PACHC MEMO 15-02

Please share with: Executive Management, Finance and Billing Staff

December 17, 2015

TO: Chief Executive Officers of Pennsylvania Community Health Centers and Rural Health Clinics

FROM: Cheri Rinehart, President and CEO

SUBJECT: HealthChoices 2016

SUMMARY: Effective January 1, 2016, the Pennsylvania Department of Human Services DHS) is transferring the obligation to pay federally qualified health centers (FQHC) and rural health clinics (RHC) at their prospective payment system (PPS) rate for eligible encounters from DHS to the HealthChoices managed care organizations (MCOs). This means that the DHS quarterly wraparound (MCO Settlement Report) will no longer be used to reconcile to PPS once eligible encounters through December 31, 2105 are reconciled to PPS by DHS. It also means that health center processes and procedures that support timely and accurate claims submission and monitoring as well as MCO processes and procedures that support accurate payment are critical to health center cash flow. In addition, DHS is requiring all HealthChoices plans to contract with all FQHCs/RHCs willing to contract at PPS.

BACKGROUND: DHS first required payment at the PPS rate to FQHCs/RHCs of plans that participated in Gov. Corbett's Healthy Pennsylvania private coverage option (PCO) in response to PACHC's advocacy to ensure that health centers were not marginalized under the Healthy PA initiative. Effective January 1, 2015, Healthy PA insurers were required to pay FQHCs/RHCs PPS rates and were required to contract with all FQHCs/RHCs. After Gov. Wolf was sworn into office in January 2015, he announced he would expand Medicaid through the HealthChoices program rather than through the PCO and because the transition from the PCO to HealthChoices began early in the Wolf administration, DHS made the decision to permit health centers to put PCO encounters on their quarterly wraparound reports rather than work with the PCO insurers to ensure accurate payment.

DHS then decided, on a go-forward basis, to support improved health center cash flow and to ensure health centers are engaged as important HealthChoices partners by MCOs, to adopt these two Healthy PA plan requirements—payment by the MCOs at PPS and contracting with all FQHCs/RHCs—into the HealthChoices MCO contracts (see Attachment 1 for the language from

the contracts). While PACHC appreciated and embraced DHS' goals, we expressed, in both meetings and in correspondence, our concerns about the potential unintended consequences of this approach (see Attachment 2, September 18, 2015 PACHC letter to DHS outlining our concerns).

CURRENT STATUS: DHS heard our concerns and made the decision to, rather than reverse course and go back to the quarterly wraparound process, implement several oversight mechanisms to ensure that the requirement did not result in a decreased reliance on health centers, an increase in claims denials, or a reduction in health center cash flow. DHS is currently in the midst of establishing these processes.

In addition, DHS hosted a conference call for all HealthChoices MCOs on Dec. 1 to ensure that all are aware of the requirements and to respond to any questions raised. During that call, DHS emphasized:

- MCOs that don't have systems in place to begin paying at PPS Jan. 1 are responsible for making health centers whole to PPS retroactive to that date
- MCOs must pay on T1015 and T1015 with U9 modifier codes, but can work with health centers to ensure they also get the CPT codes the MCOs need for HEDIS data
- All HealthChoices MCOs are required to contract with all FQHCs/RHCs in their zone
- DHS will be monitoring all FQHC/RHC payments and will generate reports that show payments and claims detail by MCO; MCOs not paying PPS will be put on corrective action, which can impact NCQA rating
- DHS will also be monitoring encounters by MCO and FQHC/RHC to ensure patient attribution algorithms are not steering individuals from health centers and patients continue to have the freedom to choose FQHCs/RHCs as their primary care providers

A copy of the FQHC/RHC information DHS provided to MCOs as part of the call is available (see Attachment 3: DHS FQHC_RHC Info for MCOs). DHS also provided the contract language as well as the FQHC/RHC Provider Handbook.

In addition, in response to PACHC's concerns that all MCOs had not yet reached out to all health centers and that they might not have the necessary systems in place to pay at PPS Jan. 1, 2016, this week, DHS contacted every HealthChoices MCO to reiterate the requirements and require a report from each MCO on the status of implementation by Dec. 21, with an additional update no later than Dec. 30.

MEMBER ACTION: More than ever, health center relationships and communications with MCOs need to be strong. You want and need them to see you as the important partner you are in helping them meet their charge, in controlling costs while increasing quality, and in qualifying for additional funding under their value-based purchasing arrangements with DHS. Some specific areas of focus should include:

HealthChoices MCO Communications. It is important that if you have not heard from all of your HealthChoices MCO insurers, that you reach out to those who have not yet contacted your health center to confirm processes and rate accuracy. If you are unclear of a point of contact for an MCO, please contact PACHC.

Contracts. When your health center is presented with a contract by HealthChoices MCOs, please take the time to read the fine print—and negotiate the conditions—before signing. Some of the issues health centers have alerted us to include:

- Claims Submission Deadlines. Timely claims submission deadlines that are too short result in claims denials. A minimum of 180 days is recommended.
- PPS Rate Changes. Clauses that release the insurer from making you whole to your PPS rate retroactively to effective date when your rate changes and instead only obligate them to the new rate on a go-forward basis, which can result in the loss of significant revenue and is contrary to DHS requirements. MCOs are responsible for making you whole to PPS for all eligible encounters on or after January 1, 2016.
- Bonus payments. The PPS payment requirement does not preclude MCOs from offering pay-for-performance bonus opportunities on top of PPS, and DHS is encouraging MCOs to develop value-based purchasing arrangements. It should clearly be articulated in your contracts that these value-based payments are on top of PPS reimbursement.
- Access to all-claims data. If your health center is entering into pay-for-performance (P4P) or other value-based payment arrangements to qualify for revenue above PPS, you need data to know which of the patients attributed to your health center as their PCP are visiting the emergency department, seeing specialty providers, etc. so that you have a better opportunity to work with these higher utilizers of higher cost care.
- Multiple claims per day. The MCOs are required to pay your PPS rate for medical, dental and behavioral health claims for eligible encounters covered under the HealthChoices program. DHS has retained its policy that this can include multiple encounters in a day for medical, dental and behavioral health and has recently determined that multiple encounters under the same category (e.g. medical) are permissible if medically necessary.

Claims Processes. Never has it been more important for health centers to have good systems, processes and procedures in place to ensure timely and accurate billing as well as monitoring of and response to any claims denials.

Monitoring and Feedback. If your health center is encountering any challenges with HealthChoices MCOs secondary to these new requirements, it is critical that you both contact the MCO and let PACHC know so we can offer field surveillance to DHS to augment their data analytics.

PACHC Action: PACHC is in regular contact with DHS on implementation issues and questions. We meet monthly with DHS officials, but also have regular communication between meetings. We are committed to keeping you informed of any changes or developments on this subject and, as we have been, will provide regular updates in our weekly publication, *News*

CHCs Can Use. In addition, to support health centers in ensuring appropriate processes and systems are in place to ensure accurate and timely billing and claims management, PACHC offered a financial and billing assessment to 15 health centers on a first-come, first-served basis. Participants have been effusive in their feedback on the value of these assessments so we are considering offering a second opportunity in 2016, as well as new Billing Manager and CFO Boot Camps.

FOR MORE INFORMATION: We urge you to contact us with questions and feedback. Feel free to send your inquiry or information to pachc@pachc.org or to contact me or Jim Willshier directly.