CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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Janie Miller
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Neville Wise
Acting Commissioner

August 12, 2011

RE: Managed Care organizations
General Provider Letter# A-84

Dear Medicaid Provider:

This letter is intended to provide additional information and guidance relating to the expansion of Managed Care in the Kentucky Medicaid program.

As you are aware, the Department for Medicaid Services (DMS) has entered into contracts with three new Managed Care Organizations (MCOs) to provide services to Medicaid Members statewide beginning October 1, 2011. The new MCOs are CoventryCares of Kentucky, Kentucky Spirit Health Plan, and WellCare of Kentucky. These MCOs are in the process of establishing their Provider Networks and may have contacted you recently regarding participation in their respective networks.

Based upon the providers enrolled by the MCOs, DMS is developing a Medicaid MCO Provider Directory for members to use in making an informed choice about the MCOs. The provider directory will be available on-line and in a written format. To facilitate the completion of this directory, MCOs must submit their Provider Network files to DMS weekly on August 17, August 24, and August 31, 2011. In order for your provider name, address, and telephone number to be included in any of the MCO weekly provider files sent to DMS, and to be included in the Medicaid Provider Directory that will be made available to members, you are encouraged to review, sign and submit your provider agreement to the MCO(s) as soon as possible, but no later than August 29th. To ensure that your patients may choose among multiple MCOs and provide for continuity of care, you are encouraged to enroll with all three MCOs.

In the past several weeks, many of you have contacted the DMS by telephone or in writing regarding questions relating to the MCO Provider Networks and to express concerns relating to their enrollment of providers. Therefore, the DMS is taking this opportunity to share with you the most frequent provider questions relating to this issue and the Department's answers to those questions. These particular questions and answers, along with those originally enclosed in General Provider Letter – A-83, issued on July 22, 2011, will be posted on the DMS website at http://chfs.ky.gov/dms/default.htm.

We hope this information is helpful. If you have any questions relating to this letter or need additional information, please contact the Department for Medicaid Services at 800-635-2570.

Sincerely,

Neville Wise
Acting Commissioner
Department for Medicaid Services

Enclosure

Department for Medicaid Services
MCO Questions and Answers

General Questions

1) **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.

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

Response: Yes, if the provider wishes to participate in the MCO's provider network.

If a provider does not sign a provider agreement with a 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 MCO's Network provider because the time to reach the MCO's Network Provider would have resulted in risk of serious damage to the Member's health;
- Services for children in Foster Care; and
- Family Planning Services.

For Kentucky Spirit Health Plan and WellCare, reimbursement for the above mentioned out-of-network services 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, reimbursement for the above mentioned out-of-network services 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 out-of-network services except as identified above.

3) **Question:** Can an MCO require a provider to limit its participation with only one MCO?

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

4) **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 Critical Access Hospitals, Graduate Medical Expenses, Intensive Operating Allowance, Urban Trauma Center, Commission for Children with Special Health Care Needs and Public Health Departments.

5) 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 the Medicaid MCO provider directory and to be included as a network provider for purposes of determining adequacy of the MCOs network.

DMS will be making provider directories available to Medicaid Managed Care Members. In order 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.

DMS will also be reviewing and assessing the MCOs provider network for adequacy beginning September 1, 2011. Only contracted providers may be included in the adequacy assessment.

Physician Related Questions

1) **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.

2) Question: Were the KenPac payments included in the overall physician payments (in the data book), so that the MCOs should have factored this into their physician rates?

Response: No, KenPac fees were not included in the MCO physician data.

3) Question: Under the Affordable Care Act, (ACA) PCPs are to be paid 100% of the Medicare rate, which would be an increase compared to 100% of the Kentucky Medicaid rate.

Response: The ACA provides for the above physician fee increase in calendar years 2013 and 2014. DMS will increase funding to the MCOs to cover the increase in cost when final rules and Medicare rates are available.

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: What inpatient hospital services are included in the MCOs scope of services and payments?

Response: Every regular Medicaid hospital payment including acute care through the DRG system and providers payments for psychiatric and rehabilitation are included in the MCOs scope of hospital services and payments.

6) Question: How will hospital settlement payments be made for dates of services prior to October 1, 2011?

Response: It is the responsibility of DMS to make settlement payments pursuant to Medicaid regulations for dates of service prior to October 1, 2011, including the 95% outpatient hospital settlement payments.