HOSPITAL QUESTIONS

1) Question: How will the transition to MCOs affect my Disproportionate Share Hospital (DSH) payments?

Response: The Commonwealth will continue making DSH payments in the same manner as it has in the past i.e. these payments will be made annually by DMS in addition to the payments received for Medicaid hospital services.

2) Question: How will I get reimbursed for Graduate Medical Expenses (GME)?

Response: You will receive GME payments from DMS for Medicaid non-MCO patients as you have in the past and will receive GME payments from the MCOs for Medicaid Managed Care patients pursuant to the terms and conditions of your contract with the MCO.

3) Question: How will Critical Access Hospitals (CAHs) be paid under the MCOs?

Response: There are special provisions in the contract between DMS and the MCOs relating to CAHs payments. MCOs must pay CAHs in accordance with 907 KAR 10:815 which is approximately 101% of the Medicare payment rate.

4) Question: Under Medicaid Managed Care, will DMS continue to require hospitals to file cost reports?

Response: Yes, hospitals will continue to file cost reports with DMS. DMS will continue to cost settle for services provided to non-MCO Medicaid patients.

5) Question: Are MCOs required to use the same claim payment filing time standards as the Medicaid program?

Response: Yes, MCOs are required to allow providers to file a claim one year from the date of service.

6) Question: Are hospitals required to sign a provider agreement with the MCO(s) in order to receive payment from the MCO(s)?

Response: Yes. If the hospital wishes to participate in the MCOs provider network.

If a hospital does not sign a provider agreement with an MCO, the MCO is required to pay for the following services as an out-of-network provider;

- Care for which the MCO has approved an authorization for the Member to receive services from an Out-of-Network Provider;
- Emergency Care that could not be provided by the MCOs Network Provider because the time to reach the MCOs Network Provider would have resulted in risk of serious damage to the Member's Health;
- Services for children in Foster Care.

For Kentucky Spirit and WellCare, the above covered out-of-network services, reimbursement shall be no less than 100% of the Medicaid fee schedule rate until January 1, 2012 after which the rate shall be no less than 90% of the Medicaid fee schedule/rate.

For CoventryCares, the above covered out-of-network services, reimbursement shall be at 100% of the Medicaid fee schedule rate until January 1, 2012 after which the rate shall be at 90% of the Medicaid fee schedule/rate.

The MCO is not required to pay for hospital services except as identified above.

7) Question: Can an MCO require a provider to limit their participation with only one MCO?

Response: No. MCOs are prohibited from including exclusivity provisions in their contracts with providers.

8) Question: Are MCOs required to follow DMS' payment methodologies for reimbursement?

Response: MCOs may use any type of payment methodology or reimbursement system they choose. Special conditions apply for CAH, GME, IOA, Commission for Handicap Children, Public Health Departments and Urban Trauma payments.

9) Question: How will MCOs pay Primary Care Centers (PCCs) and Rural Health Clinics (RHCs)?

Response: MCOs are required to pay PCCs and RHCs no less than the rate that is paid to other clinic or primary care providers in the network. On a monthly basis, DMS will make estimated payments to cover what would have been paid under the prospective payment system. On a quarterly basis, DMS will conduct a reconciliation of the monthly payments taking into consideration encounter data submitted by the MCOs.

10) Question: Why is it important for me to sign a contract with the MCO since I have already signed a letter of intent?

Response: It is important for you to sign a contract with the MCO to be included in any provider directory and to be included as a network provider for purposes of determining adequacy of the MCOs network.

DMS will be making available provider directories to Medicaid Managed Care Members around August 25, 2011. In order for a physician or hospital to be included in the provider directory, the provider must have a contract with the MCO. Medicaid Managed Care members will be given a choice to keep their assigned MCO or to change their assigned MCO. DMS will provide Medicaid Managed Care members with a provider directory which will include participating physicians and hospitals to allow members to make an informed choice. To prepare the provider directory, MCOs must provide DMS a list of contracted providers by August 17, 2011, which will be available on-line or in a written format. **In order to be included in the provider directory, signed contracts must be received by the MCOs by August 15, 2011.**