

Medicaid Managed Health Care Mandatory Statewide Expansion Initiative

Health Plan Questions & Answers

Question #1: ODJFS has indicated that MCPs must have initiated the credentialing review before submitting any provider for approval. Please clarify the term, "initiated" for the MCPs. For instance, does that mean that a signed contract must be received? Or does primary source verification need to be started? Or does verification need to be completed?

Answer #1: ODJFS will accept a provider submission if the MCP has obtained a fully executed agreement from the provider and the MCP has initiated the credentialing process. ODJFS considers the credentialing process to be initiated upon the MCP starting the primary source verification process. The MCP must notify ODJFS within one day if a provider submitted to ODJFS subsequently does not meet the credentialing standards. Although ODJFS will accept provider submissions for providers that have not been fully credentialed, it is the MCP's responsibility to follow all applicable credentialing standards and ensure only credentialed providers are seeing members.

Question #2: Are MCPs still required to provide weekly status reports outlining the MCP's provider recruitment activities?

Answer #2: In the recent eight county specific procurement process, ODJFS monitored MCP's contracting activities and required MCPs to provide weekly updates of provider recruitment and contracting efforts. ODJFS will not require MCPs to submit weekly reports for regional managed care expansion contracting activities.

Question #3: I reviewed the RFA Regional Provider Panel Specifications as posted on the web and do not see any actual requirements for a minimum # of providers by county or region by type. Am I misunderstanding the material, looking at the wrong document or just too impatient?

Answer #3: The initial Regional Provider Panel Specification documents posted on the web were only samples and the specific requirements were not included. The web site has now been updated and the actual requirements are now posted.

Question #4: Does the state currently provide a case management fee to PCPs and, if so, how much?

Answer #4: ODJFS does not provide case management fees to PCPs under the traditional Medicaid fee-for-service program.

Question #5: To clarify, is the franchise fee to be assessed upon the MCP's premium payments of all its managed care business, or just the premiums of the Medicaid enrollees?

Answer #5: Pursuant to Ohio Revised Code Section 5111.176, effective January 1, 2006, all Medicaid-contracting MCPs must begin paying a quarterly franchise permit fee to ODJFS. This franchise permit fee represents four and one half percent of all of the managed care premiums that the MCP receives for providing or arranging for the provision of health care services to all of their Ohio members or enrollees.

Question #6: Our MCP has numerous participating providers currently located in an expansion county outside our existing service area. As we prepare them for PVS submission, can we go ahead and submit them now or should we wait for a later time? And, should we submit them on the new Medicaid Addendum, or can we use the older existing addendum?

Answer #6: Currently-contracting MCPs are only permitted to submit providers located outside of their contract service area if those providers are located in a Designated Alternative Provider Area. All provider submissions related to the statewide Medicaid managed care expansion RFA are to be submitted pursuant to the procedures and timelines that will be specified in the RFA expected to be issued in November 2005. See Question #7 for clarification on whether the new addenda are to be utilized.

Question #7: Is the following statement true? "Existing MCPs will not need to have currently contracted providers sign a new Medicaid Addendum unless the MCP wishes to provide coverage to the ABD population. In that case, providers would need to sign a new addendum and elect to serve the ABD population via Attachment A. ODJFS considers the "Counties of Coverage" paragraph on the old Addendum's Attachment A to provide sufficient detail in regards to the counties/regions in which MCP members may reside and still be seen by the provider executing the addendum."

Answer #7: If an MCP wants to utilize an existing contracting provider to provide services to MCP members in the entire region and/or if the MCP hopes to also be selected by ODJFS to serve ABD consumers, the MCP needs to ensure that the provider has agreed to do so in the Medicaid Addendum. MCPs will be responsible for determining if and when their current providers will need to sign the new Medicaid Addendum. However, the MCP must only submit such subcontract changes to ODJFS for hospitals or if there is a change to a PCP's capacity.

Question #8: It is noted that the Minimum Provider Panel requirement for hospitals in Cuyahoga County is one hospital system that includes fifty (50) pediatric beds and five (5) pediatric intensive care unit (PICU) beds. For purposes of meeting this requirement, can ODJFS clarify if the MetroHealth Medical Center qualifies as a "health system".

Answer #8: ODJFS defines a hospital system as two or more general hospitals that are covered under one provider contract.

Question #9: How frequently will the managed care contracts between the MCP and ODJFS be open for re-bidding?

Answer #9: ODJFS has no present plans to open the managed care contracts for this procurement process up for re-bid. However, ODJFS is committed to waiting at least three years before any re-bidding will take place.

Question #10: At what point will plans be able to submit applications for Medicaid provider numbers in the statewide expansion counties?

Answer #10: Currently-contracting MCPs are aware that ODJFS assigns county-specific Medicaid provider numbers to MCPs in order for them to submit provider panel information to ODJFS. All provider panel submissions related to the statewide Medicaid managed care expansion will be explained in the RFA, expected to be issued in November 2005. Since the statewide Medicaid managed care expansion is predicated on MCPs covering an entire region (i.e. group of counties), ODJFS will be issuing actual regional provider numbers to those MCPs selected through the RFA process. ODJFS will provide "dummy" regional provider numbers that plans will be able to utilize specifically for provider panel submissions in response to the RFA.

Question #11: As discussed at an expansion related meeting held recently by the BMHC, CNMs and CNPs (Certified Nurse Midwives and Certified Nurse Practitioners) will no longer be considered CORE providers and submitted on the PVS. Please explain the way we should go about addressing this; i.e. should we remove all existing CNMs and CNPs at this time through the regular PVS process; should we continue to maintain this data on the PVS until further notice from ODJFS; will ODJFS remove them on their end, etc.

Answer #11: Although CNMs and CNPs are both still federally-required provider types, for the purposes of the statewide expansion, ODJFS will no longer require MCPs to submit CNPs to ODJFS for approval. This decision was made in recognition of MCPs having no difficulty in contracting with more than adequate numbers of CNPs. However, ODJFS will continue to require MCPs to submit contract documentation for CNMs. The specific procedures and timelines for provider panel submissions will be included in the RFA, expected to be issued in November 2005. Currently-contracting MCPs are reminded that they are to continue to submit and maintain CNP data for counties presently served by the MCP.

Question # 12: Within the new Medicaid Addendums, Attachment B seems to indicate that a group practice may have a total capacity of 50 patients spread across the physicians within the group. Is that interpretation correct, or does each physician in the group need a minimum capacity of 50 patients to be submitted through PVS?

Answer # 12: ODJFS requires that **each** primary care physician (PCP) agree to serve a minimum of 50 members at each practice site in order to be approved by ODJFS as a PCP and included in the MCP's total capacity calculation. However, there are situations where a physician will only agree to serve as a PCP for very small number of the MCP's members. In these situations, the MCP may contract with the physician to provide primary care services to less than 50 members but the MCP would not submit that physician to ODJFS for approval as a PCP nor would the MCP list that physician as a PCP in its provider directory. These physicians will, however, still need to execute a contract with the MCP and the appropriate Medicaid Addendum.

Question # 13: The Fairfield County PCP Capacity listed under the Central Region has a capacity listing of 5,660 with the number of FTE's as 2.38. The number of FTE's should actually be 2.83, correct? CareSource is requesting clarification if needed on this but confirmation that we should use 2.83.

Answer # 13: Correct. This has been corrected on the PCP Capacity Requirement charts that are currently posted on the Bureau of Managed Health Care's website.

Question # 14: Does ODJFS plan on issuing reimbursements to plans for RHC's with the same methodology used as FQHCs in terms of wrap payments to the managed care payment?

Answer: ODJFS is federally required to ensure that Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) receive the same level of reimbursement for providing services to all Medicaid consumers, whether or not they are enrolled in an MCP. ODJFS requires MCPs to reimburse FQHCs/RHCs at the same rate they would reimburse a similar provider for the same services. O.A.C. rule 5101:3-28-07 provides the specifications on how FQHCs are to receive their supplemental payment from ODJFS. O.A.C. rule 5101:3-16-04 of the Ohio Administrative code enables RHCs to receive a supplemental payment in a manner identical to that of the FQHCs. MCPs are not to reimburse FQHCs and RHCs according to the Medicaid fee schedule for FQHCs and RHCs. The FQHC or RHC will bill ODJFS for the difference in the MCP reimbursement and the amount it would have received under the cost-based reimbursement system. This is frequently referred to as the “wrap around payment.”

Question # 15: How will local county health departments be affected by the expansion and Medicaid changes? In some circumstances, the local county health departments do not have full-time physicians on staff. If this is the case, will the health department be able to contract with the MCP? We have contacted a couple of northwest Ohio community health departments and they stated a belief that they are exempt from contracting with the MCP and they have been trying to get some clarification.

Answer # 15: Only Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) receive special consideration under the Ohio Medicaid managed care program. County health departments are treated like any other health care provider. County health departments may contract with a managed care plan (MCP) to provide primary care services to the MCP's Medicaid members if they meet all of the applicable PCP credentialing requirements set forth by ODJFS and the MCP. If a county health department is not contracting with an MCP, thus an out-of-network provider, the MCP will require prior authorization for a Medicaid member to receive services from the county health department and may deny payment for unauthorized services.

Question # 16: Will ODJFS require PVS submission of core providers who are located outside of the state of Ohio?

Answer: MCPs will only be permitted to submit out-of-region hospitals required to meet the minimum provider panel requirements or to receive bonus points in the Request for Applications process. No other out-of-region providers are to be

submitted to ODJFS. However, this in no way prohibits an MCP from contracting with out-of-region providers.

Question 17: If an MCP contracts with a vendor for BH, vision and dental services, do we have to submit the vendors signed contracts for the network that they have developed to ODJFS as a part of the network adequacy approval process? If yes, can those vendor types submit LOAs or do MCPs have to submit their fully executed contracts?

Answer: If an MCP contracts with a third-party administrator (TPA) for behavioral health, vision or dental services and the contract provides for both the direct delivery of health care services and the delegation of the MPC's administrative duties, (credentialing, utilization review, claims payment, etc.) the MPC's contract with the TPA must include the Medicaid Combined Services Addendum executed as part of the agreement. Section #20 of the Medicaid Combined Services Addendum requires that the TPA include all elements of the addendum and/or OAC rule 5151:3-26-05(D) in any sub-agreements with providers. Thus, it is not sufficient that the vendor has LOAs or LOIs with providers, actual contracts with the required terms must be executed. The Combined Services Addendum also requires that a listing of all of the providers covered by the agreement be included as part of the addendum. It is not necessary to submit copies of the TPA's sub-agreements with the individual providers covered by the agreement to ODJFS. It is the responsibility of the MCP to ensure that every provider covered under the agreement with the TPA has the required contract with the TPA and that every provider has been properly credentialed.

Question 18: On your Website there is an Adobe file that shows the Fee For Service payments by code for providers. It is labeled as Appendix DD to rule 5101:3-1-60. Is this file available in Excel? It would be very helpful to us for negotiations as we develop our provider network to have this file in Excel and we weren't able to convert it with its current format.

Answer 18: No. We have contacted the area that produces this information and it is not available in any other format at this time.

Question 19: Is it possible to get an Excel file that shows membership population data by zip code, gender and age? This will help allow us to ensure we are building our network to meet the individual needs of each unique geographic area. We did receive the file that shows CMC eligible counts by county.

Answer 19: No. As it was explained at the September 20, 2005 Applicants' Conference, the information that was included on the CDs is the only format that this information is available.

Question # 20: Is it acceptable to have providers sign a Letter of Agreement (LOA) and the Medicaid Addendum or is an actual contract required?

Answer # 20: MPCs must have providers sign the MPC's baseline contract and the appropriate Medicaid Addendum. Letters of agreement or intent are not sufficient and no exceptions will be made.

Question # 21: Can you please provide a list of covered benefits?

Answer # 21: The Medicaid covered services are available in Appendix G of the ODJFS MCP Provider Agreement, available at:

http://jfs.ohio.gov/ohp/bmhc/documents/pdf/GenericPA_SFY_06.pdf

Additional information on the Medicaid Covered Services is available on the ODJFS Electronic Manuals, available at:

<http://emanuals.odjfs.state.oh.us:80/emanuals/medicaid>

Question # 22: Several hospitals have indicated to us that they are not contracting with anyone at this time because they do not want to sign contracts with 18 bidders when they know only 3 will be successful. Instead, the hospitals want to wait and contract only with the plans that are awarded business from the state. If the managed care plan documents attempts to contract with each facility, will ODJFS recognize this and will it be sufficient for the RFP submit all? If not, what incentive can ODJFS implement to encourage participation by the hospitals. Some states have implemented rules whereby providers that do not contract after 3 legitimate attempts have been made, can be paid less than Medicaid as an incentive for the provider to contract. Will ODJFS consider this method?

Answer: Two Ohio Administrative Code change proposals (OAC rule 5101:3-26-03 and OAC rule 5101:3-26-05) are expected to become effective on January 1, 2006 to address situations where hospitals refuse to contract with Medicaid managed care plans. These rule changes were proposed in response to Amended Substitute HB 66, which mandates that all Covered Families and Children (CFC), with limited exceptions, and certain Aged, Blind and Disabled (ABD) Medicaid consumers be enrolled in the full-risk managed care program. The OAC rule proposals may be viewed at the Register of Ohio website at <http://www.registerofohio.state.oh.us/>.

Question # 23: With the statewide expansion, will ODJFS begin using regions in place of counties in 2006, and if so-will MCPs begin to receive members (in 834 files) with a Medicaid Provider number that tie to a particular region?

Answer # 23: ODJFS will be using regions for the statewide Medicaid managed care expansion and the member files ODJFS provides to MCPs will tie members to the region where they reside.

Question # 24: We are trying to find out what Ohio Medicaid pays Holzer Clinic. We have been led to believe that they receive an amount higher than the regular fee-for-service rates. Is this correct?

Answer # 24: The Ohio Medicaid FFS program reimburses Holzer Clinic pursuant to the criteria outlined in Ohio Administrative Code rule 5101:3-1-60.1. Our understanding is that Holzer Clinic is the only provider that has submitted documentation to ODJFS demonstrating that they meet the criteria set forth in this rule. Holzer Clinic is not classified as an FQHC or an RHC so there are no applicable supplemental payment provisions.

Question # 25: Has ODJFS made a determination on whether the new Commercial Activity Tax (Reference HB 66 or Sec. 5751.01) will be levied on Medicaid Health Insuring Corporations? If this new tax on premiums does apply to Medicaid Plans, does ODJFS intend to include this new tax in the rate development in order to be bottom line neutral to the Medicaid plans?

Answer # 25: The only tax that resulted in a direct adjustment to the capitation rates received by managed care plans was the Medicaid managed care franchise fee. ODJFS does not make the determinations as to whether or not the Commercial Activity tax applies to Medicaid managed care plans.

Question # 26: The Medicaid Addendum says that "providers providing...services to Vendor's members enrolled pursuant to a Medicaid Agreement..." This seems to suggest that the Vendor should have a separate Medicaid Agreement that this would attach to (and as such it is called a Medicaid Addendum). As you are probably aware, carriers and vendors call their base contracts with their providers different things. In situations where the carrier/vendor has a base agreement called something other than "Medicaid Agreement" - could we change the language in the Addendum to reflect the accurate name? For instance, if the base agreement is called a Provider Participation Agreement, could we substitute the words "Medicaid Agreement" with the words "Provider Participation Agreement"?

Answer # 26: The second sentence on page 2 of the model Medicaid Addendum provides:

“Participating providers providing health care services to (MCP Name’s) members enrolled pursuant to a Medicaid Agreement agree to abide by all of the following specific terms:”

The term “Medicaid Agreement” references the contract between ODJFS and the MCP, which enables the MCP to provide comprehensive health care services to Medicaid consumers through the Medicaid managed care program. Thus, Medicaid members are enrolled in the MCP pursuant to the Medicaid Agreement between ODJFS and the MCP. The “Medicaid Agreement” in this context is not referencing the baseline contract between the MCP and the provider subcontractor. Changing the term “Medicaid Agreement” to “Provider Subcontractor Agreement” in this context would change the meaning and intent of this provision to the extent that the Medicaid Addendum would be invalidated.