

<i>COMMUNITY CARE</i>		
POLICIES AND PROCEDURES		
PROVIDER RATE SETTING	Date Issued: 081309	Policy #ADM017 HCAL, HCYA, HCBK
Administrative	Date Reviewed:	Page 1 of 4

POLICY:

Community Care publishes base fee schedules for each HealthChoices network for most in-plan services, and individually negotiates rates with providers for residential services and some specialized services. Each base fee schedule is developed collaboratively with the primary contractor taking into account the strategic priorities for that specific network, with final approval given by the primary contractor. Negotiated rates are developed individually for each provider within the parameters set by the primary contractor for the specific network(s) in which the provider participates. This policy will be made available to providers within the Provider Manual and on the Community Care web site. Any updates, including issue of the original approved policy, will be sent to providers in the form of a Provider Alert.

PROCEDURE:

A. Community Care Rate Setting Process

1. For each HealthChoices network the base fee schedule is reviewed with the Primary Contractor on an annual basis in advance of the rate setting process with the Department of Public Welfare (DPW). This review process commences four to six months in advance of the upcoming program year. Utilization trends and strategic priorities for the network are reviewed and any changes proposed to enhance the network of care for members are included in the rate proposal submission to DPW for the coming program year.
2. Community Care seeks input from the provider community regarding priorities for base fee schedule rate change considerations in each network through its formal Provider Advisory Committees as well as through ongoing standing local meetings with provider groups in advance of the DPW rate setting process on at least an annual basis.
 - a. Providers may request changes to the base fee schedule at any time, however these requests are generally not considered on an individual basis but will be held and reviewed at the appropriate point for each network
 - i. The program year is January through December for the Allegheny and Chester networks; provider requests for rate consideration in these networks must be submitted no later than September 1st each year and will be reviewed prior to the start of the new program year
 - ii. The program year is July through June for the Berks, Carbon-Monroe-Pike, North Central and York-Adams networks; provider requests for rate consideration in these networks must be submitted no later than March 1st each year and will be reviewed prior to the start of the new program year

<i>COMMUNITY CARE</i>		
POLICIES AND PROCEDURES		
PROVIDER RATE SETTING	Date Issued: 081309	Policy #ADM017 HCAL, HCYA, HCBK
Administrative	Date Reviewed:	Page 3 of 4

- i. Identify a specific provider with whom to initiate the alternative reimbursement strategy
 - ii. Issue a Request for Qualifications (RFQ) to assess the ability of providers to respond and offer the service proposed within the scope of the alternative reimbursement strategy
 - iii. Issue a Request for Proposal (RFP) to solicit formal provider response to offer the service proposed within the scope of the alternative reimbursement strategy
 - iv. Notify providers of the implementation of an alternative reimbursement strategy including specific procedural and contractual detail related to the initiative
2. Community Care will seek direct input from providers and other stakeholder groups as appropriate in developing alternative payment arrangements. Community Care is committed to sharing with providers the basis financial assumptions involved in the calculation of the proposed alternative reimbursement strategy.

C. Provider Request Process for Rate Changes

1. Provider must submit a request for a rate change to its assigned provider representative in writing no later than four months prior to the initiation of the program year for the specific network (please see A.2.a). At a minimum the submission must include:
 - a. For a rate where there is an established Medical Assistance (MA) rate
 - i. a copy of the rate letter from MA
 - ii. a copy of all documentation submitted to MA in support of the rate request
 - iii. any available information demonstrating improved quality or outcomes for members related to the request
 - b. For a rate other than a rate set by MA
 - i. a detailed budget of projected revenue including payment from all other sources, if any
 - ii. a detailed budget of expenses including all direct and indirect costs
 - iii. any available information demonstrating improved quality or outcomes for members related to the request
2. Additional detail may be requested by Community Care if necessary to conclude a review of the request.

<i>COMMUNITY CARE</i>		
POLICIES AND PROCEDURES		
PROVIDER RATE SETTING	Date Issued: 081309	Policy #ADM017 HCAL, HCYA, HCBK
Administrative	Date Reviewed:	Page 4 of 4

3. If the rate requested is related to a new program or expansion of an existing program, submission of a service description is also required.
 - a. Providers may submit a service description in their own format or in the standard format used by Community Care
 - b. If the provider submits in their own format they must address all other points outlined in the standard Community Care format in a separate document
 - c. The Community Care standard format can be obtained from the provider's assigned provider representative

4. Community Care reviews requests for rate changes on an annual basis in conjunction with the rate setting process when there is adequate access or choice for members within the network as documented by geo-access, therefore providers should not expect a response to their request in advance of the start of the program year.

5. Community Care reviews requests for rate changes on an ad hoc basis if there is a change to adequate access or choice for members within the network as documented by geo-access; in these instances provider may expect a response once a determination has been made.