KENTUCKY ASSOCIATION OF HEALTH PLANS

House Bill – 8
Ambulance Provider Payment Implementation

May 2021

House Bill 8 - Overview

Background

Timeline

Process & Coordination

Questions

House Bill 8 - Background

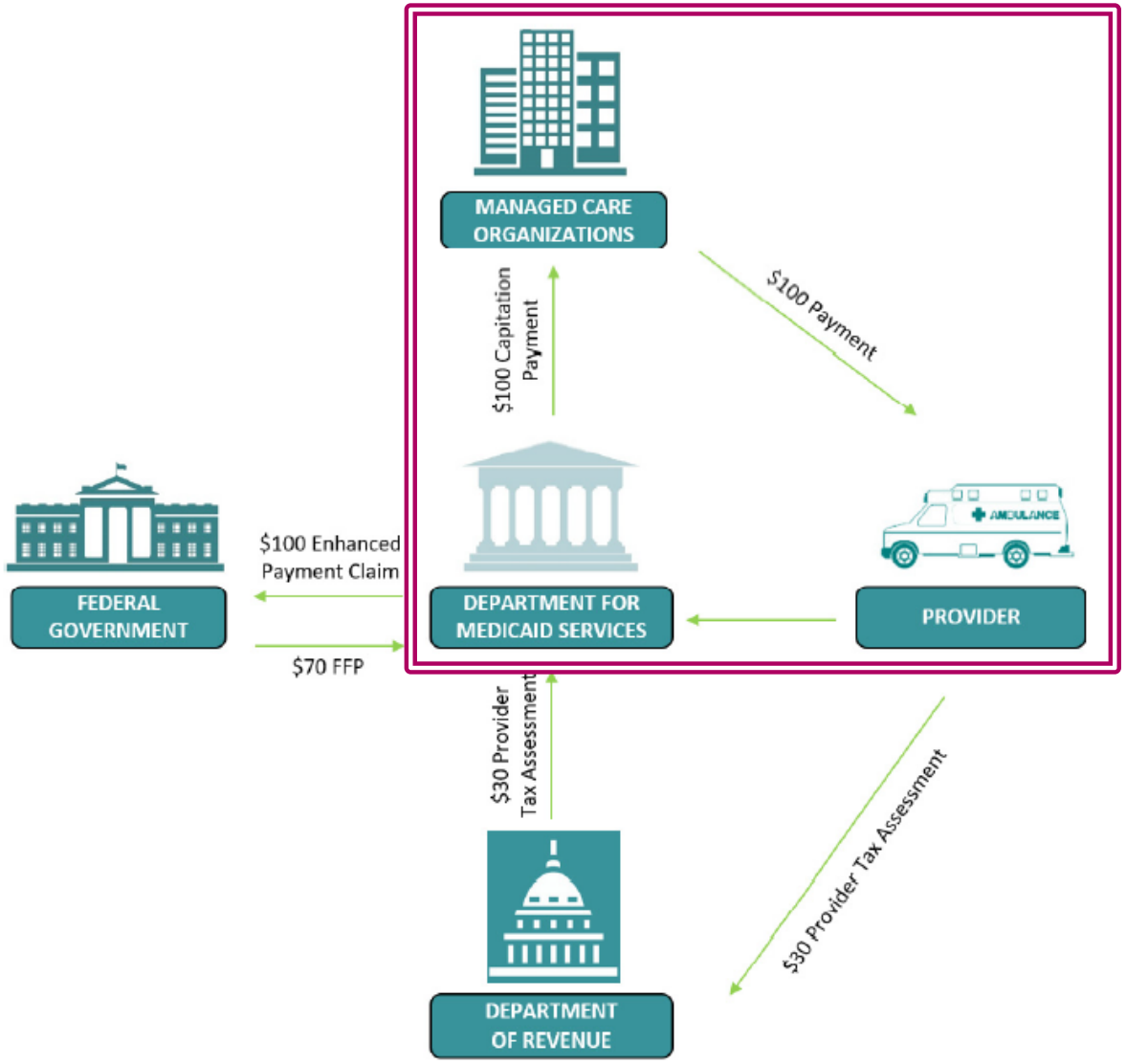
KY House Bill 8

- Passed in the 2020 legislative session.
- Authorizes enhanced payment programs for FFS and MCO ground ambulance services.
- Ground ambulance provider is defined as Classes I – III by KRS 142.301
- Reimburses up to available provider tax funding

Goals of APAP Program

As a result of the new directed payment financing mechanism, KY stakeholders elected to leverage this opportunity to achieve the following goals:

- Provide enhanced reimbursement for qualifying ground transports
- Promote access to high quality care and reduce unnecessary spending



House Bill 8 - Timeline

Date	Responsible Party	Event
March		
3/31	CMS/DMS	CMS approval received for the 2021 State Plan Amendment
April		
4/1	CMS/DMS	CMS approval received for the 2021 Preprint
4/15	Provider	6/30/20 GEMT revenue surveys due
4/30	MSLC	Send 2021 revenue/tax amounts to DOR
May		
5/1	DMS/MCO	DMS work with MCOs to set up payment system
June		
6/1	DMS/MCO	Estimated 1st enhanced payment due to providers (6 months of payments)
6/15	MSLC	Begin draft of 2022 preprint/SPA, interim per-transport add-ons, and fiscal impact modeling
July		

Time is of the essence. Provider and MCO's have until June 1st to complete all required contracting and connectivity processes prior to the first payment.

House Bill 8 – Process & Coordination

Steps Required to Complete Contracting

- ❑ Execute and submit the MCO Payment Agreement
- ❑ Submit a valid IRS W-9 Form w/ Tax Identification Number
- ❑ Validate and/or Enroll in MCO Electronic Payment Process
- ❑ Process will vary by MCO for ACH/EFT enrollment

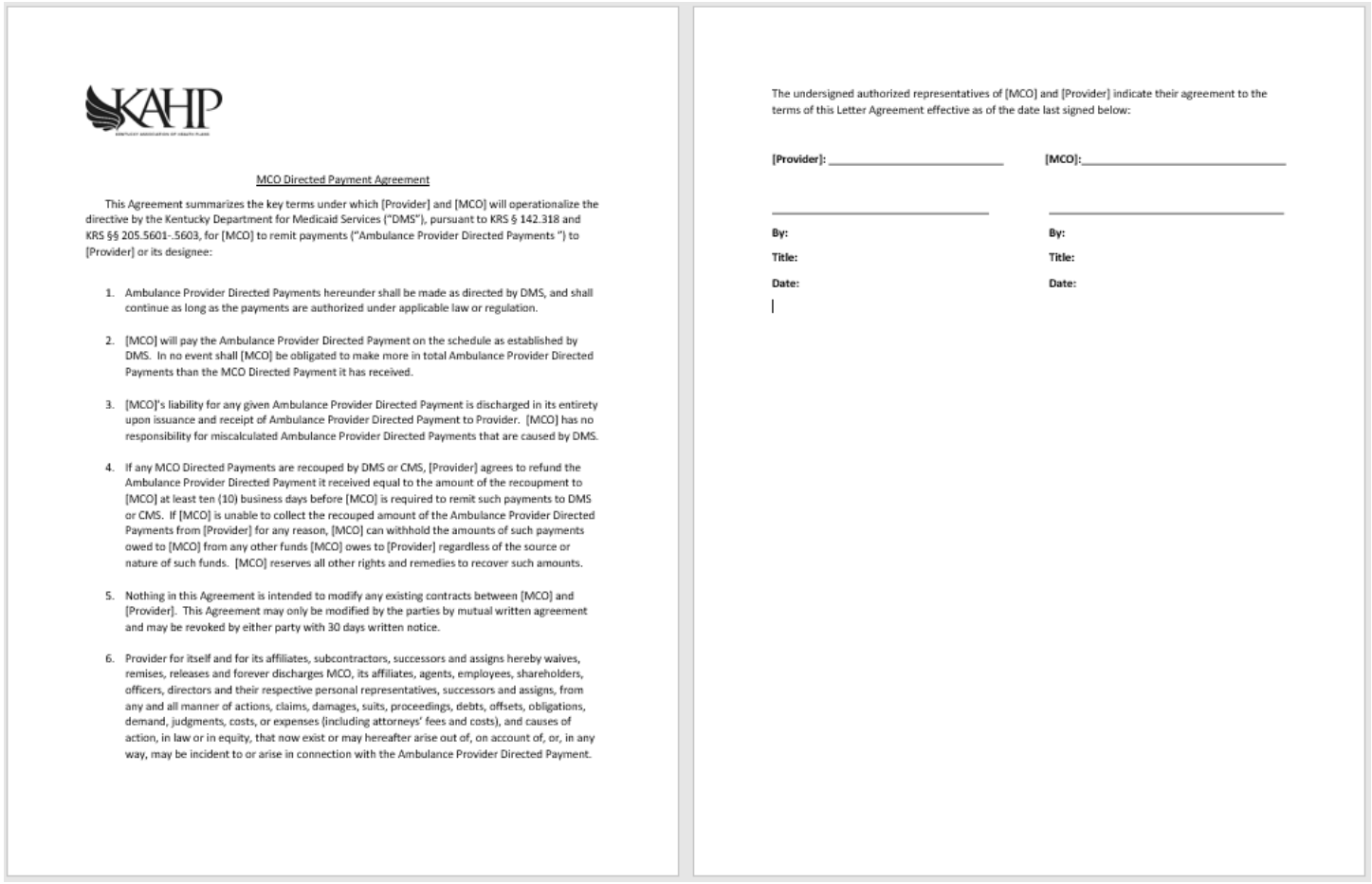
MCO	Email
Aetna	KyProviderRelations@Aetna.com
Anthem	Jeff.Geldert@Amerigroup.com
Humana	KYMedicaidMarketFinance@Humana.com
KAHP	tom@gosssamfordlaw.com>
Molina Passport	KYDirectedPayments@passporthealthplan.com
United	hb8supportingdocs@uhc.com
Wellcare	Anthony.Piagentini@Wellcare.com

House Bill 8 – Process & Coordination (MCO Payment Agreement)

MCO Payment Agreement

Payment Agreements outline the relationship between MCO and providers within the KY Ambulance Provider Assessment Program (APAP)

- ❑ Execute the MCO Payment Agreement
- ❑ Submit MCO Payment Agreement to MCO inbox



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MCO Directed Payment Agreement

This Agreement summarizes the key terms under which [Provider] and [MCO] will operationalize the directive by the Kentucky Department for Medicaid Services ("DMS"), pursuant to KRS § 142.318 and KRS §§ 205.5601-.5603, for [MCO] to remit payments ("Ambulance Provider Directed Payments ") to [Provider] or its designee:

1. Ambulance Provider Directed Payments hereunder shall be made as directed by DMS, and shall continue as long as the payments are authorized under applicable law or regulation.
2. [MCO] will pay the Ambulance Provider Directed Payment on the schedule as established by DMS. In no event shall [MCO] be obligated to make more in total Ambulance Provider Directed Payments than the MCO Directed Payment it has received.
3. [MCO]'s liability for any given Ambulance Provider Directed Payment is discharged in its entirety upon issuance and receipt of Ambulance Provider Directed Payment to Provider. [MCO] has no responsibility for miscalculated Ambulance Provider Directed Payments that are caused by DMS.
4. If any MCO Directed Payments are recouped by DMS or CMS, [Provider] agrees to refund the Ambulance Provider Directed Payment it received equal to the amount of the recoupment to [MCO] at least ten (10) business days before [MCO] is required to remit such payments to DMS or CMS. If [MCO] is unable to collect the recouped amount of the Ambulance Provider Directed Payments from [Provider] for any reason, [MCO] can withhold the amounts of such payments owed to [MCO] from any other funds [MCO] owes to [Provider] regardless of the source or nature of such funds. [MCO] reserves all other rights and remedies to recover such amounts.
5. Nothing in this Agreement is intended to modify any existing contracts between [MCO] and [Provider]. This Agreement may only be modified by the parties by mutual written agreement and may be revoked by either party with 30 days written notice.
6. Provider for itself and for its affiliates, subcontractors, successors and assigns hereby waives, remises, releases and forever discharges MCO, its affiliates, agents, employees, shareholders, officers, directors and their respective personal representatives, successors and assigns, from any and all manner of actions, claims, damages, suits, proceedings, debts, offsets, obligations, demand, judgments, costs, or expenses (including attorneys' fees and costs), and causes of action, in law or in equity, that now exist or may hereafter arise out of, on account of, or, in any way, may be incident to or arise in connection with the Ambulance Provider Directed Payment.

The undersigned authorized representatives of [MCO] and [Provider] indicate their agreement to the terms of this Letter Agreement effective as of the date last signed below:

[Provider]: _____ [MCO]: _____

By: By:

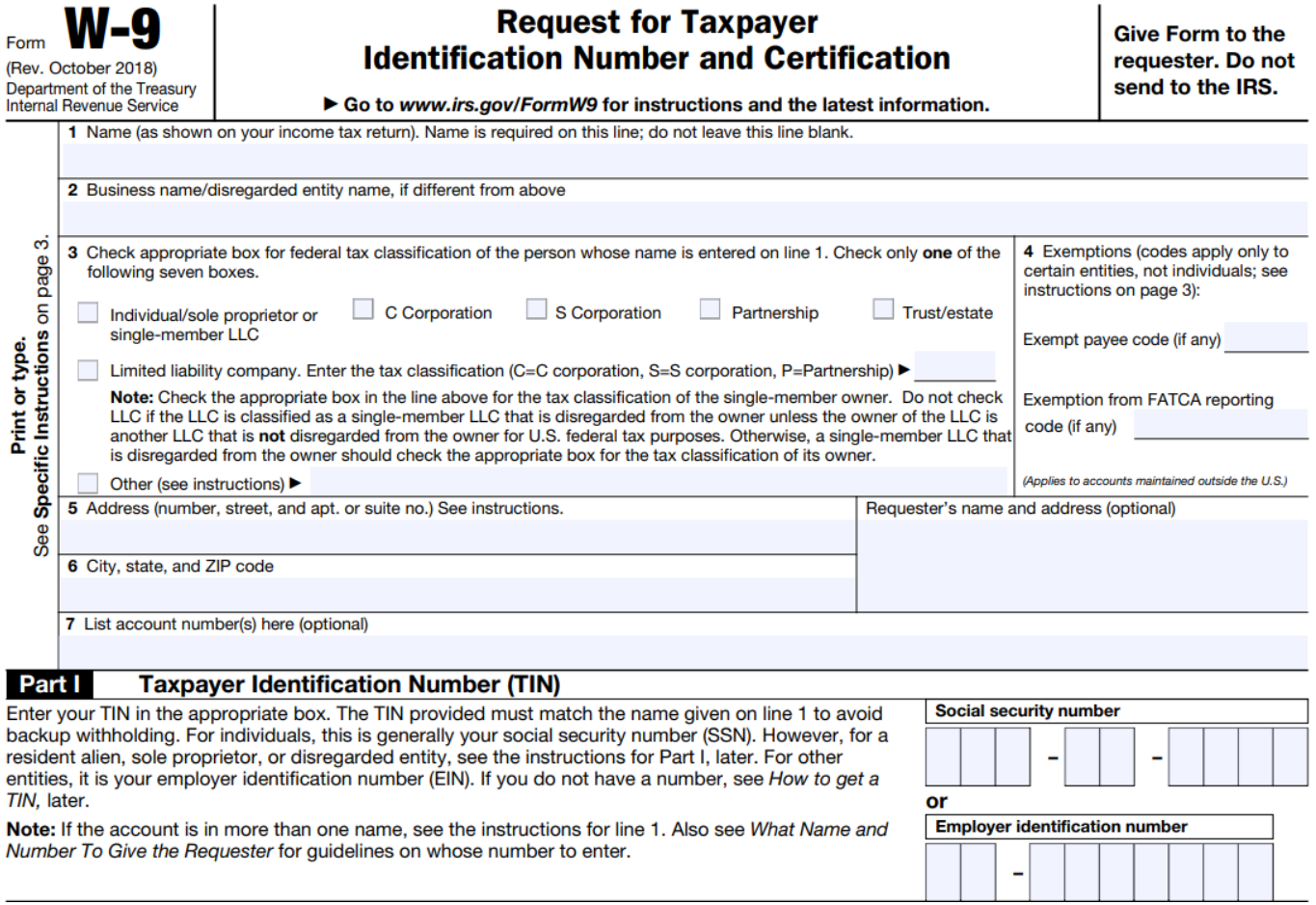
Title: Title:

Date: Date:

House Bill 8 – Process & Coordination (IRS W-9 Form)

Steps Required to Complete Contracting

- ❑ Submit a valid IRS W-9 Form with Tax Identification Number



Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ►

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I **Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

– –

or

Employer identification number

–

STEP #2

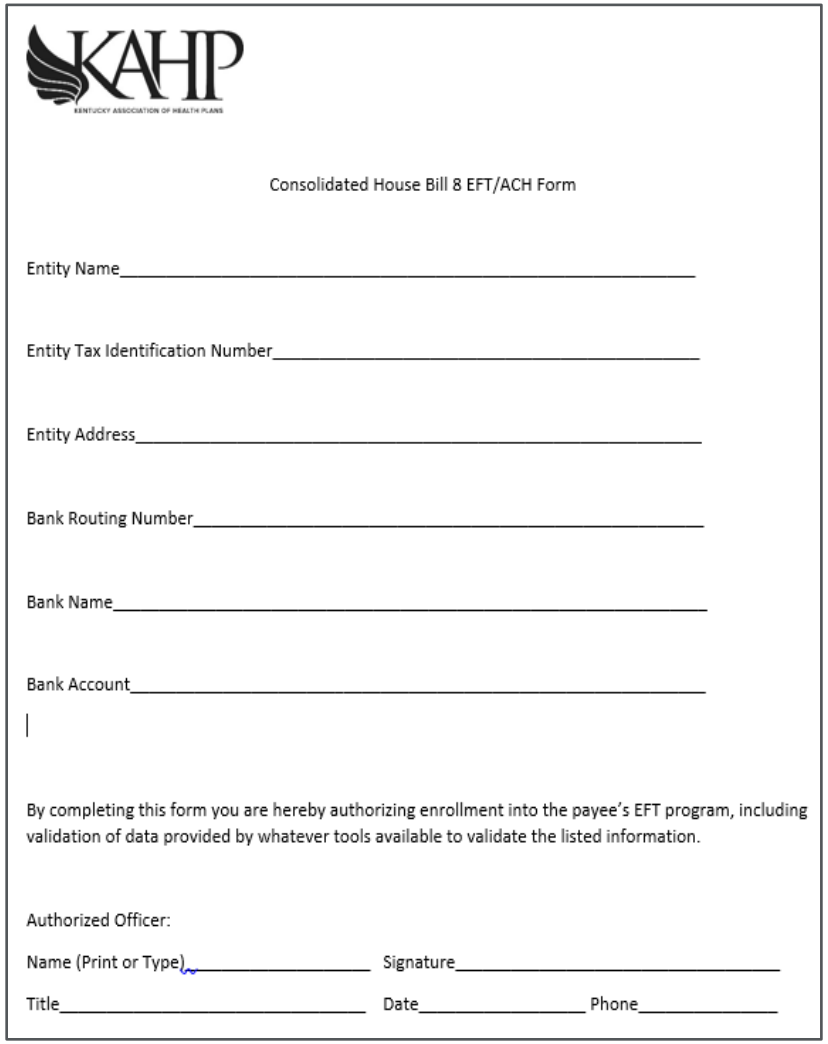
House Bill 8 – Process & Coordination (ACH/EFT Enrollment)

The below steps apply to Aetna, Anthem, Humana & Molina Passport. All providers must submit this form regardless of Par status

Steps Required to Complete ACH/EFT

- ❑ Complete Form
- ❑ Submit to MCO email address

MCO	Name	Email
Aetna	n/a	KyProviderRelations@Aetna.com
Anthem	Jeff Geldert	Jeff.Geldert@Amerigroup.com
Humana	n/a	KYMedicaidMarketFinance@Humana.com
Molina Passport	Scott Worthington	KYDirectedPayments@passporthealthplan.com



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Consolidated House Bill 8 EFT/ACH Form

Entity Name_____

Entity Tax Identification Number_____

Entity Address_____

Bank Routing Number_____

Bank Name_____

Bank Account_____

By completing this form you are hereby authorizing enrollment into the payee's EFT program, including validation of data provided by whatever tools available to validate the listed information.

Authorized Officer:

Name (Print or Type)_____ Signature_____

Title_____ Date_____ Phone_____

STEP #3 – Aetna, Anthem, Humana & Molina Passport

House Bill 8 – Process & Coordination (ACH/EFT Enrollment)

The below steps apply to Wellcare

Steps Required to Complete ACH/EFT

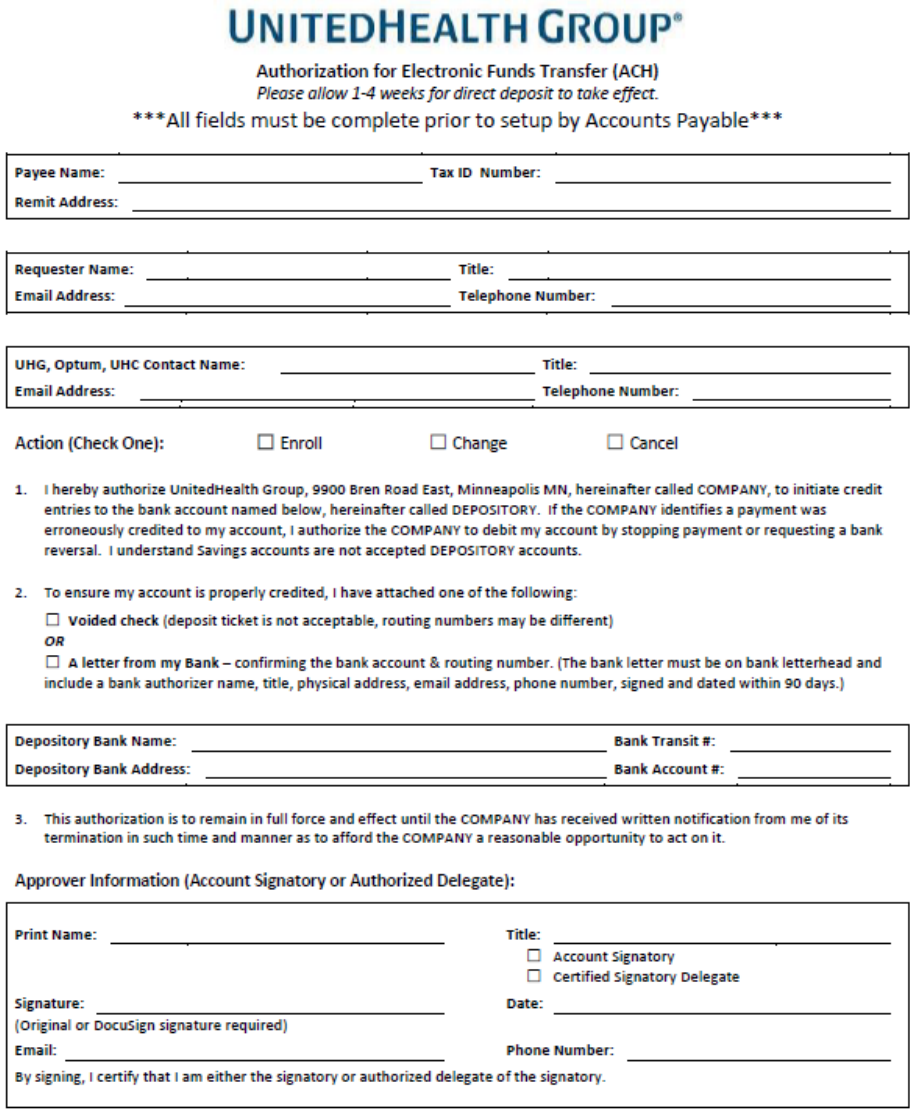
- Register with WellCare of Kentucky's Provider Portal and elect EFT/ACH payment or default to paper check. Providers who are already registered should log into the system to validate payment information. A link to the provider registration portal is included here: payspanhealth.com

House Bill 8 – Process & Coordination (ACH/EFT Enrollment)

The below steps apply to United

Steps Required to Complete ACH/EFT

- Complete ACH enrollment form
- Obtain bank letter issued in the last 90 days
- Submit all documents to:
  - hb8supportingdocs@uhc.com or
  - Secure Fax to: 855-755-4699



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Authorization for Electronic Funds Transfer (ACH)

Please allow 1-4 weeks for direct deposit to take effect.

All fields must be complete prior to setup by Accounts Payable

Payee Name: _____ Tax ID Number: _____

Remit Address: _____

Requester Name: _____ Title: _____

Email Address: _____ Telephone Number: _____

UHG, Optum, UHC Contact Name: _____ Title: _____

Email Address: _____ Telephone Number: _____

Action (Check One): ☐ Enroll ☐ Change ☐ Cancel

1. I hereby authorize UnitedHealth Group, 9900 Bren Road East, Minneapolis MN, hereinafter called COMPANY, to initiate credit entries to the bank account named below, hereinafter called DEPOSITORY. If the COMPANY identifies a payment was erroneously credited to my account, I authorize the COMPANY to debit my account by stopping payment or requesting a bank reversal. I understand Savings accounts are not accepted DEPOSITORY accounts.

2. To ensure my account is properly credited, I have attached one of the following:

   ☐ **Voided check** (deposit ticket is not acceptable, routing numbers may be different)

   OR

   ☐ **A letter from my Bank** – confirming the bank account & routing number. (The bank letter must be on bank letterhead and include a bank authorizer name, title, physical address, email address, phone number, signed and dated within 90 days.)

Depository Bank Name: _____ Bank Transit #: _____

Depository Bank Address: _____ Bank Account #: _____

3. This authorization is to remain in full force and effect until the COMPANY has received written notification from me of its termination in such time and manner as to afford the COMPANY a reasonable opportunity to act on it.

Approver Information (Account Signatory or Authorized Delegate):

Print Name: _____ Title: _____

☐ Account Signatory

☐ Certified Signatory Delegate

Signature: _____ Date: _____

(Original or DocuSign signature required)

Email: _____ Phone Number: _____

By signing, I certify that I am either the signatory or authorized delegate of the signatory.

STEP #3 – United

House Bill 8 – Questions

Questions?
www.kahp.org

MCO	Email
Aetna	KyProviderRelations@Aetna.com
Anthem	Jeff.Geldert@Amerigroup.com
Humana	KYMedicaidMarketFinance@Humana.com
KAHP	tom@gosssamfordlaw.com>
Molina Passport	KYDirectedPayments@passporthealthplan.com
United	hb8supportingdocs@uhc.com
Wellcare	Anthony.Piagentini@Wellcare.com