

Primary Care Provider Incentive Payment Program
Frequently Asked Questions

1. Are Medicaid Health Plans (MHPs) required to re-submit encounter financial data for Coordination of Benefits (COB)/Third Party Liability claims?

For this issue it was discovered that most plans were incorrectly reporting Medicare financial data to the Michigan Department of Community Health (MDCH). We are asking plans to resubmit Medicare and other payer "dual" encounters using the payer ID numbers for Medicare part A and part B and any other payer if possible. On request of the MHPs, the deadline for plans to resubmit data was extended to **June 2014**.

2. What if the MHPs or providers believe that MDCH applied the wrong Medicare locality code and therefore the wrong Medicare regional rate?

We can only use the data that appears in encounters; if there is no address, the rate will default to the Medicare out-state (lower) rate. If the plans determine that zip code data for place of service was submitted by their providers, but not reported correctly for the PCP payments, they should submit some samples via the File Transfer Protocol (FTP) systems and include an issue summary inside an appeal form per the established review/appeal process. **UPDATED***** We have confirmed that some encounters appear to have been submitted with null zip+4 fields and in these cases we are going to cross reference to the base 5 zip code data only.

3. What if the MHPs are unable to locate a provider indicated in the MDCH PCP payment data?

We ask that MHPs try to establish contact with providers using internal provider records. If it is not possible to find a provider after six months, Health Plans should inform MDCH and a gross adjustment reduction/off-set will be applied.

4. Are there any changes in process and timing?

The general process remains the same. For "look-back" adjustments; we discovered that several MHPs submitted encounter claim replacements without original unique key identifiers (ERN/TCN). This prevents the original look-back process design from moving forward. We have implemented a new look-back process that sums "new" claim data for a look-back period by rendering National Provider Identifier (NPI), then sums the original payments and calculates a look-back ratio factor by rendering NPI. This ratio is then applied to all new claims for a look-back period in order to correctly reduce or increase payment to providers.

5. What if the MHP or provider thinks they have identified discrepancies in the MDCH PCP payment data?

An appeal process was created and agreed to by the MHPs and MDCH during the process development phase of the project. The appeal form should be used to summarize any issue(s); the MHPs should also submit sample data along with these forms in order to support the stated appeal issues. It is also suggested that health plans follow the testing protocols prior to forwarding to the State. If claims changed on MHP systems subsequent to the last pricing, future pricing periods will include reconciliation calculations using void/replacement coding in encounters. This should account for most claim changes if reported correctly in encounters.

6. What should MHPs do with returned checks?

MHPs should review with providers/groups to determine why the funds were returned to the MHP. We ask for a good faith effort by the MHPs to establish why the funds were refused or returned, and if possible to rectify with providers/groups. To avoid additional administrative burden, we suggest a six month administrative waiting period to try to resolve the issue prior to returning funds to the State.

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7. How do providers submit complaints to MHPs?

An appeal process was created and agreed to by the MHPs and MDCH during the process development phase of the project. The appeal form should be used to submit sample data if a plan or provider believes a discrepancy exists in the data (we must have supporting data to make any changes). It is also suggested that the health plan testing protocols are reviewed prior to forwarding to the State. This testing protocol and appeal process has been successful in sifting out most data issues, or for explaining why a claim was excluded from the enhanced rate payments (i.e., missing rendering NPIs, Federally Qualified Health Center [FQHC] look-alikes, provider on the Specialty Network Access Fee [SNAF] list, provider not yet marked as eligible in the Community Health Automated Medicaid Processing System [CHAMPS], etc.).

8. What if there is a discrepancy between Fee-for-Service (FFS) and MHP payments?

The MHPs were provided with a file that explains the Managed Care Organization (MCO) PCP calculation. The "floor" for the MCO PCP incentive payments is based on our capitation rate structure, which is slightly different from FFS, and therefore pays differentials that will not be identical to FFS. We are aware of the 99213 rate difference in the capitation vs. FFS fee schedule. In 2008, the amount built into capitation for 99213 was significantly higher than Medicaid FFS fee schedule. If plans did not raise primary care fee schedules in 2008/09 proportionally to the capitation increase (for primary care specifically), this may cause a gap between MHP paid amount to provider vs. what our starting floor was for the primary care differential. We have double-checked the calculations used to establish the PCP incentive base floor and they are correct, but we understand this may be a sensitive issue for the MHPs and provider communities. However, since this rate floor is based on the correct capitation amount that the State of Michigan paid to plans and matched against federal matching dollars, there may be no additional funding available to make providers whole for this "gap" amount if the contracted MHPs did not raise their base fee schedule.

9. What if groups feel that they should get to retain the primary care incentive payments? What if they feel that forwarding these payments to providers would violate provisions of the Stark law?

UPDATED*3Q14PC:** CMS has recently issued new guidance reversing prior interpretation. In some instances, groups with certain salary arrangements with providers may keep this revenue. Please see the L letter announcing this decision: http://www.michigan.gov/documents/mdch/L_14-34_464731_7.pdf.

After reviewing the portion of the question regarding Stark, we disagree and do not see any conflict between Stark and this provision of the ACA.

The PCP-IPP payments adjust existing, fully adjudicated and completed claims for only certain primary care services; therefore these "base" adjudicated claims are considered already complete and would not be a unique risk factor in the referral/self-referral or other Stark provisions. Assuming arguendo that any of the base encounter claim information related to a claim or claims that violated Stark provisions, such violation would have occurred separate from the supplemental payments under the PCP-IPP program. The flow-through payments up to Medicare levels is secondary to the base claim and based on State and Federal guidance that would seem to qualify the payments as sufficiently arms-length. Federal ACA guidance provides strict guidelines for payments based on services that have already occurred and verified through data files already submitted and adjudicated within state information systems.

Unless and until CMS changes policy in this regard, the PCP-IPP enhanced payments are to be considered separate from the base claims and the "full benefit" of these adjustments must go to the indicated rendering providers represented in the encounter claim data files.

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10. Should health plans pay sanctioned providers?

MDCH agrees that debarred/sanctioned providers should not get any of these payments when the provider is on the Sanctioned Provider List as of date of payment. MDCH has recognized this issue and sanctioned providers will be blocked going forward based on the most recent sanctioned provider list as of date of PCP incentive payment processing in all future quarters.

11. Have some of the PCP payments for the fourth quarter of FY 2013 been issued in error due to some claims being adjusted under FQHC/Local Health Department (LHD)/Rural Health Clinic (RHC)/Tribal Health Center (THC) protocols?

Yes. Some encounters were not marked with any FQHC identifier in encounters, but are still eligible for cost settlement as "look-alikes." There are similar issues with LHDs, RHCs and THCs. These will be blocked going forward using billing NPI information that will be provided by MDCH cost settlement staff. This appears to be the only method to identify the data. As of the first quarter of the FY 2014 pay cycle, MDCH has identified all known claims paid in the fourth quarter of FY 2013 pay cycle and has/will be sharing the data with all MHPs. MDCH asks that MHPs process recoupments as necessary and hold the funds. MDCH will then initiate a gross-adjustment off-set the week of July 1, 2014.

12. If a provider becomes eligible mid-year but had board certification in one of the eligible specialty categories prior to being marked as eligible in CHAMPS, what happens?

Providers who become newly eligible for the enhanced primary care rates will be eligible to receive the enhanced rates retroactively to January 1, 2013. Payment will be processed in future "look-back" adjustment cycles.

13. Are providers who are in the SNAF program eligible for the enhanced primary care rate payments?

No. Providers in SNAF are considered to be already eligible for enhanced rates that exceed Medicare, and therefore they must be excluded from the enhanced primary care provider incentive payments.