PCP Rate Parity Technical Workgroup
April 11, 2013; 1p-2:30p
AHCCCS, 701 E Jefferson, Phoenix
HRD Training (Turquoise) Room, 3rd Floor

Attendees*

Bridgeway
Janine Kirkland

Care1st
Brent Ratterree
Kathy Thurman

DDD
Donna Schneider

DES
D Gardner

DES CMDP
Amanda Erickson

Health Choice Arizona
Mia Villa
Sarah Sautter
Melissa Small

Health Net
Gay Ann Williams
Kay Zeigler
Dee Dee Lawson

Mercy Care
John Monte
Mark Palmisano

Phoenix Health Plan
Lavaun Skallereep
Mary Kahler
Liz Liska

United Healthcare
Deb Alix
Jeff Greenspan
Cheryl Howard
Helen Bronski

University of Arizona Health Plan
Kim Bolton
Mary Consie

AHCCCS
Shelli Silver
Lori Petre
Rebeca Haugse

**Plus other attendees via phone.*

Draft meeting notes from the last workgroup held on March 20, 2012 were distributed along with an updated Encounter Flow. These documents can be found on the AHCCCS website.

A one-page picture of our webpage that is dedicated to this topic was also distributed as an FYI. The website includes links, provider attestation information, FAQs and other key information related to this project.

On March 19, 2013, Shelli sent an email to the Plans with the link to the Provider Attestation information to be posted to their individual websites regarding attestation. She will also forward this to Health Net.

As of today, 2,071 providers have attested. Although the number is significantly higher since the last Workgroup, AHCCCS hopes to see that number increase.

Shelli mentioned she gave the workgroup the opportunity to send any questions and that we would cover those received today. Some plans asked that we revisit the COB examples and Medicare. The COB and Medicare are the most difficult in terms of data flow. The other set of questions had to do with the attestations and the dates which will also be touched upon in the meeting.

Encounter Flowchart Overall

An initial Encounter Flowchart was distributed in the last meeting, but was amended slightly based on feedback from the workgroup.

Lori said the biggest changes were the indicators themselves which previously had no dates associated with them and now will. A group met internally to talk about the structuring of those dates. Proposed details have been added in the first box, under #3, as to what those dates will be. In addition to the

indicator, there will also be an effective begin and end date for that indicator as well as a date record added. All of those elements will be included in the weekly provider extract.

A new indicator was added so it will be very clear when an entity has been a "6" for a year, then if there is an audit and it is found that the 60% was unmet it isn't like that indicator will disappear, but it will be replaced by a new indicator of "N" and that will clearly tell you that it is the loss of eligibility for the enhanced rate.

Referencing the second box, there was a question from the last meeting about the modifiers impacted. Lori stated she confirmed with the rate staff that there was no impact to modifiers and there are no modifier rate changes related to the parity rate.

Lori said the other significant changes to the Encounter Flow are the addition of a section a the back regarding the attestation flow, and the addition of examples related to Medicare and Encounter reporting.

A question was raised regarding retroactive loss of eligibility to the enhanced rates. Shelli said the assumption is that if anyone loses eligibility, then they were never qualified. However, we did send a question to CMS regarding, if a provider self-attests one time and one time only for the two years and for example, the provider attests that they are board certified, what if that board certification expires, can he recertify as 60%. This particular question was submitted to CMS on April 3, 2013. As of today, AHCCCS has not received a response. Shelli will inform the workgroup as soon as an answer is received.

– MCO Reporting

The meeting continued with reviewing updates additional scenarios/examples of MCO encounter reporting to AHCCCS. Referring to scenario #2, Mary noted that this example works as long as the HP's allowed amount is greater than or equal to the primary payer's allowed amount. While reviewing scenario #3, Shelli noted that the interest paid will be found in the CAS segment. In reference to scenario #5, when the subcap arrangement is greater than the parity payment, Shelli stressed that the MCO cannot lower the payment when the contractual arrangement is to pay more than parity. In this case, the MCO would continue to pay their original subcap rate. Lori will add another example to reflect this particular scenario. Shelli offered the following example: If there was no subcap arrangement but the fee schedule payment was $115 and the enhanced rate was $113, the MCO would still do nothing differently which means $115 is reported as the paid amount.

Next, Shelli led the workgroup in reviewing the new scenarios starting with scenario 6. While Shelli was describing example A of this scenario, Mary asked where this example got the allowed amount of $20. Shelli said that is what would be reported and referred to the note under #6 "The HP Allowed Amount is the lesser of the patient responsibility or the calculation of the non-enhanced payment rate minus Medicare." Mary was concerned because that is not what gets loaded in the HP Allowed Amount. Shelli responded that we realized since the very beginning that we recognized that the reporting will require changes to the MCO's programming. Mary directed her concern to the workgroup noting that a change in that programming would mean that there would be the need to have different COB rules on a line-by-line basis in each MCO's system. Lori asked Mary if the $20 is captured in a field or something calculated through other fields. Mary confirmed that is captured by the plan and could conceivably be reported to AHCCCS. Lori said there is no field for the COB Allowed Amount under 5010 so further analysis of reporting options is needed.

Shelli confirmed that if the workgroup agreed that they could report both fields, AHCCCS can program the formula on its end. Lori said for the purposes of these examples, she will call the filed "calculated lesser of amount".

Shelli will check with Katrina to respond to the Workgroup's question regarding FFS Medicare member versus SNP enrolled member. Lori said the QMB duo calculation is different and Lori will offer more examples.

The review of Reporting of Encounters flowchart continued starting with scenario #7 on page 4. Referring to the second example, Lori noted that because the patient responsibility is the lesser of, then that will be the amount. As in the example, it was $15 before the parity rate and $15 after the parity rate and that is the reason there is no additional payment. The workgroup asked which field is needed on the encounter. Shelli replied that in this example, AHCCCS has all of this information because it is already sent from the MCO. The only difference on the flow that will be revised is that AHCCCS will perform the calculation (HP Allowed; HP Paid).

Encounter Flow – MCO Payments

Shelli reminded the group that Encounter data reporting is critical as instead of the MCO invoicing AHCCCS, AHCCCS will take in all the encounter data and do these calculations to compute the cost settlement amount on a quarterly basis. AHCCCS will send the MCO a file that will contain the CRN pertinent data and what is believed to be the cost settlement. The MCO will have the opportunity to rebut that with AHCCCS. Shelli reminded the workgroup about the tight timeframe. If the MCO wants to go back and forth, AHCCCS will certainly allow that but does not want to be reason for the delay in payment. She noted that there are two years, actually 21 months from the end of the contract year in which the date of service occurred to go to CMS to pull down the federal funds. This is based this on adjudication date. There was discussion regarding adjusted claims. Shelli wanted to point out that there were several questions more related to the grievance process, claims dashboard, retro-recoupment, timeliness, but stated answers are not ready today but are in progress. She will get back to the workgroup with answers via email and/or a Q&A type process.

The meeting continued with Lori leading the workgroup onto MCO Payments on page 5 of the Encounter Flow. She noted that the last paragraph is new regarding the retroactive reprocessing of impacted claims. She emphasized that this process should not be requiring providers to resubmit claims to the MCO after the delay period and if the provider submitted it to the MCO, then the provider is entitled to that additional payment when we do get approval from CMS. Mary asked Lori to reflect new "cost settlement" terminology.

Another piece that needs to be completed is the layout of the report that will support this process. Lori will send an email to the workgroup to solicit all of the key data elements that they will need to have in the report such has how the data should be sorted and other elements that will be useful. Shelli added that this is really the "cost settlement report". The workgroup asked if the payment just showed a point in time. Lori said it could or it can show previous *and* current amounts whichever would make the review process easier and to keep these things in mind when responding to her email. Also, there is a second report that may be useful that can include if there was a change such as a Provider being eligible then flipped to non-eligible. Lori confirmed that there is a need for a replacement on these encounters to get rid of the parity.

Attestation Flow

The workgroup reviewed the new Attestation Flow. Lori will clarify will clarify with Valerie regarding self-attesting (ref #3 of this flow).

Next Meeting

John Monte asked for commercial COB and Medicare examples to walk through. There will also be a review of other open action items.

In summary, Shelli supplied CMS all the documentation to secure retroactive funding and is anticipating a response around June 2013. There will another follow up workgroup scheduled in approximately three weeks.

Action Items

4/20/2013 workgroup

- Forward to Health Net the email that was sent email to the MCOs on March 19, 2013 with links to post to their individual websites regarding attestation. (Shelli)
- The EDI business analysts are trying to come up with a solution and we will have that calculated as part of our logic.
- Meet with Katrina to respond to the workgroup's question regarding FFS Medicare member versus SNP enrolled member. (Shelli)
- Offer more examples regarding the QMB dual calculation. (Lori)
- Add another example to scenario #5 of the MCO Reporting flow. (Lori)
- Reflect the new "cost settlement" terminology in the flow charts referring to MCO Payments. (Lori)
- Send an email to the workgroup to solicit all of the key data elements the MCOs will find useful in the report layout. (Lori)
- Shelli stated that AHCCCS will continue to work and research the open issues.
- Shelli to follow-up on Grievance related questions.
- Consider amending ACOM Recoupment/Reprocessing policy. If AHCCCS removes a flag from a provider due to the provider's failure to meet qualifications, consider allowing the Contractor to notify AHCCCS of the recoupment rather than asking AHCCCS for approval. – Still in Progress