PACHC Memo 11-09
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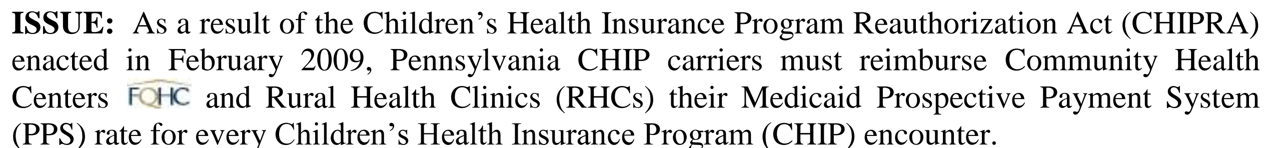
Financial Management Team

October 4, 2011

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

FROM: Cheri Rinehart, President & CEO

SUBJECT: CHIP Prospective Payment System (PPS) Implementation



ISSUE: As a result of the Children's Health Insurance Program Reauthorization Act (CHIPRA) enacted in February 2009, Pennsylvania CHIP carriers must reimburse Community Health Centers FQHC and Rural Health Clinics (RHCs) their Medicaid Prospective Payment System (PPS) rate for every Children's Health Insurance Program (CHIP) encounter.

BACKGROUND: Section 503 of CHIPRA requires payment of CHIP encounters for FQHCs and RHCs to be at least equivalent to their Medicaid prospective payment system (PPS) rates, effective October 1, 2009. Prior to the passage of the CHIPRA legislation, states were not required to make FQHCs/RHCs "whole" based on the difference between their PPS rate and the actual amount received based on the rate structure. Consequently, some of the payments made by CHIP insurers to FQHCs/RHCs for CHIP-covered services have been less than the PPS payments called for under CHIPRA and the Benefits Improvement and Protection Act of 2000 (BIPA). CHIPRA requires states to make supplemental payments to providers in the amount of the difference, if any, between the original payment received by the FQHC/RHC from the CHIP insurers and the total payment a FQHC/RHC would otherwise have received had the encounters been paid at their PPS rate.

PA CHIP pays FQHCs/RHCs exclusively through nine commercial managed care organizations (MCOs) that provide coverage to almost 200,000 PA CHIP-enrolled children. The MCOs contracted by the Pennsylvania Insurance Department (PID) to administer the CHIP program historically have reimbursed FQHCs/RHCs based on a combination of fee-for-service (FFS) and capitation payments, based on their commercial rate structure.

In order to develop and implement a CHIPRA-compliant FQHC/RHC payment system for Pennsylvania health centers, last year the Pennsylvania Insurance Department (PID) secured a

Center for Medicare & Medicaid Services (CMS) grant. PA CHIP contracted with Mercer Government Human Services consulting, an actuarial firm, to develop and document a compliant PA CHIP PPS or alternative payment methodology (APM). PA CHIP also contracted with the Pennsylvania Association of Community Health Centers (PACHC) to provide outreach, education and facilitation services to assist FQHCs/RHCs during the development of and transition to the PA CHIP PPS or APM. PA CHIP retained responsibility for the overall project, including management of the CHIP MCOs, required supplemental payments to FQHCs/RHCs, evaluation, and sharing of lessons learned with CMS and other states. The project involved several key implementation steps:

STEP 1: Rate Determination. The law gives flexibility to states to pay FQHCs/RHCs either their Medicaid PPS rate or an APM rate. After evaluating the principle payment alternatives based on cost-effectiveness, ease of use and overall appropriateness, PID made the decision to use each health center's Medicaid PPS rate as the CHIP encounter rate.

STEP 2: Identification of Encounters. Determining an appropriate and cost-effective method of obtaining encounter information was an issue since insurance cards did not include a CHIP identifier. As a result, all of the CHIP insurers/MCOs were required by PID to "re-brand" their insurance cards in order to identify CHIP members, effective no later than January 2011. Although this step did not resolve encounter identification issues retrospectively, it will allow FQHCs/RHCs to track their CHIP patient encounters on a go-forward basis.

STEP 3: Retrospective Cost Settlement Methodology. A methodology for computing the total payments due to each FQHC/ RHC retrospectively to October 1, 2009 was developed. All Pennsylvania FQHCs/RHCs were invited to participate in one of the two teleconferences that PACHC facilitated in February 2011 to give PID the opportunity to share their thought process in development of the methodology and seek feedback. The key question raised by FQHC/RHC participants on the call was how vaccines and immunizations would be handled: health centers asserted that since they participate in the Vaccine for Children (VFC) program and vaccines and immunizations are not included in their PPS rate, reimbursement for vaccines should be excluded in determining any applicable wraparound payment. PID subsequently determined that reimbursements for vaccine and immunization products would not be included when determining wraparound payments.

STEP 4: Retrospective Cost Settlement. The first wrap-around payment reports were issued to FQHCs/RHCs beginning in April 2011. These reports included information for the entire federal fiscal year beginning October 1, 2009 and ending September 30, 2010, as well as for the quarter ending December 2010. Health centers were given an opportunity to review the reports and either accept or dispute the cost settlement information. In the process of reviewing the information provided, some MCO's discovered that their information contained errors. Revised reports were issued September 22, 2011. These reports contained information for two federal fiscal years (October 1, 2009 through September 30, 2010 and October 1, 2010 through September 30, 2011). However, the September 22nd reports only contain partial information for the second fiscal year—through June 30, 2011. Health centers have 30 days in which to dispute the information contained in the revised reports sent September 22, 2011.

STEP 5: Retrospective Wraparound Payment. While PID is ultimately responsible for ensuring that FQHCs/RHCs are paid according to CHIPRA, wraparound payments will come directly from the MCOs to the FQHC/RHC. To simplify the process, PID will ask a single CHIP MCO to make the total retrospective payment to the FQHC/RHC. That is, one MCO will be designated by PID for each FQHC/RHC to make the net CHIP wraparound payment for all MCOs with whom the health center contracts. You will need to discuss with your auditor how this aggregate payment should be handled.

STEP 6: Prospective Cost Settlement. After the initial retrospective cost settlement process explained in Steps 4 and 5 above, PID will implement a quarterly wraparound process. Since the process will be based on paid data, the information will be cumulative for the fiscal year. In other words, the first quarter reports for federal fiscal year October 1, 2011 - September 30, 2012 are anticipated to be sent during the month of January 2012 and will contain paid information for the period October 1, 2011 through December 31, 2011; the second quarter report will contain paid information for service dates October 1, 2011 through March 31, 2012 and should be sent during the month of April 2012; the third quarter report will contain paid information for service dates October 1, 2011 through June 30, 2012 and should be sent during the month of July 2012; and the fourth quarter report will contain paid information for service dates October 1, 2011 through September 30, 2012 and should be sent by PID to health centers during the month of October 2012.

STEP 7: Quarterly Wraparound Payment. As mentioned above, while PID is ultimately responsible for ensuring that FQHCs/RHCs are paid according to CHIPRA, to attempt to simplify a complicated process as much as possible, wraparound payments will come directly to each health center from a single PID-designated CHIP MCO. To reiterate, rather than each MCO making a wraparound payment to the FQHC/RHC, one MCO will be designated by PID to make the total net payment to each FQHC/RHC.

IMPLICATIONS FOR HEALTH CENTERS: With the enactment of CHIPRA and development of a CHIPRA-compliant payment system in Pennsylvania, FQHCs and RHCs will now be paid their Medicaid PPS rate for CHIP encounters. Accurate reimbursement is dependent on development of effective systems to track CHIP encounters and payments.

MEMBER ACTION NEEDED: There are a number of action items Pennsylvania health centers should take to ensure they are receiving optimal benefit from the CHIPRA payment requirements for FQHCs/RHCs. Most important is the development of an effective system to track CHIP encounters and paid claims to support accurate payment reconciliation. It is also important that health centers understand the CHIP PPS payment reconciliation process, which consists of:

Eligible Encounters. An "eligible encounter" as defined by Pennsylvania Medical Assistance is a visit in which there is face-to-face contact between a patient and the physician, dentist, or mid-level practitioner who exercises independent judgment in the provision of health care services.

Monitoring & Tracking. Pennsylvania's CHIP system, which utilizes nine private insurers, makes monitoring and tracking CHIP encounters and payment more challenging than in most states and it is incumbent on each health center to have good systems in place to validate encounter and payment numbers by CHIP insurer to reconcile quarterly reports that will be used to determine wrap-around payments.

CHIP Encounter Reports. Codes utilized to identify eligible encounters within an MCO's claims database included the following Current Procedural Terminology (CPT) codes: 99201-99215, 99381-99429, 10021-19499 and the Healthcare Common Procedure Coding System (HCPCS) code T1015. Reports include all fee-for-service and capitation payments made to a health center for CHIP members during the applicable timeframe. PID's plan on a go-forward basis is to send quarterly CHIP encounter reports to each health center for review.

Data Validation. FQHCs/RHCs are provided 30 days by PID to review the CHIP encounter report data. The PID wraparound process relies predominantly on FQHC/RHC CHIP member encounter and reimbursement claims data *provided by the CHIP MCOs*. The data provided by the MCOs is used to calculate whether an FQHC/RHC may be eligible for an underpayment settlement. In turn, the MCO's data is dependent upon the encounter and claims data submitted by FQHCs/RHCs for CHIP services. This means that if an FQHC/RHC has not submitted comprehensive utilization data to an MCO, either because of capitation payment methodologies currently in place or for any other business practice reason(s), it is possible that the number of CHIP member encounters rendered at that FQHC/RHC may be underreported by the MCO due to the incomplete nature of the representative claims within their database.

Acceptance/Dispute of Wraparound Report Calculations.

a. FQHC/RHC Agrees with MCO Data. After 30 days, unless the data provided by the MCO is objected to by the FQHC/RHC, PID will use the MCO data to determine whether an FQHC/RHC may or may not be eligible for an underpayment settlement. FQHCs/RHCs that have no objections are not required to do anything and may simply retain the reports for their records if desired. All payments will come from the PID-designated MCO for the health center, not PID.
b. FQHC/RHC Disagrees with MCO Data. If an FQHC/RHC has objections regarding the accuracy of the data supplied by the MCO, the FQHC/RHC should email the MCO's PPS point of contact and coordinate the exchange of detailed claims-level data. Resolution of encounter data disputes will be between the MCO and FQHC/RHC, however, the FQHC/RHC should copy PID at email address RA-IN-CHIP-PPS@state.pa.us so that PID is aware that the accuracy of the MCO data is being disputed. Please note: before determining whether a discrepancy actually exists, FQHC/RHCs should be aware that the data provided by the MCOs is abstracted from a claims database rather than a point-of-care or date-of-service database and thus issues such as claims lag will naturally create a certain amount of divergence between the two data sets. The claims data used by the MCO to provide the aggregate numbers for each FQHC/RHC high level summary report, as well as any other supporting documentation necessary to resolve the discrepancy, will be sent by the MCO directly to the FQHC/RHC. In turn, the FQHC/RHC should send their

detailed level claims experience to the MCO for review and copy PID. If an FQHC/RHC has not followed up with an MCO within 30 days of receiving the MCO's detail level data, the MCO will notify PID that the objection has not been resolved and the MCO data originally provided to determine whether the FQHC/RHC is eligible for an underpayment settlement will be used by PID. If an MCO fails to provide the FQHC/RHC with supporting documentation within 30 days, the FQHC/RHC should contact PID. PID will address each dispute on a case-by-case basis.

c. Resolved Discrepancies. If notification of the discrepancy resolution is received prior to the end of the FQHC/RHC 30-day review period of the FQHC/RHC high level summary reports, the data will be included in the current underpayment settlement report. Resolutions that occur after this period will be deferred to the next reporting period.

d. Failure to Resolve Discrepancies. It is expected that the MCO and the FQHC/RHC will resolve most discrepancies independently without PID intervention. If, however, after exchange of supporting documentation between the MCO and the FQHC/RHC agreement cannot be reached by the parties, the MCO and FQHC/RHC will notify PID who will have an appropriate staff member review both the MCO's and the FQHC's/RHC's supporting data. Both the FQHC/RHC and the MCO will be notified of PID's determination via email. Please note: Resolutions requiring PID's assistance may significantly delay inclusion of the data in current or future wraparound reports.

Payment. Each FQHC/RHC will receive one "net" check from a CHIP MCO with whom they participate. PID will not be making any payments directly to an FQHC/RHC. If a dispute occurs with one MCO, this will only delay payment from that MCO--payment from other MCOs will not be delayed. *You will need to confer with your auditor to determine how best to handle this aggregate CHIP revenue.*

As you can see from the process described above, it is imperative that FQHCs/RHC establish a process for indentifying CHIP encounters and paid claims.

PACHC ACTION: PACHC will continue to work with the Pennsylvania Insurance Department to ensure that CHIP carriers are reimbursing FQHCs/RHCs accurately. We ask that you copy PACHC on correspondence regarding any data disputes.

FOR MORE INFORMATION: Contact Cindi Christ at cindi@pachc.com or (717) 761-6443, ext. 204 with questions.