



KENTUCKY

Cabinet for Health and Family Services

Medicaid Managed Care Forums

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES

September 2015

AGENDA

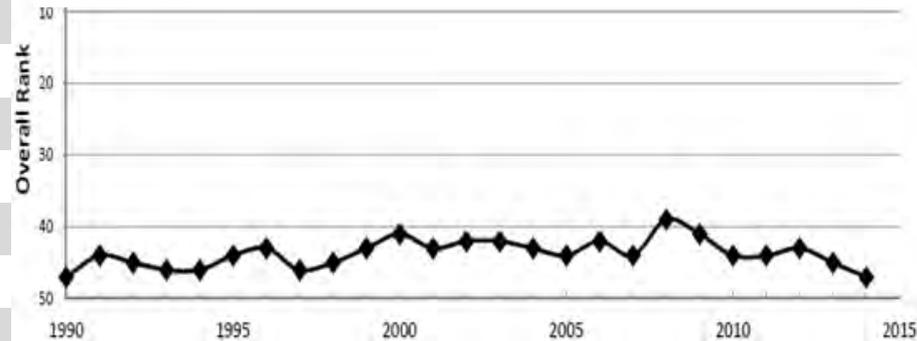
| | |
|--------------------|--|
| 7:30 a.m. | Registration |
| 8:15 a.m. | Welcome and Introductions Department for Medicaid Services Updates |
| 9:30 – 10:15 a.m. | Department for Public Health Update |
| 10:15 – 10:30 a.m. | Break |
| 10:30 – 11:30 a.m. | Department for Behavioral Health, Developmental and Intellectual Disabilities |
| 11:30 – Noon | Questions and Answers |
| Noon – 1:30 p.m. | Lunch (on your own) |
| 1:30 – 4:30 p.m. | MCO and Agency Breakout Sessions |

How Are We Doing?

KENTUCKY

RANK

| | |
|-------------------------------|----|
| POOR MENTAL HEALTH DAYS | 50 |
| CANCER DEATHS | 50 |
| PREVENTABLE HOSPITALIZATIONS | 50 |
| CHILDREN IN POVERTY | 50 |
| SMOKING | 49 |
| DRUG DEATHS | 49 |
| POOR PHYSICAL HEALTH DAYS | 47 |
| OBESITY IN ADULTS | 46 |
| UNDEREMPLOYMENT RATE | 45 |
| PREMATURE DEATH/100,000 | 44 |
| CARDIOVASCULAR DEATHS/100,000 | 43 |
| PHYSICAL INACTIVITY | 42 |
| LOW BIRTHWEIGHT | 38 |
| DIABETES IN ADULTS | 33 |
| LACK OF HEALTH INSURANCE | 28 |
| HIGH SCHOOL GRADUATION | 22 |



America's Health Rankings

2014

Medicaid at a Glance

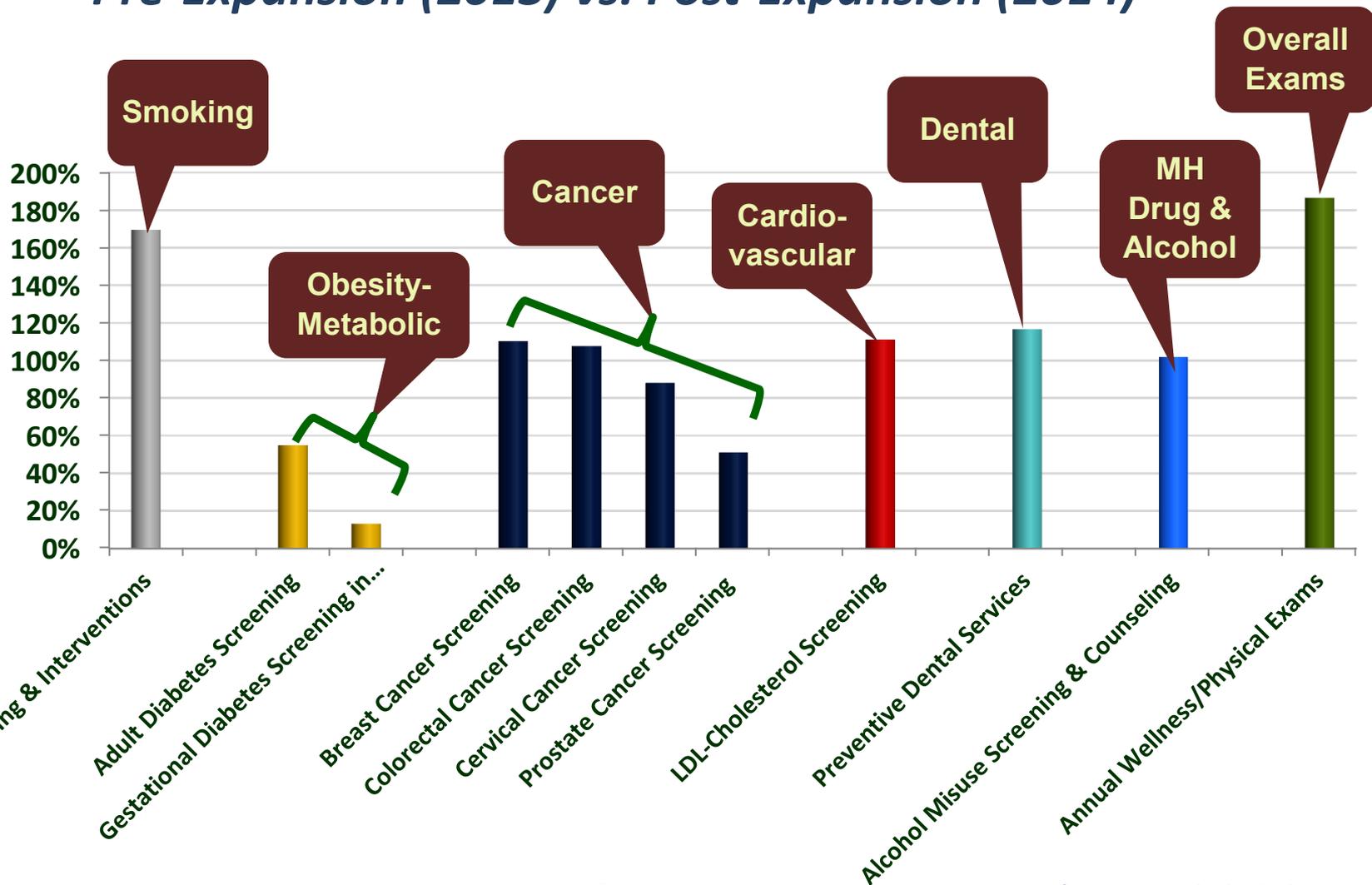
- 1.2 Million Members
- \$9 Billion Budget
- Managed Care Delivery System
- ACA Changes
 - ✓ Medicaid Expansion
 - ✓ Behavioral Health Delivery System
 - ✓ Expanded Provider Network
 - ✓ State Based Exchange – kynect
 - ✓ Streamlined Eligibility and Enrollment

Expansion Demographics

- Average age = 38
- Evenly distributed between males and females
- Health Status
 - High Cholesterol
 - Diabetes
 - COPD
 - Asthma
 - Depression

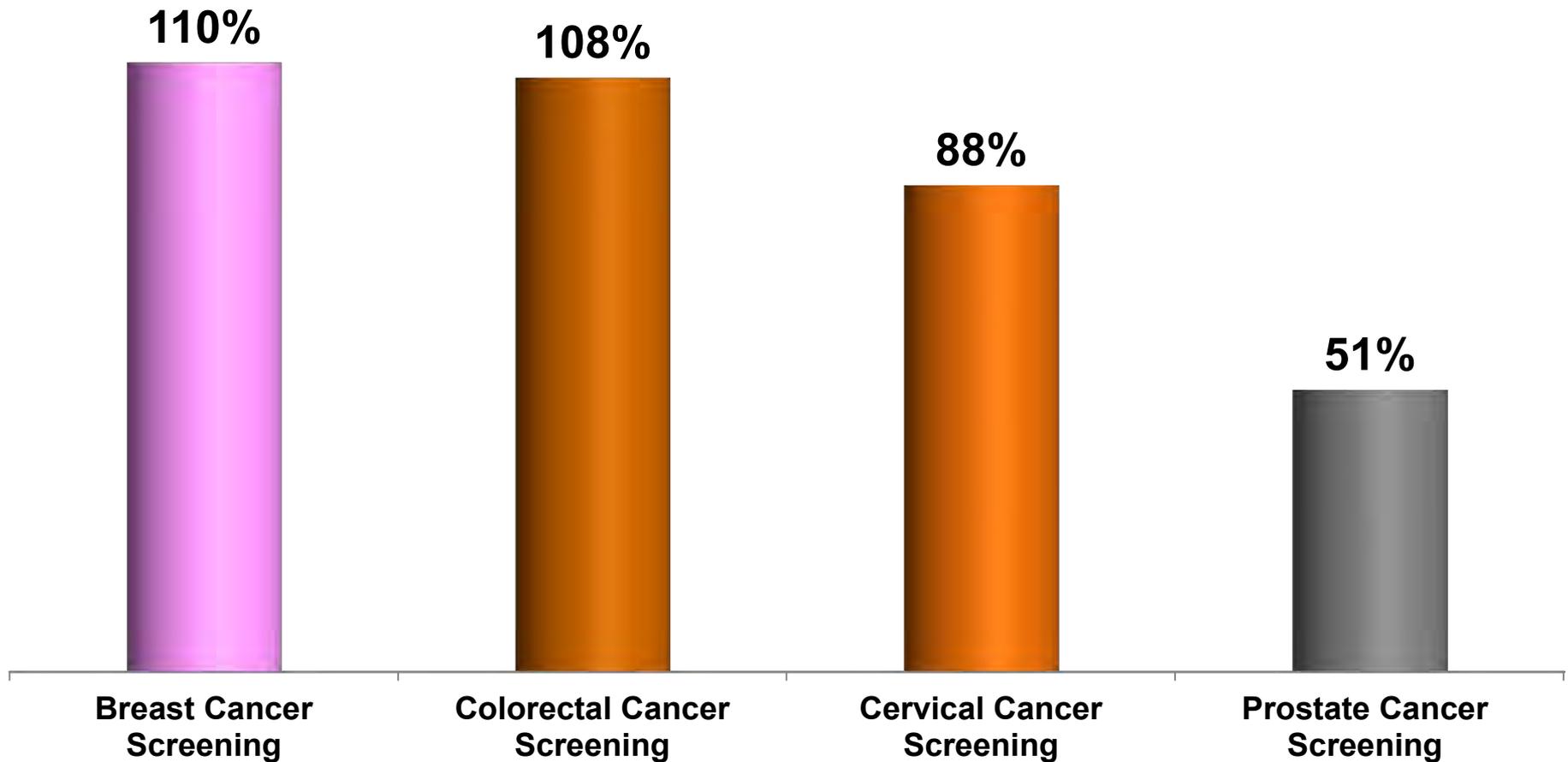
Overview of Selected Preventive Services

Relative *Increases* in number of Medicaid screenings
Pre-Expansion (2013) vs. Post-Expansion (2014)



Cancer Screening

Relative *Increases* in number of Medicaid screenings of selected Cancers Pre-Expansion (2013) vs. Post-Expansion (2014)



Medicaid Expansion Payments to Providers

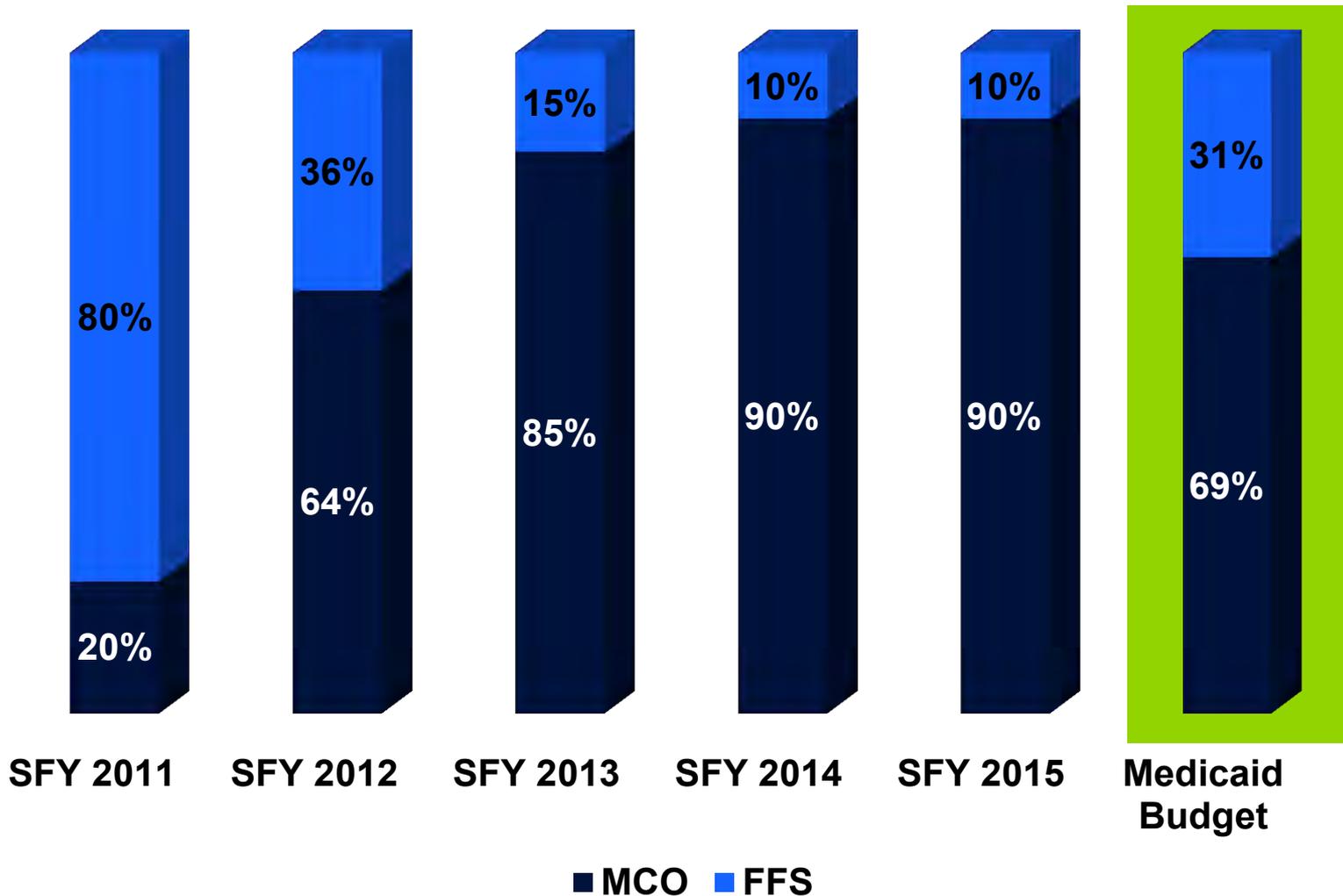
| Payments from 1/2014 through 6/10/2015 | | |
|--|-----------|----------------------|
| Hospital | \$ | 918,685,939 |
| Pharmacy | \$ | 487,054,134 |
| Physician, FQHC, Primary Care, etc. | \$ | 416,767,441 |
| Other | \$ | 119,947,655 |
| Dental | \$ | 44,605,246 |
| Behavioral health | \$ | 29,808,286 |
| Medical equipment | \$ | 24,810,524 |
| Total | \$ | 2,041,679,225 |

MEDICAID MANAGED CARE ORGANIZATIONS

Managed Care Overview

- Implemented November 1, 2011
- Must provide medically necessary services as outlined in Medicaid regulations
- Flexibility regarding prior authorizations and payments
- Flexibility to create value-added services
- Does not serve Medicaid members in long term care facilities or 1915(c) waivers

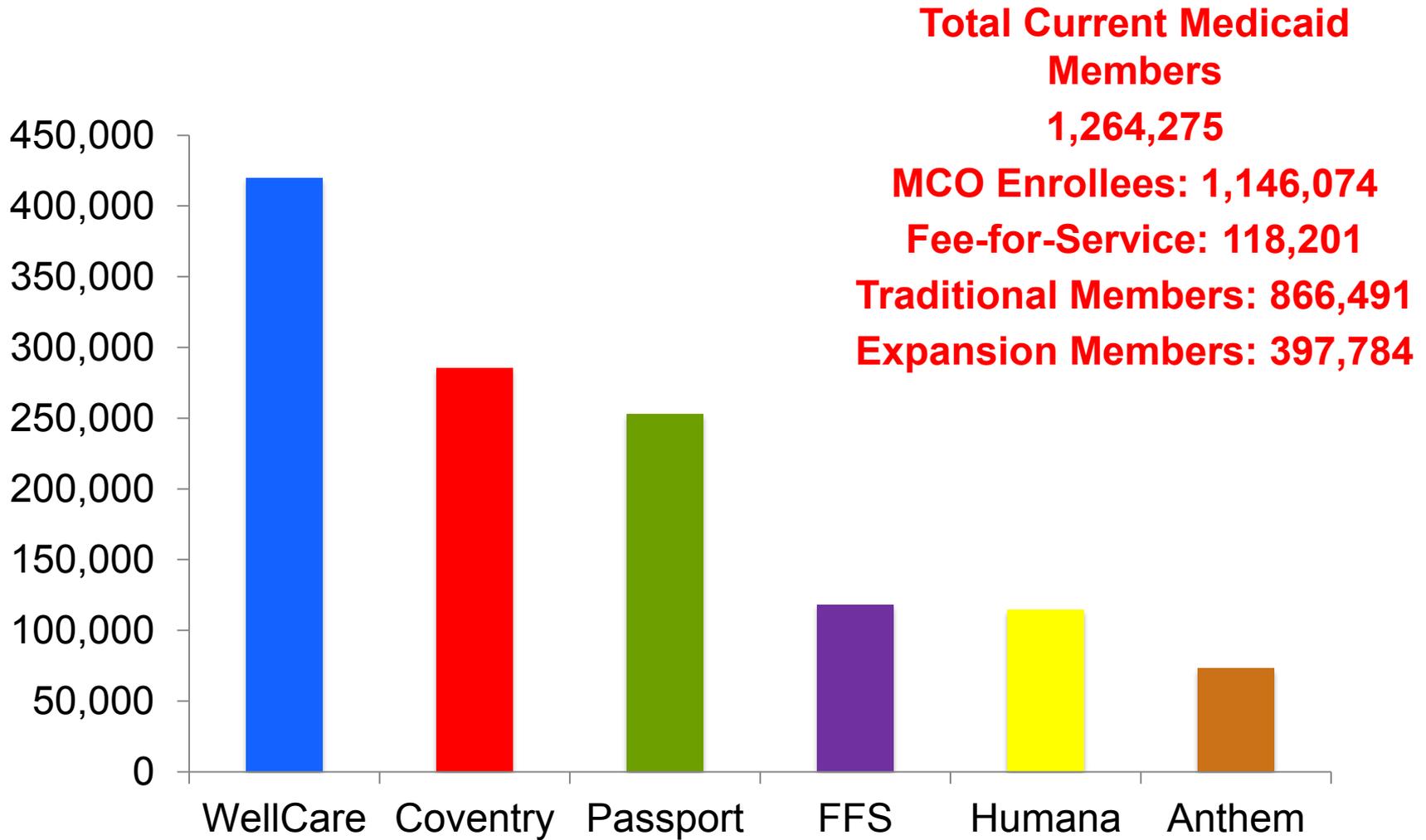
Membership and Budget Distribution



MCO Contracts

- Competitive Bidding Process in 2015
- New Contracts July 2015
- 5 MCOs Serving Medicaid Members
 - Anthem
 - Coventry/Aetna
 - Humana
 - Passport
 - WellCare

KY MEDICAID POPULATION



MCO Contract Changes

- Same contract for all MCOs.
- Statewide Coverage by all MCOs.
- Imposes a Medical Loss Ratio Requirement.
- Includes CMS mandated “risk corridor” for the ACA expanded Medicaid.
- Requires use of specifically named national standards to determine “medical necessity.”
- Provides for **ONE FORM** for a Member or a Provider to file an **appeal** with the MCO.
- Provides for **ONE FORM** to request **Prior Authorization** to the MCO.

MCO Contract Changes

- **MCO Credentialing of Providers must follow National Committee for Quality Assurance standards (NCQA).**
- **Increases access standards for behavioral health services.**
- **In order to be counted when determining whether an MCO's network meets access standards, the Provider must accept Medicaid Patients.**
- **Mandates more aggressive involvement of MCOs when persons with Severe Mental Illness (SMI) are being discharged from mental health hospitals.**

MCO Contract Changes

- **Strengthens the Penalty Section for MCO noncompliance.**
- **Creates a HEDIS Measures Incentive Program.**
- **MCOs must update their on-line provider networks within 10 days of a change.**
- **Provides clarification for Retro Eligibility and Prior Authorizations.**
- **Increases Oversight of Claims Denied for Medical Necessity.**

Open Enrollment

October 19 – December 11

Going Forward

- Deliver Better Care to Our Members
- Spend Our Dollars Wisely
- Have a Healthier Population
- Increase Our Health Rankings



PREVENTION
IS BETTER
THAN CURE



WORKING WITH KENTUCKY MEDICAID

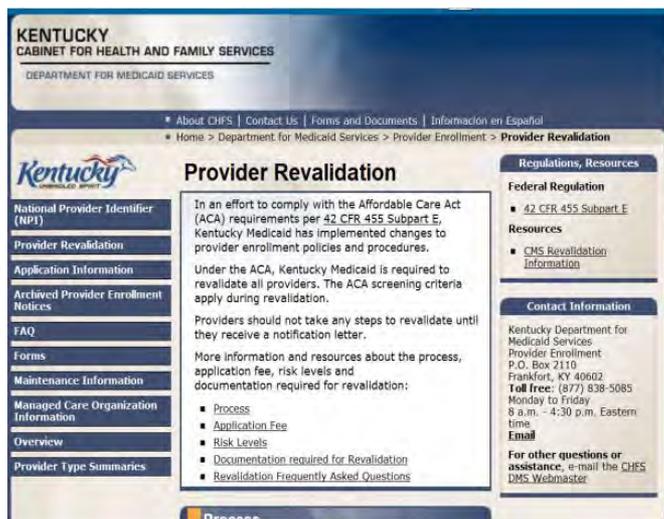
Provider Enrollment & Maintenance

RECENT CHANGES

- New MAP-811 Enrollment Application
- No more Annual Disclosure of Ownership
- No more KAPER-1 or Dental Credentialing Form
- 45-day processing for substance use providers

Enrollment Forms

- [MAP- 811 \(Enrollment\)](#) (rev. May 2015) **New** (with [MAP-811 Addendum E](#) - Direct Deposit Authorization/Cancellation Form - and verification of bank account/routing number such as voided check or bank letter if provider chooses to enroll in direct deposit)
- [MAP-900 \(Revalidation\)](#) (rev. May 2015) **New**
- [Map 347](#) - Statement for Authorization of Payment
- [MAP-347 Group Linkages](#) **New**
- [MAP 572A](#) - Private Auto Provider
- [Map 572B](#) - Foster Parent Provider Agreement
- [MAP-612](#) - Statement for Authorization of Payment (Physician Assistant)
- [MAP-811 Addendum E](#) - Direct Deposit Authorization/Cancellation Form - and verification of bank account/routing number such as voided check or bank letter if provider chooses to enroll in direct deposit
- [MAP-814](#) - EPSDT Special Services Short Form
- [MAP-4100A](#) - Acquired Brain Injury Waiver Program Provider Information and Services
- [Supports for Community Living Statement of Services to Be Provided](#)



The screenshot shows the 'Provider Revalidation' page on the Kentucky Medicaid website. The page includes a navigation menu with links for 'About CHFS', 'Contact Us', 'Forms and Documents', and 'Información en Español'. The main content area is titled 'Provider Revalidation' and contains the following text: 'In an effort to comply with the Affordable Care Act (ACA) requirements per 42 CFR 455 Subpart E, Kentucky Medicaid has implemented changes to provider enrollment policies and procedures. Under the ACA, Kentucky Medicaid is required to revalidate all providers. The ACA screening criteria apply during revalidation. Providers should not take any steps to revalidate until they receive a notification letter. More information and resources about the process, application fee, risk levels and documentation required for revalidation: Process, Application Fee, Risk Levels, Documentation required for Revalidation, Revalidation Frequently Asked Questions'. On the right side, there are sections for 'Regulations, Resources' (including '42 CFR 455 Subpart E' and 'CMS Revalidation Information') and 'Contact Information' (listing the Kentucky Department for Medicaid Services, Provider Enrollment, P.O. Box 2110, Frankfort, KY 40602, Toll free: (877) 838-5085, Monday to Friday 8 a.m. - 4:30 p.m. Eastern time, and an email link). At the bottom, there is a 'Process' button.

REVALIDATION

- All providers every five years
- Screening criteria according to risk level
 - Limited, Moderate, High
- Certain providers require Application Fee
- **Wait to receive a notification letter.**

Provider Enrollment & Maintenance

ANSWER ALL QUESTIONS ON THE FORM!

- If it does not apply, be sure to indicate **N/A**. Many of the questions do not apply to an individual.
- Do not answer a question and check N/A.
- We cannot assume the answer. It must be complete.

Common issues:

- Ensure the **entire legal name** is entered – no initials.
- Ensure the number listed is the Medicaid provider number for the provider that the form pertains to.
- Do not put NPI or Tax ID if it asks for Medicaid provider number.
- If an attachment is needed, make sure the **attachment is clearly labeled** with the question number and the **question** indicates “**see attached**”.
- Ensure the correct **taxonomy** is listed.
- **Sign the form**

Disclosure of Ownership

If a change in ownership **has** occurred per 907 KAR 1:671 Section 6(11):

Must be reported within 35 days.

Provider must re-enroll under the new ownership (**Map-811 Application**)

If a change in ownership **has not** occurred per 907 KAR 1:671 Section 6(11):

An ownership discrepancy statement must be submitted along with the **Disclosure of Ownership** explaining:

- What the changes are
- When the changes occurred

Ownership discrepancy statement must be signed by an individual owner. If there is no individual owner, an officer or board member must sign the statement.

Is it a change of ownership?

Provider is a Corporation

- It is **NOT** a change in ownership if there is a change in stockholders, board of directors, board of trustees, officers, or members.
 - Disclosure of change still required with a detailed statement describing the change and when it occurred.
- It **IS** a change in ownership if the corporation merges and original provider corporation ceases to exist
 - New application is required.
 - New provider number will be issued.



NOTE: We are not providing legal advice. Information is based on the CMS State Operations Manual. Determinations are very case and fact specific. Be sure to evaluate your circumstances independent of this information and seek private legal advice.

Is it a change of ownership?

Provider is a Partnership

- Removal, addition or substitution of an individual partner **IS** a change of ownership
 - New application is required.
 - New provider number will be issued.



Provider is a Sole Proprietorship

- **Any** change **IS** a change in ownership even if original owner is part of the new ownership.
 - New application is required.
 - New provider number will be issued.

NOTE: We are not providing legal advice. Information is based on the CMS State Operations Manual. Determinations are very case and fact specific. Be sure to evaluate your circumstances independent of this information and seek private legal advice.

Provider Enrollment & Maintenance

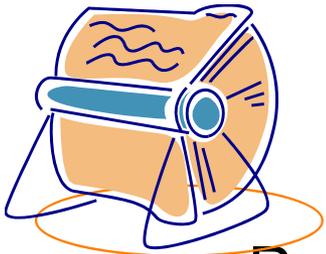
For more information or
to subscribe to a Listserve,
please visit:

<http://www.chfs.ky.gov/dms/provEnr/>

Provider Type Summaries

Subscribe to the new Provider Enrollment Listserv

If you are interested in
receiving e-mail notices on
Provider Enrollment, click
[here](#) to add or delete
subscriptions at any time.



CONTACT INFORMATION:

Provider Licensing and Certification Branch

1-877-838-5085

program.integrity@ky.gov

PROVIDER AUDITS

Provider Audits

Top Billing Errors

1. Incorrectly submitted ICD codes on hospital claims that lead to incorrect DRG grouping and incorrect reimbursement.
2. Readmissions that are submitted as separate admissions for reimbursement when the second admission that occurred within 14 days of the first admission is related to the first admission.
3. Incorrect calculations of physician injectable drugs that were administered in the physician's office. The conversion factor to calculate the units was either not used or applied incorrectly.

Provider Audits

Top Billing Errors Continued

4. Transfers of a patient from one facility to another without a discharge. These were incorrectly reimbursed due to failure to submit the accurate discharge status.
5. Claims that were incorrectly submitted with an inaccurate billable amount leading to excessive reimbursement from the usual and customary charge.
6. Claims submitted that did not follow the CPT coding guidelines, NCCI edits including allowed MUE, and regulation limits.

Top Billing Errors Continued

7. Duplication of the same service for the same day and recipient, such as Evaluation and Management codes or DRG duplications.
8. Duplication of lab tests between the lab, hospital and physician
9. Billing Medicaid as the primary insurance for services eligible for payment by Medicare when the member/recipient was dually eligible.

Provider Audits

Top Billing Errors Continued

10. Billing for add-on codes alone when the primary code is required to be billed in conjunction with the add-on.
11. Transportation claims that were submitted without an associated service. This is required by regulation that the transportation has medical treatment associated with the transport.
12. Durable Medical Equipment that was reimbursed greater than the regulations allows. Rented past 10 months without a conversion to purchased and rental payments not applied to the purchase when it finally was purchased.

Provider Audits

- Written dispute within 30 days of receipt. Calls to the Recovery Audit Contractor or KY Medicaid does not preserve the provider's right to appeal.
- Send complete documentation according to instructions.
- Payment Plan.

Why is my claim denied?

| Error | Description | Number of Denials | % of Top Ten |
|---------------|--|-------------------|--------------|
| 1010 | Rendering Provider Not A Mem Of Billing Grp | 20,045 | 18.0% |
| 4021 | No Coverage for Billed Procedure | 16,741 | 15.0% |
| 2017 | Services Covered Under Member's MCO Plan | 15,097 | 13.6% |
| 5001 | Exact Duplicate | 11,803 | 10.6% |
| 1036 | Rendering Prov Type/Claim Type Invalid | 9,783 | 8.8% |
| 3317 | This Service was not Approved by Medicare | 9,110 | 8.2% |
| 1955 | Cannot Determine Medicaid Nbr for Billing Prov | 9,028 | 8.1% |
| 2003 | Member Ineligible on Detail Date of Service | 7,075 | 6.4% |
| 268 | Billed Amount Mission | 6,881 | 6.2% |
| 4407 | Bnft Plan/Aid Categ Restriction for Cov Rev Code | 6,874 | 6.2% |
| Totals | | 111,414 | 59.0% |

MCO Prompt Pay Complaints

KY Department for Insurance
Medicaid Prompt Payment Compliance Branch

<http://insurance.ky.gov/Home.aspx>

1-800-595-6053, option 5 or 502-564-6106

DOI.MCOCCompliance@ky.gov

Changing Health Care Landscape



The Future

➤ Partner Portal – Kentucky Online Gateway



KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

▪ About CHFS | Contact Us | Forms and Documents | Información en Español
▪ Home > Department for Medicaid Services > **Kentucky Medicaid Partner Portal Application Information (MPPA) page**

Kentucky
UNBRIDLED SPIRIT

DMS Home

Kentucky Medicaid Partner Portal Application Information (MPPA) page

Kentucky Medicaid Waiver Management Application (MWMA)

Medicaid Assistance Program (MAP) Forms

Medicaid Enterprise Management System (MEMS) Procurement

Medicaid Tobacco Cessation Program

Programs and Services

Fee and Rate Schedules

Boards and Committees

Kentucky Medicaid Partner Portal Application Information

Welcome to the Kentucky Medicaid Partner Portal Application Information Web page. This page will serve as a one-stop resource for the latest information related to the Medicaid Partner Portal Project and its implementation.

More information:

- [What is the Medicaid Partner Portal Application?](#)
- [What is the project Focus and benefit?](#)
- [When will the Medicaid Partner Portal be implemented?](#)
- [Additional Questions?](#)
- [Additional Resource Links](#)

Please be sure to visit this page periodically as content will be updated on an ongoing basis.

What is the Medicaid Partner Portal Application?

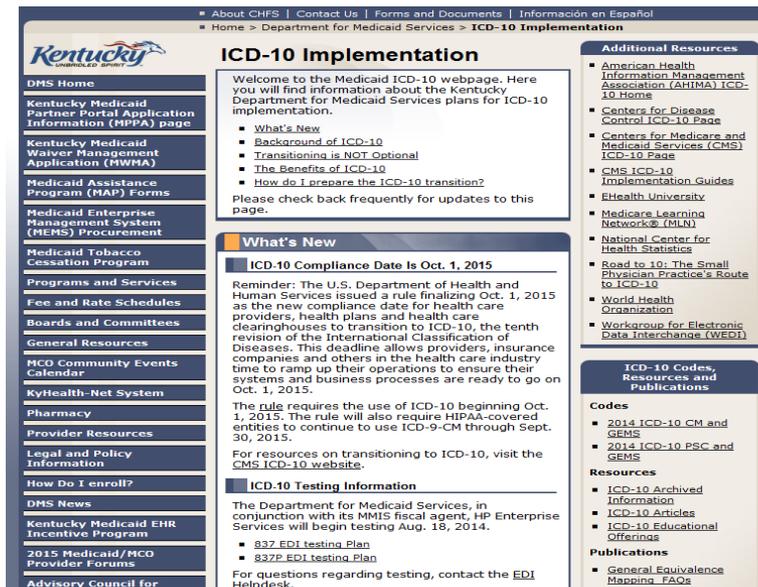
Additional Resource Links

- [New Partner Portal Onboarding Message](#)
- [Program Integrity](#)
- Coming Soon - Partner Portal Training Material

The Future

➤ ICD-10 – October 1, 2015

<http://www.chfs.ky.gov/dms/ICD10.htm>



The screenshot shows the 'ICD-10 Implementation' webpage. The main heading is 'ICD-10 Implementation'. Below it, a welcome message states: 'Welcome to the Medicaid ICD-10 webpage. Here you will find information about the Kentucky Department for Medicaid Services plans for ICD-10 implementation.' A list of links includes 'What's New', 'Background of ICD-10', 'Transitioning is NOT Optional', 'The Benefits of ICD-10', and 'How do I prepare the ICD-10 transition?'. A 'What's New' section highlights the 'ICD-10 Compliance Date is Oct. 1, 2015' with a reminder that the U.S. Department of Health and Human Services issued a rule finalizing Oct. 1, 2015 as the new compliance date. It also mentions that the rule requires the use of ICD-10 beginning Oct. 1, 2015, and that HIPAA-covered entities must continue to use ICD-9-CM through Sept. 30, 2015. A 'Resources' section lists 'ICD-10 Codes, Resources and Publications' and 'ICD-10 Testing Information'.

➤ Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability

A Proposed Rule by the Centers for Medicare & Medicaid Services on 06/01/2015

ACTION Proposed Rule.

SUMMARY

This proposed rule would modernize the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems. The proposed rule would align the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans; implement statutory provisions; strengthen actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promote the quality of care and strengthen efforts to reform delivery systems that serve Medicaid and

➤ CMS Proposed Rule for Medicaid Managed Care – July 27, 2015

Cabinet for Health and Family Services

State Innovation Model (SIM)

DESIGN

Challenges & Opportunities for



CMS' SIM Model Design Timeline and Deliverables

CMS has implemented a one-year performance period for the SIM Model Design initiative. Requirements for deliverables are outlined below.

| Deliverable | Due Date | Components of Submission |
|---|---------------------------------|--|
| Q1 Quarterly Progress Report | May 30, 2015 | <ul style="list-style-type: none"> • Quarterly progress report • Population health plan (Draft) • Driver diagram (Draft) |
| Q2 Quarterly Progress Report | August 30, 2015 | <ul style="list-style-type: none"> • Quarterly progress report • Value-based health care delivery and payment methodology transformation plan (Draft) |
| Q3 Quarterly Progress Report | November 30, 2015 | <ul style="list-style-type: none"> • Quarterly progress report • Health information technology plan (Draft) • Operational and sustainability plan (Draft) |
| Full Draft State Health System Innovation Plan | December 30, 2015 (Optional) | |
| Final State Health System Innovation Plan | January 31, 2016 | |
| Final Progress Report | April 30, 2016 | |

NOT TOO LATE TO PARTICIPATE

[About CHFS](#) | [Contact Us](#) | [Forms and Documents](#) | [Información en Español](#)
[Home](#) > [Office of Health Policy](#) > [State Innovation Model \(SIM\)](#) > [SIM Home Page](#)



Kentucky State Innovation Model (SIM)

SIM Stakeholder Meetings

Our stakeholder kickoff meeting was held Tuesday, March 17, 2015 in Frankfort. We witnessed robust stakeholder participation and established great momentum for the year ahead.

Stakeholder Meeting Presentations

[March 17, 2015](#)

[April 2, 2015](#)

[May 6, 2015](#)

[May 15, 2015](#) - Presentation by The Advisory Board Company for small and rural hospitals in Kentucky.

[June 9, 2015](#)

[July 8, 2015](#)

Upcoming Meetings

Please mark your calendar for our next full stakeholder meetings. No advance registration is required:

Our **August stakeholder meeting** will be held **Tuesday, Aug. 4, 2015 from 1-3:30 p.m.** at the **Kentucky Historical Society**, Brown-Forman Kentucky Room, 100 West Broadway, Frankfort. **Chris Koller, president of the Milbank Memorial Fund**, will speak on the topic of **Multi-Payer Primary Care Transformation**.

Navigation Menu:

- OHP Home
- Certificate of Need
- Health Policy Development
- Health Care Information Center
- Articles and Other Resources
- Olmstead Planning
- State Innovation Model (SIM)
 - Contact KY SIM
 - Email us
 - Workgroup Charters
 - [Payment Reform Workgroup](#)
 - [Integrated and Coordinated Care Workgroup](#)
 - [Increased Access Workgroup](#)
 - [Quality Strategy/Metrics Workgroup](#)
 - [HIT Workgroup](#)

<http://chfs.ky.gov/ohp/sim/>