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KANCARE PROVIDER REIMBURSEMENT

Three managed care organizations (MCOs)—Aetna, Sunflower Health Plan, and United Healthcare—contract with the State to provide Medicaid services to eligible individuals under KanCare. Each MCO is paid a monthly rate by the Kansas Department of Health and Environment (KDHE), the agency that administrates Medicaid for the State of Kansas. Each MCO uses these funds to contract with, and reimburse, hospitals and physicians for the services they provide to Medicaid beneficiaries. This memorandum describes certain guidelines surrounding provider accessibility and payment, as well as the way MCOs are paid by the State.

Provider Requirements

Although Medicaid is administered by the State, the program is required to meet federal laws and regulations. One such law instructs states to cover a prescribed list of services as part of their state Medicaid programs. Examples of required services include inpatient and outpatient hospital, laboratory, and immunization services. Kansas is authorized to add to the list of required services, and each MCO is contractually obligated to provide all required services to individuals statewide. In addition to these required services, MCOs can provide value-added services, or services that the MCO chooses to add in addition to those required by the State. Because each MCO has the option to add its own value-added services, the range of covered services often differs among MCOs and from year to year. Examples of value-added services include hospice, chiropractic, and occupational therapy services.

MCOs contract with a variety of medical providers across the state to provide both mandatory and value-added services. Federal regulations require each MCO to "maintain sufficient provider networks to provide adequate access to covered areas for all enrollees,"[1] making it necessary for MCOs to sustain a comprehensive provider network. In 2016, the Centers for Medicare and Medicaid Services (CMS) issued a final rule requiring states to establish network adequacy standards. These include establishing time and distance standards for access to services and an annual assessment of the adequacy of each MCO in meeting these standards.[2] As part of this ongoing monitoring, KDHE requires each MCO to submit a quarterly Geographic Mapping Report that outlines the location and specialties of their statewide provider network. These reports are published on the KanCare public website.[3]

1 https://www.medicaid.gov/medicaid/downloads/adequacy-and-access-toolkit.pdf

2 https://www.medicaid.gov/Medicaid/downloads/strengthening-the-consumer-experience-fact-sheet.pdf

3 https://www.kancare.ks.gov/policies-and-reports/network-adequacy

Provider Reimbursement

Medical providers who provide services to Medicaid beneficiaries are reimbursed directly by the MCOs with whom they contract. MCOs are contractually obligated to reimburse providers at or above the fee-for-service Medicaid rate set by the State, a list of which can be found on the KanCare website. While the State sets and requires each MCO to pay this minimum reimbursement rate, MCOs have the ability to negotiate with providers. These negotiations, which do not involve the State, can result in varying reimbursement structures and rates among MCOs.

In most cases, providers are reimbursed on a fee-for-service basis based on the services they provide to each beneficiary. For example, a doctor provides a service, submits a claim for that service, and is reimbursed by the MCO.

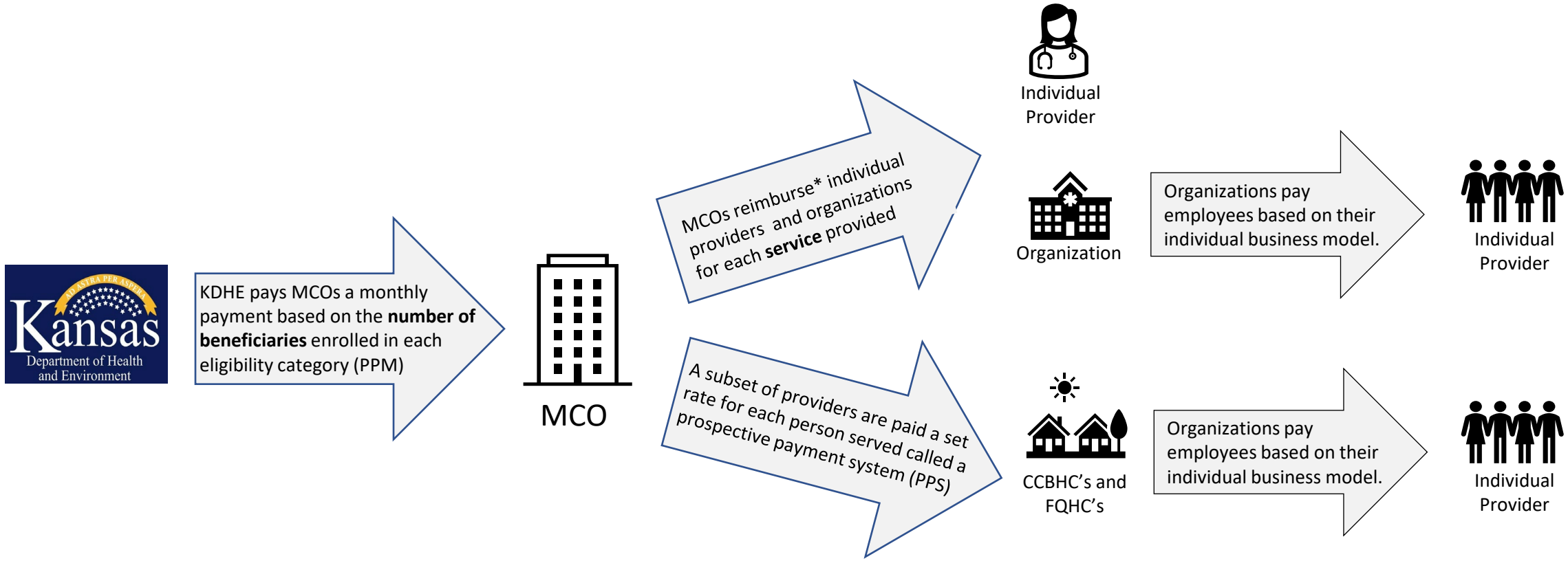
Certain facilities, such as federally qualified health centers (FQHCs) and certified community-based health centers (CCBHCs), instead use a prospective payment system (PPS). Under a PPS, facilities are reimbursed a set rate for each individual served. This rate is based on the average cost per person at each specific health center, so the rate will vary from one facility to the next. The State has authority to establish either a daily or a monthly pay rate and reestablishes the rate on a yearly basis.

MCO Rates

MCOs reimburse providers using funds provided by KDHE. KDHE pays each MCO a set per-member per-month rate as specified in their contracts. Each monthly payment is based on the number of individuals enrolled in each eligibility category that month and the anticipated services they will require, including pharmaceuticals. This is referred to as a capitated rate.[4]

When establishing the rates at which MCOs are paid, KDHE must comply with federal regulations that require such rates to be developed in accordance with accepted actuarial practices and certified by qualified actuaries.[4] This means that rates must be high enough to attract a provider base that can meet contractual requirements for availability and accessibility of services. KDHE's actuaries review the MCO rates on a regular basis and adjust rates as needed to ensure that they remain actuarially sound.

4 https://www.macpac.gov/subtopic/medicaid-managed-care-payment/



- Each MCO develops its own provider reimbursement rates but must reimburse at or above a minimum rate that is determined by the State. The Medicaid program is jointly funded by the State and federal government. The ratio that each pays changes on an annual basis in accordance with the Federal Medical Assistance Percentage.

- Acronym Guide
  - MCO – Managed Care Organization
  - CCBHC – Certified Community Behavioral Health Clinic
  - FQHC – Federally Qualified Health Center