none"> ✓ <i>COPD or Asthma in Older Adults</i> ✓ <i>Dehydration</i> ✓ <i>Diabetes Long-Term Complications</i> ✓ <i>Diabetes Short-Term Complications</i> 	<ul style="list-style-type: none"> ✓ <i>Hypertension</i> ✓ <i>Low Birth Rate</i> ✓ <i>Lower Extremity Amputation w/ Diabetes</i> ✓ <i>Perforated Appendix</i> 	<ul style="list-style-type: none"> ✓ <i>Uncontrolled Diabetes</i> ✓ <i>Urinary Tract Infection</i>

History and Physical 180 Day Utilization (H&P 180)

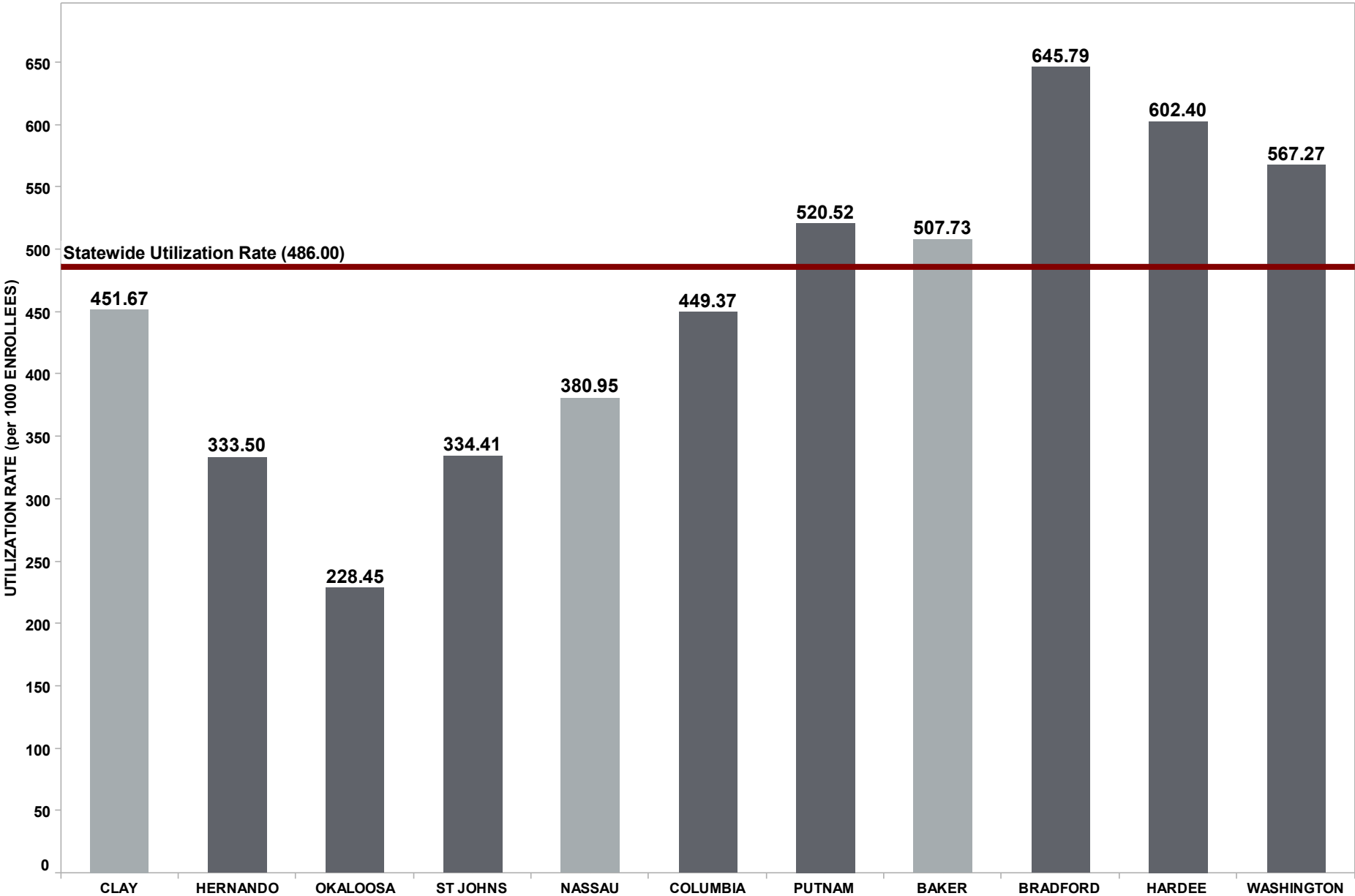
- The History and Physical 180 analysis identifies the percentage of MCO enrollees receiving an evaluation and management visit within 180 days of enrollment into an MCO.
- The History & Physical MCO measure is used to review the frequency of specific Evaluation and Management (E&M) services provided to Medicaid recipients after joining a health plan. This report excludes specific Child Checkup reporting. The CPT codes used include new and established patient E&M codes with a comprehensive or focused history for the visit.
- The categories utilized for the History and Physical measure are delineated into whether this service took place and within what time period of enrollment into a health plan. The chart depicts these categories and the various percentages attained for each.

PRIMARY CARE SERVICES UTILIZATION RATE
URBAN COUNTY GROUP



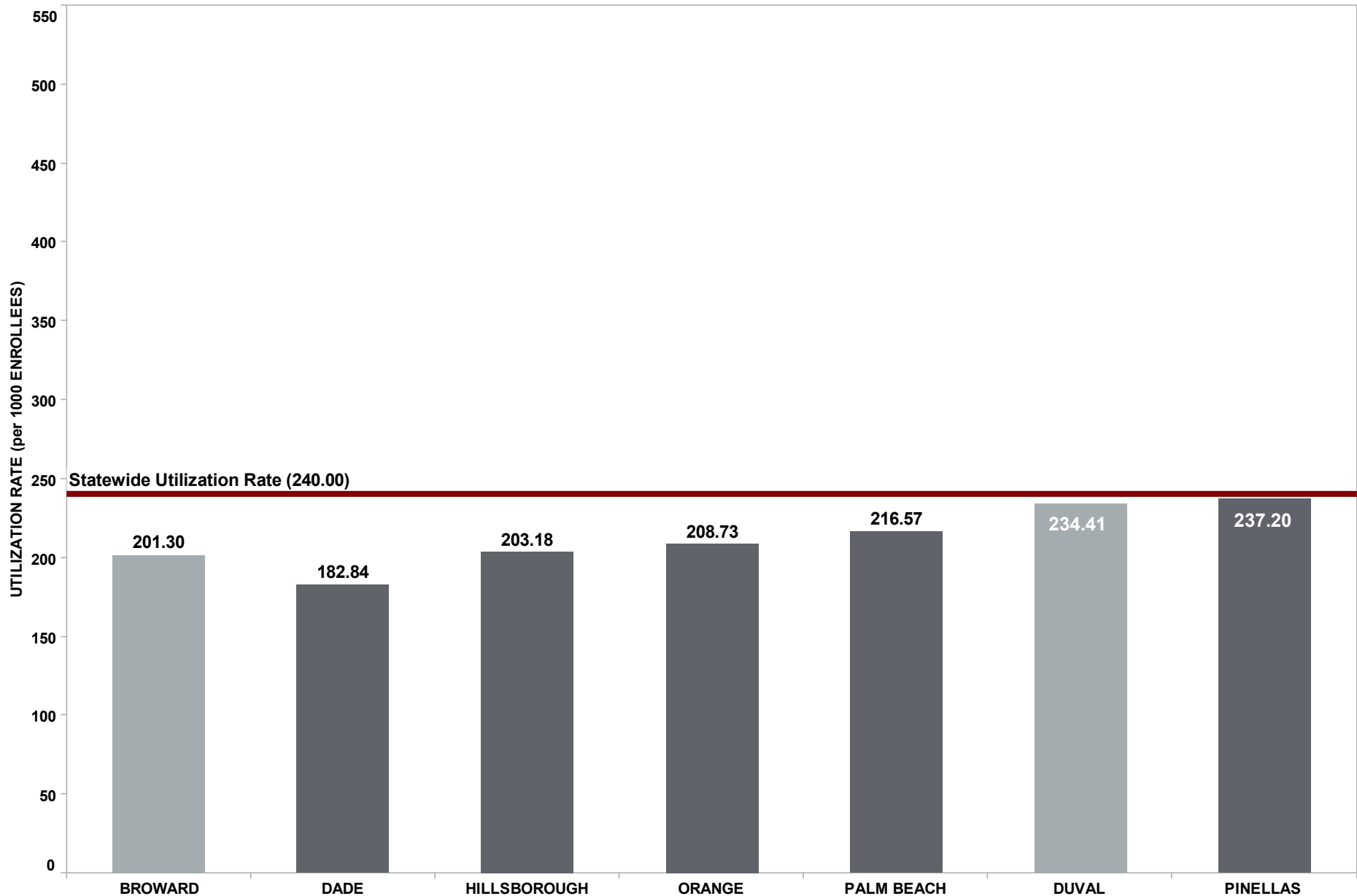
Status
■ NON-REFORM
■ REFORM

PRIMARY CARE SERVICES UTILIZATION RATE
RURAL COUNTY GROUP



Status
■ NON-REFORM
■ REFORM

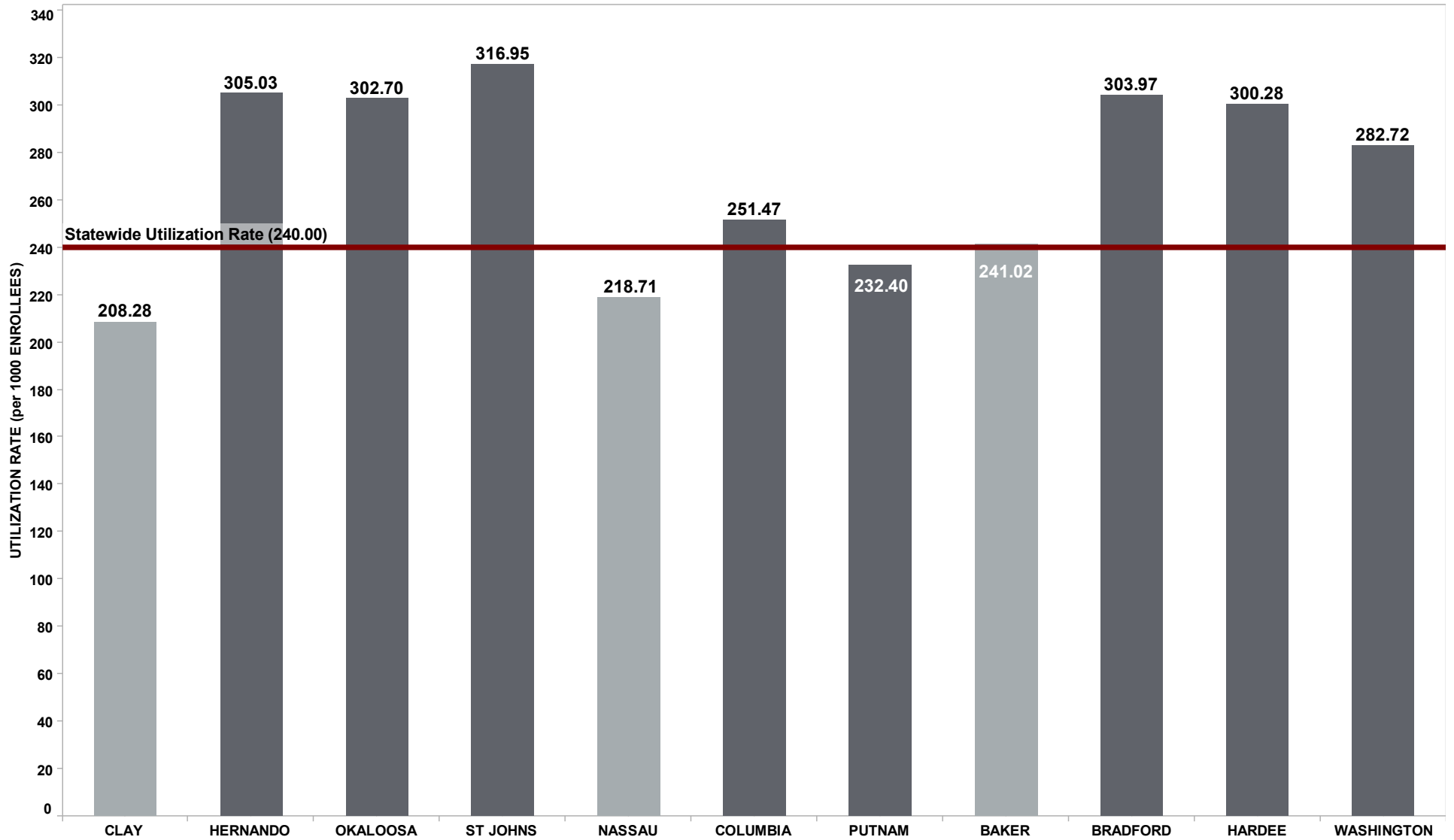
EMERGENCY DEPARTMENT UTILIZATION RATE URBAN COUNTY GROUP



Status

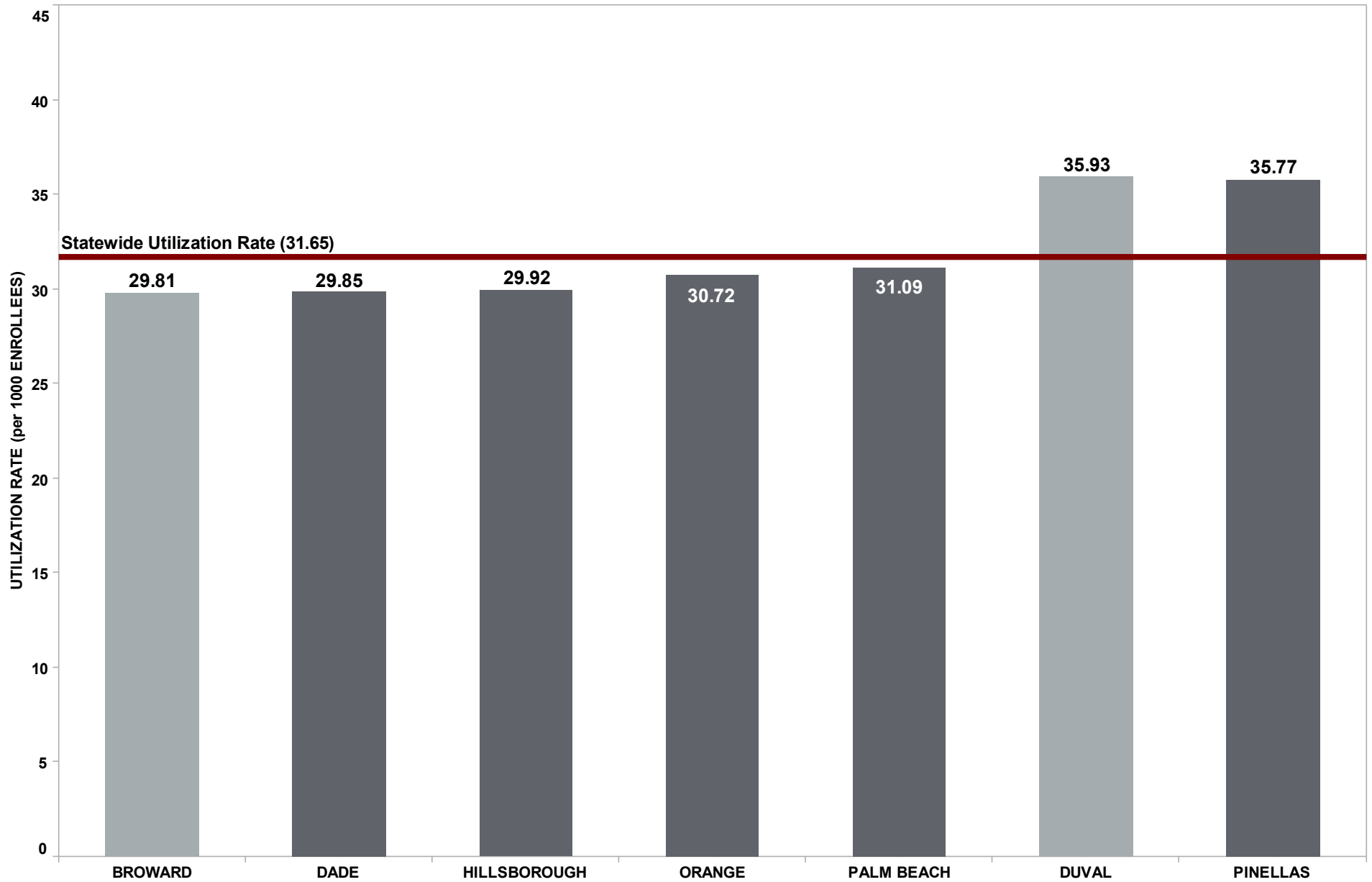
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EMERGENCY DEPARTMENT UTILIZATION RATE
RURAL COUNTY GROUP



Status
■ NON-REFORM
■ REFORM

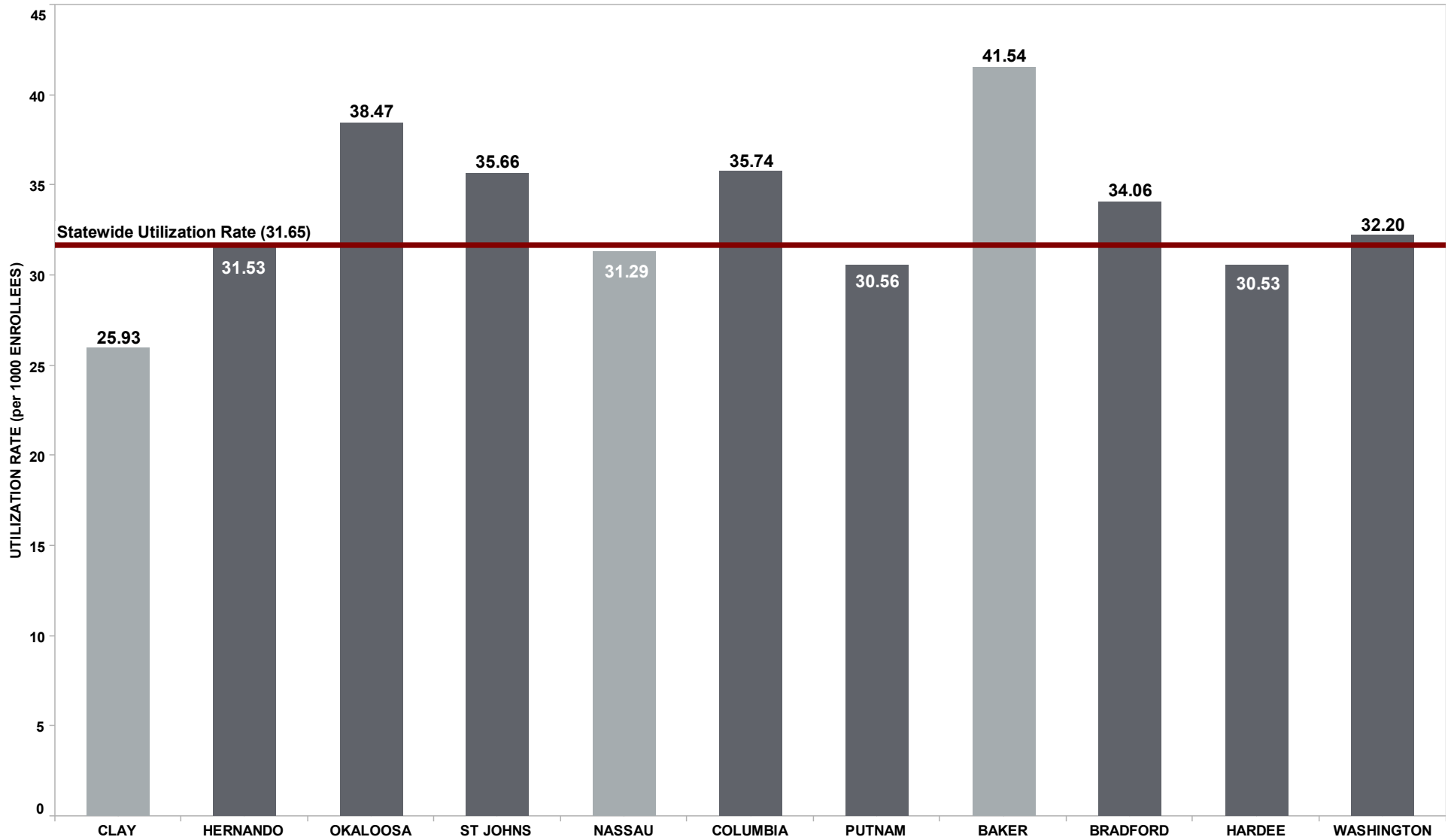
PREVENTABLE HOSPITAL ADMISSIONS (ASC) UTILIZATION RATE
URBAN COUNTY GROUP



Status

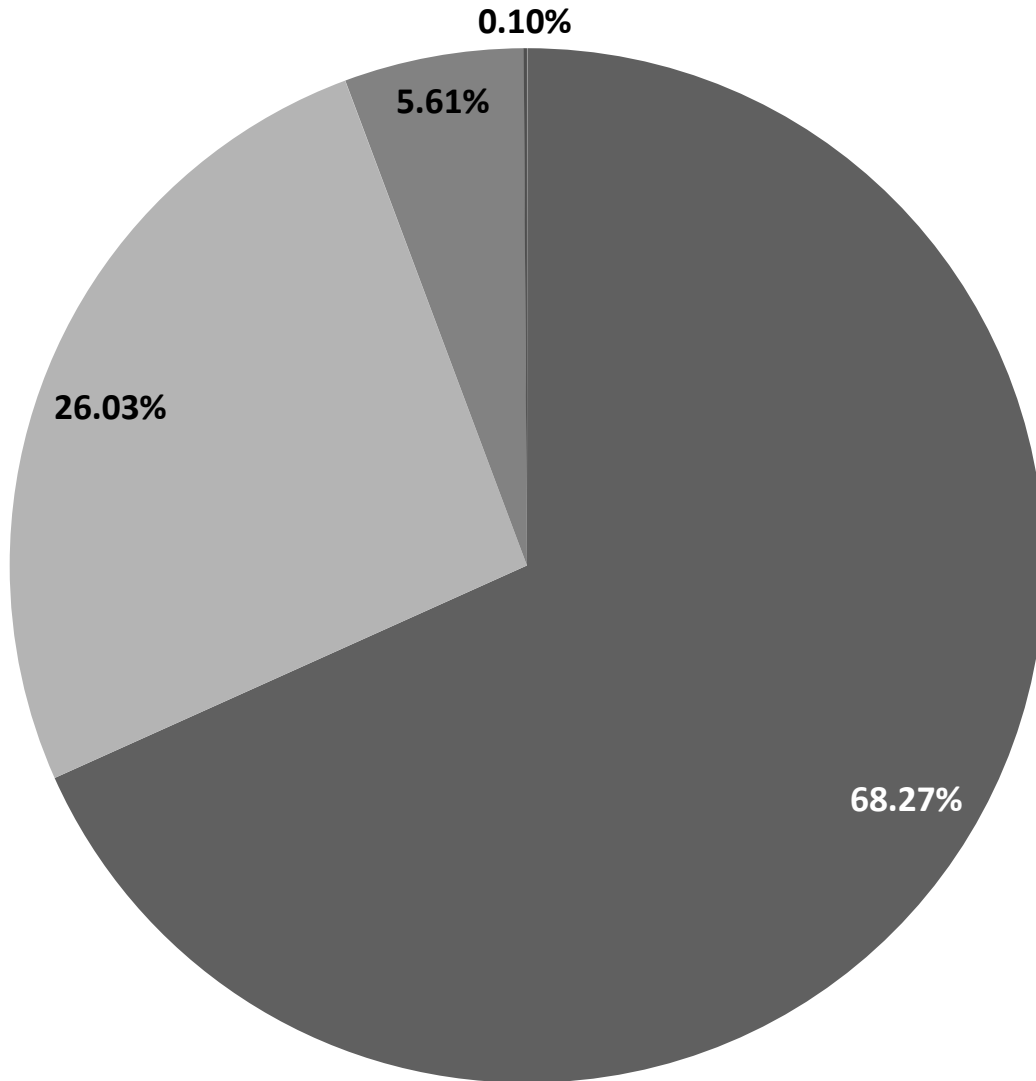
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PREVENTABLE HOSPITAL ADMISSIONS (ASC) UTILIZATION RATE
RURAL COUNTY GROUP



Status
■ NON-REFORM
■ REFORM

Percent of New Medicaid MCO Enrollees Receiving Evaluation and Management-History & Physical (H&P 180) Services by Time Elapsed Since Enrollment, Statewide SFY 2009 - 2010



- New enrollees who received a History & Physical within 180 days of joining a plan (68.27%).
- New enrollees who did not receive a History & Physical within 180 days of joining a plan, but did receive a History & Physical within the measurement period (26.03%).
- New enrollees who did not receive a History & Physical within SFY 2009-10 but received other medical services within the measurement period (5.61%).
- New enrollees who did not receive a History & Physical or any medical services within the measurement period (0.10%).