Fee for Service (FFS) Subcommittee
Meeting Minutes
February 11, 2015

Opening statements

Mr. Robert Gardner Ex-Officio Co-Chair and Bureau Director of the Bureau of Fee for Service Programs called the meeting to order at 10:05 AM, followed by introductions of the attendees. There were no objections to the previous meeting's minutes. A vote was taken and the minutes were approved.

Introduction of In-House Radiology

Mr. Gardner began by reviewing program changes that will occur as a result of the expansion of the Managed Care Organization (MCO) population, stating that due to this expansion the number of Radiology Medical Review requests has reduced in Fee-for-Service, however still remains a sizable entity, consisting of approximately 600,000 clients.

Prior to the MCO expansion the Bureau of Fee for Service Programs (BFFSP) outsourced Radiology Medical Review services to support a population size of approximately 500,000 to 600,000 clients per month. This has now reduced to approximately 100,000 clients per month due to the MCO expansion.

As of December 1, 2014 the contract for out-sourcing the Radiology services was up for renewal, and considering the massive decrease in clients needing this service in the BFFSP's population, extending the contract was not economical. Subsequently BFFSP brought these services in-house.

As part of this process, the Department added the imaging module to the existing McKesson Interqual CareEnhance Review Manager Enterprise Clinical Decision Support tool and acquired a Radiologist and additional Nurse Reviewers to support the requests.

Mr. Gardner continued by explaining that the BFFSP is in the process of trying to obtain a Prior Authorization portal that would allow providers to enter their own information in an effort for a more expedited approval or denial. Under this system nurses would have the authority to approve procedures. This will not change the requirement for the current process that requires physician review for denied services (including radiology).

Ms. Mary Ellen Corrum, Director of Practice Economics & Payer Relations for the Pennsylvania Medical Society offered to involve the providers she represents to

help to lobby the Department of Human Services (DHS) in an effort to forward the implementation of such a portal.

Similarly Mr. Robert Greenwood (Nonmember) Vice President of Finance and Insurance for The Hospital and Healthsystem Association of Pennsylvania (HAP) would strongly support such an effort by having the hospitals represented by HAP do what they can to help sway DHS in the portal purchasing decision. Mr. Gardner added that there may be a small provider fee to obtain a logon and password and added that the final decision would in all likelihood be tied to the budget later this year.

While not outlined in the agenda, Mr. Gardner offered comments related to Governor Wolf's plans for the Federal Medicaid expansion implementation. He stated that there will be a phased-in timeline that is driven by readiness of the information technology platforms. Each of the phases will likely be staggered through spring, summer, and fall. Mr. Gardner suggested that those who were interested should attend the upcoming MAAC meeting on February 26th when Mr. Ted Dallas, the Acting Secretary will outline the approach.

Mr. Gardner also suggested that subcommittee members and others in attendance should check the HealthChoices PA Expansion website www.healthchoicespa.com <http://www.healthchoicespa.com> often for changes as they will happen at an ever increasing pace.

The phased-in approach will help to ensure that recipients do not lose coverage by managing the Expansion implementation more efficiently. As such, coverage will continue (and overlap to a small degree) under the 1115 Waiver/ the previous Healthy PA program. As HealthChoices PA Expansion approaches, individual notifications and notices will be issued with a thirty day comment period. This process is necessary in order to safeguard federal match.

DHS is committed to conducting a seamless transition and has outlined our approach in a letter to CMS that explains that PA DHS is withdrawing the Healthy PA SPA, but will still seek Federal Funding for HealthChoices PA Expansion. This would include a transfer of all GA clients to one all-encompassing category by Spring 2015. The HealthChoices PA Expansion transition is expected to be fully complete by Fall 2015.

180 Day Projection and Update

Ms. Sarah Witmer, Division Director of Operations of the Bureau of Fee for Service, delivered an update and improvement points that have been made in the 180 day unit.

Prior to her presentation Mr. Gardner pointed out that at a previous meeting Mr.

Stan Slipakoff, Chief Compliance Officer of Healthcare Receivable Specialists Inc. offered a resolution in a PowerPoint Presentation as a way for the Bureau to get caught up on the 180 Day back log. After review it was determined that his suggestion was not feasible, but the gesture on his behalf was noteworthy and an example of the vision of this advisory subcommittee.

Ms. Witmer continued on with her report on the 180 Day presentation. One year ago there were two full time employees working 180-day exception requests with a back log of eight to nine months. This started to become costly for the hospitals and a concern for the department.

Having only two full time employees was not the only reason for the backlog. It should be of note that the system is an antiquated system and there is no money in the budget for a new system. It is not uncommon for it to take up to twenty minutes to make a final determination.

In order to pick up the pace the bureau borrowed a few individuals from other sections to spend partial weeks helping out, along with a full time data entry clerk. With this additional help the 180-day exception unit has been able to cut its backlog in half.

At the end of Ms. Witmer's presentation the subcommittee began a dialog on how they could advise their providers as to the best way to correctly bill claims initially in order to avoid them ever having to go through the 180 Day Exception Process at all. There seemed to be a general agreement by the members as the best way to cut down on the overall back log.

ACA Provider Enrollment

Ms. Barb Bardole, Provider Enrollment Specialist Supervisor for the Bureau of Fee for Service made it clear that ACA revalidation must be complete by March 24, 2016 for all provider types. Continuing, Ms. Bardole explained that perhaps their biggest obstacle in completing this goal will be providers who are negligent in sending in their revalidation information.

Ms. Kimberly Walk form the Ambulance Association of Pennsylvania and President of Ambcoach made a suggestion of sending out letters to all providers that if they fail to send in the needed information that they would be shut down. Ms. Bardole directed Ms. Walk and the rest in attendance to Bulletin 99-14-06 which does indeed explain the importance of getting the revalidation information in on time and once again explained that it does indeed include every provider type and all of their locations.

Further in an effort to ensure that providers are not only sending in their information but sending it in correctly the first time; Quick Tip 175 was issued in

December 2014 and made effective February 2015. It stipulates that the Enrollment department would no longer hold on to an application including revalidations that were sent in completely filled out or were incorrect, and that they would be sent back to the provider with instructions on how to correct the application or explain what documentation is missing. Providers must resubmit the entire revalidation package.

This is a timely process as every revalidation must be looked over manually. Once again in an effort to bring one of our departments up to speed and cut down on manual work hours, the enrollment department is looking into getting a portal that would allow providers to send in their necessary information, and the portal would auto check everything that is currently being done by hand.

Ms. Bardole reminded the group that not all applications are created equal. Applications vary in complexity depending on the provider type and can contain multiple service locations, which require more time when processing.
Mr. Gardner interjected at this point to make a plea to all of the members, who include representatives for a variety of different provider groups, to please ask their providers to provide accurate information for the service locations in their practices. He expounded that this includes correct information on service locations that are open as well as locations that have closed.

Mr. Greenwood asked for clarity concerning the separation of 01-183 clinics from the service location for the 01-010. He states there was confusion during the separation of these two provider types into unique service locations back in May of 2014 and asked if we could supply any clarification to the bulletins that had been issued.

Mr. Gardner responded by agreeing to help in getting any information out to hospitals that would help with enrollment getting the proper information especially concerning these provider types.

Ms. Bardole added that the providers were able to use either regular mail, email or a fax in order to deliver their information, but that they should only send items once, as it can become confusing when a provider sends in their information multiple times via more than one method. This duplication has causes extra work and can lead to confusion when processing applications.

In response to a query by Mr. Greenwood, Ms. Bardole explained that providers could send in emails with a read receipt so they would have insurance that their information was in fact received. However, she did make it a point to let everyone in attendance know that enrollment only had thirteen and half months to complete all revalidations and cannot personally contact every provider who submits information.

In conclusion Mr. Gardner reminded everyone that there were only thirteen and

half months to get the provider revalidations in to the enrollment department. He also made the suggestion that for the next Fee for Service Subcommittee meeting that the members should come for a visit to the hospital grounds to witness the operations of the Fee for Service facility.

Meeting adjourned at 12:01PM.