Q&A Summary for Basics of Contracting with Medicaid and MCOs, 11/23/15

#	Questions	Answers
1.	Are there models that exist where a group of ASOs/CBOs within a region engage a Third Party Administrator to centrally process their claims to Medicaid and other insurers?	Yes, there are such models. For example, the AIDS Foundation of Chicago serves as the prime contractor and third party administrator for ASOs/CBOs contracting to provide services to HIV positive and other beneficiaries enrolled in Medicaid managed care organizations (MCOs) and other insurers. Similarly, third party administrators are commonly engaged by groups of independent medical practices who join together to negotiate joint contracts with third party administrators. It is important in seeking the services of third party administrators to be aware, however, that ASOs and CBOs must provide services covered by Medicaid or other insurers, as well as to complete the paperwork required to participate in those insurers' provider networks.
2.	I work in a Detroit ED and have been told that Medicaid is not covering public health screenings. Has any emergency departments with HIV screening been successful in getting Medicaid to reimburse for HIV screening costs?	State Medicaid programs generally cover HIV screening services conducted in emergency departments (EDs), with screening defined as the collection of specimens and lab assays. They may also pay for HIV rapid test kit costs in some states. The clinician time is also commonly included as part of the overall ED visit payment rate. Increasingly, healthcare facilities and EDs specifically are computing their ED visit costs and negotiating "bundled" ED visit costs that include phlebotomy, lab, clinical, and related services into a single charge. Where we are finding challenges in encouraging EDs to initiate or expand HIV screening, is in circumstances where the ED and/or healthcare facility has not included HIV screening in their calculation of the bundled ED visit rate. Since the rate does not reflect cost assumptions about routine HIV testing, the facility and/or ED would not be compensated for those costs. Lack of inclusion of HIV screening costs has been presented by the EDs as the rationale for not conducting HIV screening. Thus, the burden is on EDs to re-compute and renegotiate their bundled rates to ensure adequate compensation for HIV screening.
3.	If we bill Medicaid for MCM services, are we required to charge self-pay patients?	Billing for MCM services for insured individuals is unrelated to billing for self-pay patients. What is relevant, however, is charging self-pay patients receiving services via the Ryan White HIV/AIDS Program (RWHAP). In this case, we would define "self-pay patients" as individuals who are not enrolled in Medicaid. Charging out of pocket fees for MCM should be consistent with RWHAP sliding fee requirements

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		and the policies of the RWHAP grantee for which your agency contracts for services. If your program is funded by Parts A or B, we suggest that you request written guidance from your grantee. If your agency receives Parts C or D funds, you should check with your HIV/AIDS Bureau (HAB) project officer for further guidance.
4.	Who can submit the disease management code S0315? It is covered by Maryland Medical Assistance through the state and the MCOs with authorization. Can this code be used by MCMs or only medical providers?	We recommend that you contact Maryland Medical Assistance staff for further guidance regarding appropriate billing for disease management services and the credentials required for provision of these services.