Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Rural Health Clinic Reconciliations

Evaluating Options to Reduce or Eliminate RHC Reconciliation Overpayments

Substitute Senate Bill 5883, Sec. 213(1)(mm); Chapter 1, Laws of 2017, 3rd Special Session, PV

December 1, 2017

Rural Health Clinic Reconciliations

Washington State Health Care Authority

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Executive Summary

The purpose of this progress report is to update the Legislature on the Health Care Authority's (HCA) evaluation of rural health clinic reconciliation repayments, as requested in 2017's Substitute Senate Bill 5883, Sec. 213(1)(mm):.

> Within the amounts appropriated in this section, and in consultation with appropriate parties, including the rural health clinic association of Washington and the centers for medicare and medicaid services, by December 1, 2017, the authority shall submit a report to the governor and appropriate committees of the legislature evaluating legislative and administrative options to reduce or eliminate any amounts owed by rural health clinics under the payment reconciliation process established in the medicaid state plan.

This report includes:

- An overview and guidance from CMS on the RHC Reconciliation Process
- The ways HCA is addressing current and past RHC Reconciliations
- HCA's review of other state's RHC reconciliation processes

For Apple Health (Medicaid) clients enrolled with a Managed Care Organization (MCO), HCA pays Rural Health Clinics (RHCs) monthly supplemental payments in addition to the negotiated payments they receive from MCOs. This payment method ensures that RHCs receive their full cost-based, provider-specific rate for eligible RHC services (otherwise known as an encounter rate). HCA is responsible for ensuring that annual reconciliations on these payments are completed to determine any underpayments (for which the state owes the clinic) or overpayments (which the clinic must return). In turn, any federal share of these payments must be returned.

HCA is striving towards more effective and efficient ways for RHCs to complete future reconciliations in a timely fashion. This includes a new payment method for RHCs that allows clinics to receive their full encounter rate at the time of service from MCOs, thus eliminating the need for RHCs to reconcile with the state.

Background

Reconciliation Process

RHCs receive enhanced reimbursement in return for serving clients in medically underserved areas. Each of Washington's 115 RHCs receives a unique provider-specific encounter rate based on allowable costs. To comply with federal regulations, HCA must ensure that RHCs receive their cost-based encounter rates for qualifying services provided to all Apple Health clients, served through HCA's fee-for-service and managed care programs[1].

In the managed care environment, HCA ensures that RHCs receive their full encounter rate by paying RHCs a monthly lump sum enhancement payment. This payment is in addition to the contracted payments RHCs receive from MCOs. The enhancement payment is meant to bridge the gap between the MCO contractual payment and the RHC encounter rate. Because the enhancement payment is based on the number of enrollees the MCO assigned to the clinic and fluctuates monthly, the payment is approximate.

Per federal and state regulations (as outlined in this report), HCA must reconcile with each clinic to ensure the clinic received its exact encounter rate for each qualifying visit. If the clinic was underpaid, HCA pays the difference. If the clinic was overpaid, HCA recoups the amount. HCA utilizes a clinic's most recently completed reconciliation data to calculate enhancement rates. It benefits both HCA and RHCs to be current on reconciliations because enhancements based on current reconciliations help avoid large under or overpayments.

Legal Framework and History of RHC Reconciliations

Overview of Federal and State Regulation

Requirement for RHC reconciliation of managed care enhancement payments is derived from the following federal and state authority:

Federal statute 42 U.S.C 1396a (bb)(5):

> (5) Administration in the case of managed care
>
> (A) In general

[1] Managed care is a health care delivery system organized to manage cost, utilization, and quality. Apple Health (Medicaid) managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and MCOs that accept a set per member per month payment for these services. Apple Health clients who are not served in managed care receive services through the Medicaid fee-for-service program, where HCA pays providers directly for each service.

> In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section 1396u–2 (a)(1)(B) of this title), the State plan shall provide for payment to the center or clinic by the State of a supplemental payment **equal** to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

Washington Administrative Code (WAC) 182-549-1450(5):

> (5) For clients enrolled with an MCO, the agency pays each RHC a supplemental payment in addition to the amounts paid by the MCO. The supplemental payments, called enhancements, are paid in amounts necessary to ensure compliance with 42 U.S.C. 1396a (bb)(5)(A).
>
> (a) The RHCs receive an enhancement payment each month for each managed care client assigned to them by an MCO.
>
> (b) To ensure that the appropriate amounts are paid to each RHC, the agency performs an annual reconciliation of the enhancement payments. For each RHC, the agency will compare the amount actually paid to the amount determined by the following formula: (Managed care encounters times encounter rate) less fee-for-service equivalent of MCO services. If the RHC has been overpaid, the agency will recoup the appropriate amount. If the RHC has been underpaid, the agency will pay the difference.

In addition, the Centers of Medicare and Medicaid Services (CMS) approved the State Plan Amendment (SPA) in 2008 (See Appendices A and B). CMS approved, via the SPA, the methodology for managed care reconciliation that dictates that state-issued enhancement payments must equal the difference between the MCO contractual payment and the RHC's encounter rate.

History of RHC Reconciliations

In 2006, a CMS audit found insufficient evidence that Washington's managed care enhancement payments met the federal requirements of Section 42 U.S.C. 1396a(bb). Specifically, the state was unable to demonstrate that enhanced payments were sufficient to make each Federally Qualified Health Center's (FQHC) or RHC's total reimbursement for each managed care visit equal to its encounter rate.

As a result of the CMS audit finding, Milliman, Inc. (an actuary firm working with HCA) was contracted in 2009 to conduct an analysis of enhancement rates, which were subsequently adjusted. Milliman, Inc. also designed a tool to calculate clinic-specific enhancement rates each year utilizing each FQHC's and RHC's actual managed care utilization and the fee-for-service encounter rate, along with appropriate trend factors.

As required by the CMS audit, the annual managed care reconciliation was introduced starting with calendar year 2009. However, due to litigation (*Neighborcare vs. Teeter*) between HCA and several FQHCs that began in 2011, both FQHC and RHC reconciliations were put on hold until the lawsuit settled in 2013. The reconciliation process for 2009 resumed in 2013. This delay affected subsequent reconciliation years; HCA did not start the 2010 reconciliation before completing the 2009 reconciliation.

Milliman, Inc. conducted the process for 2009 and 2010 reconciliations for RHCs. The process was data driven and required multiple iterations to address various data issues. Clinics expressed concerns about the complexities of the analysis and the amount of time required reviewing multiple versions of data. This further delayed the reconciliation process.

For subsequent reconciliation years, RHCs expressed interest in the new method of managed care reconciliation, the Agreed Upon Procedures (AUP) method, which is a statistical sampling method successfully utilized by FQHCs for 2010-2013. Using this method, RHCs compiled their own managed care data using guidelines provided by HCA. RHCs contracted with independent financial auditors to select and test a random sample of claims from each clinics' reconciliation data. Auditors prepared and submitted an independent report of findings to HCA for review and finalization. Reconciling 2011-2013 years all at once was HCA's effort to catch up on outstanding reconciliation years.

Although most RHCs initially welcomed the AUP method, the task of compiling the data for three years simultaneously proved administratively burdensome for many clinics. Added to that was the task of identifying and producing patient records for the auditors to conduct the AUP testing of the encounters identified in the sample. Many clinics have either closed their doors since 2011 or lost accessibility to data, furthering the difficulty to reconcile. These required reconciliations have resulted in some RHCs owing large sums to HCA due to overpayments. RHCs have voiced concern that these large overpayments are a financial hardship for the clinics. Currently, 53% of Rural Health Clinics in Washington have completed their 2011-2013 reconciliations.

In the past three years, the Legislature provided two budget provisos to relieve RHCs of the financial impact of reconciliations:

- Third Engrossed Substitute Senate Bill 5034 (2013) included $3,605,000 GFS to partially reduce the amounts RHCs owed for 2009 reconciliation recoupments.
- For state fiscal years 2016 and 2017, Engrossed Substitute Senate Bill 6052 (2015) provided a total of $1,175,000 GFS for reimbursement of audit costs for the 2011-2013 RHC reconciliations. The reimbursement, however, was available for independent clinics only, which excluded the more than half RHCs that are hospital-based.

Requesting CMS Guidance on RHC Reconciliations

In a meeting with CMS on September 27, 2017, HCA initiated consultation regarding RHC reconciliation overpayments. HCA explained the state's procedures for handling reconciliation overpayments. HCA also provided a status update on past reconciliations. CMS agreed that following the SPA as guidance for reconciliation recoupment was the correct course of action. CMS staff also confirmed the expectation of the state to return to CMS the federal share of overpayment from the clinics.

Addressing Future Reconciliations and Overpayments

HCA is making several efforts to address future reconciliation overpayments in ways that reduce the administrative and financial implications for Rural Health Clinics and HCA. These efforts, outlined below, include a new payment option for RHCs to receive their full encounter rate through MCOs (eliminating the need for reconciliations) and changes to WAC 182-549-1450, which requires that reconciliations be completed within specified timeframes.

RHC Encounter Rate Through MCOs

In response to Section 213(1)(ll) of Substitute Senate Bill 5883 (2017), HCA will implement a new payment option that allows RHCs to receive their full encounter rate through MCOs. This new payment method will be effective January 1, 2018. Allowing RHCs to choose this new payment will eliminate the need to reconcile payments with the clinics, while still meeting federal requirements to pay RHCs their full encounter rate. RHCs will receive their full encounter rate from MCOs for all eligible encounter claims. Reconciliations will be completed between HCA and each MCO, eliminating the administrative and financial impact on RHCs. Eighty-five RHCs(73% of all RHCs) have selected to participate in this payment method for calendar year 2018.

HCA is hosting *RHC Encounter Rate through MCOs* stakeholder workgroups twice a month. These workgroups include RHCs, MCOs, and HCA subject matter experts. This workgroup, which began meeting in October 2017, is working to ease the transition to this payment method for all stakeholders by explaining necessary changes to MCO systems, RHC billing practices, and HCA enhancement payments.

On September 29, 2017, HCA submitted to the Legislature a report titled *Progress Report: Rural Health Clinic Managed Care Payments: Implementing Full Encounter Rate Payments* (https://www.hca.wa.gov/assets/ssb-5883-rural-health-clinic-managed-care-payments.pdf). That report outlines the details for implementing the payment of RHC encounter rates through MCOs.

Draft New Rule: WAC 182-549-1450

The agency is amending Washington Administrative Code (WAC) 182-549-1450, *Rural health clinics—General payment information*, effective January 1, 2018. The amendment states that reconciliations will be conducted in the calendar year following the calendar year for which the enhancements were paid (the process of finalizing settlements with RHCs may extend beyond the calendar year). This revision, which applies to all MCO payments made on or after January 1, 2018, requires HCA and RHCs to complete reconciliations in a more timely fashion to adjust enhancement rates and therefore reduce under or overpayments.

Addressing Past Years' Reconciliations and Overpayments

Simplifying RHC Reconciliation Data Reporting

HCA met with the Rural Health Clinic Association of Washington (RHCAW) on July 25, 2017 and September 15th, 2017 to discuss options for reducing the administrative burden of RHC reconciliations. RHCAW suggested a new method of RHC reconciliations in which clinics could submit data to HCA that includes all RHC eligible claims. HCA would then verify this data for accuracy in ProviderOne (Washington's social and health provider payment system). If RHC data is found to include valid RHC eligible encounters and matches what is reported in ProviderOne, HCA will complete the reconciliation. If discrepancies are found, the RHC would have 30 days to review and provide a response.

HCA is working to adopt parts of this process for the 2014-2017 reconciliations. This method would eliminate the need for RHCs to hire and pay auditors. It would also avoid the findings process in which clinics must review patient charts and MCO client eligibility as part of the AUP method. This new method will also allow HCA to calculate enhancement rates in a more timely fashion by utilizing more current RHC data, thus reducing the risk of large overpayments.

HCA would also be able to work with clinics on a case-by-case basis to determine the best methods for completing reconciliations. For example, some RHCs may face difficulties completing four years of reconciliations. HCA could work with these clinic to complete the most recent year first (2016 or 2017, depending on the timing), to reset the enhancement rate prospectively, and to reduce potential over and underpayments in future reconciliations.

Other State Models

To research different payment models for RHC reconciliations, HCA reached out to other states that have similar RHC payment processes.

IHCA found that Oregon and California pay enhancements retroactively. However, Oregon pays its FQHCs using a prospective payment model and recoups any overpayments from FQHCs, similar to Washington. While conversations with both states were insightful, HCA learned that neither model aligns with Washington's federal and state requirements to administer enhancement payments for RHCs.

Oregon RHC Reconciliation Model

On August 14, 2017 HCA met with staff from Oregon's Medicaid RHC reconciliation program. HCA learned that Oregon does not issue managed care enhancements to RHCs prospectively, the way Washington does. Oregon's RHCs receive the contractual payment from MCOs only. Oregon receives RHC managed care data from the clinics on either a monthly or quarterly basis, depending on the clinics. Oregon then compares the clinics' data to Oregon's provider payment system for accuracy. Once the data is validated, Oregon determines the amount of enhancements each RHC is entitled to. This payment is issued to the clinics retrospectively on a monthly or quarterly basis. In Washington RHCs receive their enhancement payments prospectively which are later reconciled.

When comparing this process to the HCA's current reconciliation process, it became clear that moving from the traditional annual reconciliation to a monthly reconciliation process would be administratively burdensome for RHCs and HCA. A monthly process would be out of compliance with HCA rules.

California RHC Reconciliation Model

On October 3rd, 2017 HCA met with RHC program staff at California's Department of Health Care Services. HCA learned that California provides enhancement payments on a retrospective basis, as opposed to HCA's prospective method. California RHCs submit their data to the state, which retroactively pays the RHCs to ensure the clinics have received their encounter rate.

Conclusion

HCA is making intentional and concerted efforts to reduce or eliminate amounts owed by RHCs in reconciliations while still upholding state and federal requirements. Under state and federal regulations, HCA has a duty to return the federal share of these enhancement payments.

Moving forward HCA is implementing a new payment method for RHCs to receive their full encounter rate through MCOs eliminating the need for RHCs to reconcile with the state. HCA is also proactively evaluating ways to reduce the administrative burden of reconciliations in partnership with the RHCAW by implementing a new data evaluation method and examining other states' processes for RHC reconciliations.

Appendix A: 2008 Washington State Plan Amendment Approval Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

JUN 26 2009

Susan Dreyfus, Secretary
Department of Social and Health Services
Post Office Box 45010
Olympia, Washington 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number #08-010

Dear Ms. Dreyfus:

The Centers for Medicare & Medicaid Services has completed our review of State Plan Amendment (SPA) Transmittal Number #08-010.

This amendment implements an alternative payment methodology (APM) for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). The APM and Prospective Payment System (PPS) will be reconciled annually to ensure the APM at least equals the PPS rate.

This SPA is approved effective July 1, 2008, as requested by the State.

I appreciate the significant amount of work that your staff dedicated to getting this SPA approved and the cooperative way in which we achieved this much-desired outcome. If you have any questions concerning this SPA, please contact me at (206) 615-2267 or have your staff contact Mary Jones at (360) 486-0243 or Mary.Jones2@cms.hhs.gov.

Sincerely,

Barbara K. Richards
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc:
Douglas Porter, Assistant Secretary, Health and Recovery Services Administration
Louis McDermott, Chief, Office of Rates Development, Health and Recovery Services Administration

Appendix B: 2008 Washington State Plan Amendment Reconciliation

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

II. Clinic Services (cont.)

For clients enrolled with a managed care contractor, the State will pay the clinic a supplemental payment in addition to the amount paid by the managed care contractor. The supplemental payments, called enhancements, will be paid in amounts necessary to ensure compliance with Section 1902(bb)(5)(A) of the SSA. The State will pay the enhancements monthly on a per-member-per-month basis.

To ensure that the appropriate amounts are being paid to each clinic, the State will perform an annual reconciliation and verify that the enhancement payments made in the previous year were in compliance with Section 1902(bb)(5)(A). The annual reconciliation will be done as follows:

APM: (managed care encounters x APM encounter rate) less (fee-for-service equivalent) = State's payment amount

PPS: (managed care encounters x PPS encounter rate) less (fee-for-service equivalent) = State's payment amount

Covered services for Medicaid-Medicare patients are reimbursed as detailed in Supplement 1 to Attachment 4.19 (B), pages 1, 2, and 3.

C. Non-hospital-owned Freestanding Ambulatory Surgery Centers

Freestanding ambulatory surgery centers (ASC) are reimbursed a facility fee based on Medicare's Grouper, except for procedures Medicare has not grouped; in which case, DSHS groups the service to a like procedure that Medicare has grouped.

All procedures that the department reimburses to an ASC are assigned a grouper of one through eight (1-8). Each of these groupers is assigned a set fee. The department pays the lesser of the usual and customary charge or the grouper fee based on a department fee schedule.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of non-hospital-owned freestanding ASC services. The Agency's rates were set as of April 1, 2009 and are effective for services on and after that date. All rates are published on the Agency's website.

TN#08-010 Supersedes TN# 03-019 | Approval Date JUN 26 2009 | Effective Date 7/1/08

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December 1, 2017