Tennessee Primary Care Association

CEO/CFO Prospective Payment System (PPS) Training

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Today’s Agenda

- Introduction of BKD
- Medicaid RHC/FQHC PPS implementation – a look back
- Tennessee’s Medicaid RHC/FQHC PPS implementation specifics and overview of current processes
  - Rate setting
  - Managed care plan payment reconciliation
  - Scope of service changes
- Final thoughts
Introduction of BKD

BKD Firm Profile

- Founded in 1923
- Headquartered in Springfield, Missouri
- 32 offices in 12 states
- One of the 10 largest CPA & consulting firms in the country
- $405 million annual net revenue
- 2,000 personnel, including 250 partners
BKD National Health Care Group

- Health care is a significant industry niche specialty of the firm
- Community health centers and rural health clinics are a significant, and priority, focus of our national health care practice (financial statement audit, cost reporting, tax reporting and other financial consulting services)
- Serve thousands of health care clients across the United States (including approximately 150 community health centers)

Community Health Center Team Leader

- Michael B. Schnake, CPA, CGFM
  - Partner - 26 years of experience serving health care organizations with a primary emphasis on community health centers
  - Frequent speaker on financial issues for the National Association of Community Health Centers & state primary care associations
  - Significant involvement with Medicaid RHC/FQHC PPS implementation initiatives in several states
Medicaid RHC/FQHC PPS Implementation – A Look Back

Medicaid PPS

- Federal law implementing a Prospective Payment System (PPS) for state Medicaid payments to RHCs/FQHCs effective January 1, 2001
  - Medicare, Medicaid & SCHIP Benefits Improvement and Protection Act (BIPA) signed December 21, 2000 by President Clinton
Medicaid PPS

- BIPA legislation required:
  - Replacement of the phase-out and elimination of the reasonable cost payment system (system was to be repealed during 2003)
  - Establishment of a minimum Medicaid per visit payment using a PPS methodology

Medicaid PPS

- BIPA legislation required (continued):
  - Payment baseline using the average of each organization’s 1999 and 2000 reasonable cost per visit rates – thereby, resulting in unique PPS rates for each organization
  - Established a methodology for rate setting for “new RHCs/FQHCs”
Medicaid PPS

- BIPA legislation required (continued):
  - Permitted establishment of an alternative payment methodology (APM) as long as the APM resulted in Medicaid payment equal to (or greater than) the PPS methodology AND the APM was agreed to by affected organizations

Medicaid PPS

- BIPA legislation required (continued):
  - Ongoing rate adjustments for
    - Changes in the Medicare Economic Index (MEI) – annual inflation adjustment
    - Consideration of defined changes in the scope of services provided
Medicaid PPS

- BIPA legislation required (continued):
  - States to make supplemental payments to RHCs/FQHCs that contract with Medicaid managed care organizations at a payment rate that is less than the established Medicaid PPS rate
    - Supplemental payments are to be made no less frequently than every four months

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Tennessee’s Medicaid RHC/FQHC PPS Implementation Specifics
Medicaid PPS in Tennessee

- Tennessee’s Medicaid PPS implementation is outlined in the Medicaid State Plan Amendment (SPA) governing RHC/FQHC Medicaid reimbursement in accordance with requirements of the federal legislation.

Medicaid PPS in Tennessee

- Tennessee’s original SPA (2001) included:
  - Initial PPS rates established based on 1999 and 2000 Medicare cost reports
  - For “new clinics”, those that qualify after 2000, initial rates established based on a comparable clinic and/or cost report approach
  - Medicaid managed care payment reconciliation process
  - Scope of service change provision
Medicaid PPS in Tennessee

- Tennessee’s updated SPA (2006) included:
  - Establishment of an alternative payment methodology effective January 1, 2006
    - Permitted an update of PPS rates based on more current Medicare cost reports
    - Included a “hold harmless” provision – organizations had to opt in writing for the alternative payment methodology

Medicaid PPS Rate Setting

- It is important for each organization to understand the origin of the current Medicaid PPS rate(s)
- Based on a recent meeting with representatives of the Comptroller’s office, there seems to be differences in the manner in which rates have been established for Tennessee’s RHCs/FQHCs
  - Some organizations have an all-inclusive PPS rate
  - Some organizations have multiple PPS rates (core services, dental, pharmacy, optometry, and other)
Medicaid PPS Rate Setting

- Copies of correspondence related to the establishment of the PPS rates should be maintained by each organization
  - If this correspondence history/trail does not exist, it would seem appropriate to contact the Comptroller’s office to obtain such detail supporting information for each organization’s permanent records (and future reference)
  - Contact person – Julie Rogers (615.747.5216 or Julie.A.Rogers@tn.gov)

Overview of TennCare Program

- Tennessee’s Medicaid managed care program, TennCare, operates under a Section 1115 waiver from the Centers for Medicare and Medicaid Services (CMS) as a demonstration program
  - Initially effective January 1, 1994
  - Current Medicaid waiver, “TennCare II” began January 1, 2002 and is scheduled to expire June 30, 2010
  - Only program in the nation to enroll the entire state Medicaid population in a managed care program
  - Administered by the Bureau of TennCare within the Tennessee Department of Finance and Administration
Overview of TennCare Program

- TennCare services are offered through “at risk” managed care organizations (MCO) in each region of the state (recent initiative to integrate medical and behavioral health care services through the MCOs completed effective January 1, 2009)
- In addition, the TennCare Select program exists for certain limited populations

Overview of TennCare Program

- Prescription drug coverage is administered by a Pharmacy Benefits Manager (PBM) – currently SXC Health Solutions Corporation
- Dental benefits for children under age 21 are administered by a Dental Benefits Manager (DBM) – currently Doral Dental of Tennessee
Overview of TennCare Program

- Current MCOs operational include:
  - UnitedHealthcare (AmeriChoice) and BlueCare – integrated medical and behavioral health care services effective November 1, 2008 in West TN and January 1, 2009 in East TN
  - UnitedHealthcare (AmeriChoice) and Amerigroup – integrated medical and behavioral health care services effective April 1, 2007 in Middle TN

Overview of TennCare Program

- TennCare program has prompt payment requirements in the state’s contracts with the MCOs as follows:
  - For medical and behavioral health care services, 90% of clean claims must be paid within 30 calendar days of receipt; 99.5% must be paid within 60 calendar days of receipt
  - For dental services, the DBM must pay claims in accordance with the aforementioned statutory requirements for medical and behavioral health care services
  - For pharmacy services, the PBM must pay 100% of clean claims within 10 calendar days of receipt
Managed Care Payment Reconciliation

- Effective January 1, 2001, the Bureau of TennCare (in coordination with the Comptroller’s office) established a process of Medicaid managed care payment reconciliation (“wrap-around” payments)
- There was limited guidance to implement this process.

Managed Care Payment Reconciliation

- The current process of managed care payment reconciliation involves:
  - Quarterly reporting, based on calendar quarters, of TennCare visits (units of service) and payments
  - Reports are submitted to the Comptroller’s office within 60 days of the end of each quarter (i.e. January 1 to March 31 reporting period is due by May 30)
  - Reports reviewed by Comptroller’s office and payment is then processed by the TennCare Bureau
  - Cash flow delays if the reconciliation reports are not submitted and processed in a timely manner
Managed Care Payment Reconciliation

- Certain basic principles exist for accurate navigation of the current process:
  - TennCare visits and payments reported on the reconciliation form should be for paid claims having dates of service within the calendar quarter reporting period (paid claims are those claims that have been adjudicated by the MCO and, accordingly, have appeared on a remittance advice from the MCO)
  - The 60 day submission period is in place to allow for claims to be paid by the MCO subsequent to the calendar quarter; once paid, such claims are then eligible for inclusion on the reconciliation form submission
    - Example – March dates of service that are paid by the MCO in April and May can be included on the reconciliation form submitted for the calendar quarter ended March 31

- Once the reconciliation form has been submitted for a calendar quarter, any claims having dates of service in that calendar quarter and subsequently paid by the MCO continue to be eligible for "wrap-around" payment consideration by the state
  - Any such claims should be included on an amended reconciliation request form submission for the calendar quarter that includes such dates of service

- In order to accurately capture MCO visit and payment information, it is necessary for RHCs/FQHCs to recap MCO remittance advices based on paid dates of service occurring during the four calendar quarters
  - Necessary to capture units of service and related payments for each service line for which an organization has an established Medicaid PPS payment rate (core services, dental, pharmacy, optometry, and other)
Managed Care Payment Reconciliation

The current process of managed care payment reconciliation quarterly reporting involves certain musts:

- Accurate accumulation of MCO paid claims information (visits and related fee-for-service payments) for dates of service occurring within a calendar quarter
  - Remittance advice recaps should be prepared separately for each contracted MCO
- Accurate accumulation of MCO capitation payments applicable to each calendar quarter (there will not be visits that directly correspond with the capitation payments)

Managed Care Payment Reconciliation

The current process of managed care payment reconciliation quarterly reporting involves certain musts:

- Accurate accumulation of dental, pharmacy, etc. units of service and related payments for dates of service occurring within a calendar quarter (remittance advice recaps are necessary)
- Proper exclusion of denied claims
- Accurate identification of Medicaid PPS rates (remember that Medicaid PPS rates change effective July 1 for rate change adjustments due to changes in the MEI)
Managed Care Payment Reconciliation

- There are certain pitfalls that have been identified to date:
  - Reports submitted on an “accrual” versus “cash” basis (visits included in submitted report based on the date service was provided; and, subsequently included in a future calendar quarter report when payment is received from the MCO)
    - In this case, two visits (or units of service) are reported with only one corresponding payment; this can potentially result in an inaccurate Medicaid overpayment

Managed Care Payment Reconciliation

- There are certain pitfalls that have been identified to date (continued):
  - Reports submitted without an accurate accounting of denied service claims (the denied service claim is not recapped as an offset to the original service claim)
    - Once the denial issue is resolved and the claim is adjudicated by the MCO, two visits (or units of service) are reported with only one corresponding payment; this can potentially result in an inaccurate Medicaid overpayment
Managed Care Payment Reconciliation

- Based on a recent meeting with representatives of the Comptroller’s office, there are certain pitfalls that have been identified to date (continued):
  - Reports submitted based on inaccurate guidance provided by consulting firms that are not educated on the current process requirements
  - The Comptroller’s office agrees that there has been limited written guidance and very few training programs offered to help RHCs/FQHCs better understand the process requirements for achieving an accurate and expeditious settlement
    - With turnover of personnel, ongoing training programs may be very helpful

Scope of Service Changes
Scope of Service Changes

- Tennessee’s Medicaid SPA includes provisions related to the opportunity for RHCs/FQHCs to request Medicaid PPS payment rate adjustments due to changes in the scope of services.
- The SPA does not identify examples of change in scope of service “qualifying events”.
- The SPA references work sheets that the state has in place for computing the Medicaid PPS payment rate adjustment related to changes in the scope of services.

Scope of Service Changes

- There are no standard forms for RHCs/FQHCs relative to seeking a Medicaid PPS payment rate adjustment related to a change in the scope of services.
  - Potential opportunity to broaden the array of “qualifying events” and create a reporting form that will allow RHCs/FQHCs to pro-actively evaluate and navigate this important Medicaid reimbursement opportunity provided under federal law.
Final Thoughts

- Remember – the process of achieving accurate Medicaid PPS payment involves many complexities that must be properly navigated by RHCs/FQHCs
  - Seek help if needed
- Stay tuned for future developments in this area – opportunities exist for additional enhancement and clarity of the existing state processes
Thank You

- Please feel free to contact

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