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The New Amerigroup Community Care Facility Proprietary Reimbursement Method Frequently Asked Questions

Question: **What is the planned effective date for change?**
Answer: The *New Amerigroup Facility Proprietary Reimbursement Method* became effective November 1, 2018. To validate the effective date of change, please refer to the *Amendment by Notification* document attached to your packet cover letter.

Question: **Why is the reimbursement method changing?**
Answer: Amerigroup currently has a floating fee schedule tied to CMS that requires change to ensure full compliance with the Division of TennCare *Contractor Risk Agreement* (*CRA*), which prohibits the TennCare MCOs from reimbursing providers based on automatic escalators or linkages to other methodologies that escalate, such as current Medicare rates or inflation indexes, unless otherwise allowed by TennCare.

The new proprietary fee schedule and methodology is compliant with the Division of TennCare *CRA*.

Providers can access and read the *CRA* in its entirety by visiting this page on the TennCare website. (***TennCare CRA Section 2.13.2.2****)*

Participating facilities will receive an *Amendment by Notification* along with a cover letter setting out additional information about the *New Amerigroup Facility Proprietary Reimbursement Method* within the next 60 days. Section 8.1 of the Amerigroup *Provider Agreement* permits *Amendment by Notification* for this purpose.

Question: **Will this change affect my reimbursement rate?**
Answer: There will be no material change in a provider's reimbursement.

Question: **Does this change impact all hospitals?**
Answer: This change affects all hospitals with reimbursement tied to CMS.

Question: **Do I need to sign and return the amendment to Amerigroup?**
Answer: Providers who receive an *Amendment by Notification* will not be required to countersign.

Question: **Whom may I contact should I object to the amendment and/or change in terms to my reimbursement method?**

Answer: Should you object to the terms of this amendment, please submit written notice to us within 30 calendar days following your receipt of the amendment. Objections postmarked subsequent to 30 calendar days after your receipt of the amendment will not be considered timely. If you submit a timely objection, and we are not able to agree in writing on a resolution to your objection, then your agreement will terminate as provided under its terms. Written objections to the *Amendment by Mutual Consent* must be submitted as follows:

Carla Alexis, Provider Contract Manager
Provider Relations
Amerigroup Community Care
22 Century Blvd., Suite 220
Nashville, TN 37214

Question: **Whom may I contact should I have other questions regarding this change?**

Answer: Please contact your local Provider Relations representative at 615-232-2160.

Question: **When and by what method will hospitals receive the contract amendment?**

Answer: The contract amendment and cover letter were sent via certified mail effective October 9, 2018.

Question: **Why is the *Amendment by Notification* being sent after the change is effective?**

Answer: Section 8.1 of the current *Provider Agreement* stipulates:

(b) Amerigroup shall be entitled to amend this Agreement as follows without the written agreement of Provider upon thirty (30) days prior written notice to Provider, or such other notice period as required by applicable law:

(i) If the amendment is being effected by Amerigroup to comply with a Regulatory Requirement, such amendment shall be effective as of the effective date set forth in the amendment. Amerigroup shall be entitled to amend the Agreement upon less than thirty (30) days prior written notice if a shorter notice period is required in order to comply with such Regulatory Requirement.

The amendment was affected to comply with a regulatory requirement. Amerigroup met the contractual and regulatory requirement to notify providers 30 days prior to the effective date of the amendment.

Question: **Will my reimbursement method change if I am currently contracted on fixed pricing such as per diems or case rates?**

Answer: No, this change only affects hospitals on inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS) pricing methodology.

Question: **Will providers receive any files or other information needed to model the reimbursement change to validate that there is no material change?**

Answer: The pricing methodology change does not affect current contracted rates. Providers can model their current rates with no projected escalation after this change is effective. The CMS October IPPS and OPPS Pricing Adjustments will not be incorporated into the Amerigroup reimbursement.

Question: **Will providers who have concerns or disagreements regarding material changes have the opportunity to enter into a meaningful negotiation with Amerigroup?**

Answer: Yes, providers have the option to renegotiate their contract at any time.

Question: **Freezing the base rate would prevent rate escalation, but why are the weights also going to be fixed?**

Answer: The MS-DRG weights are recalibrated annually and adjusted for market conditions. The October 1, 2018, CMS update included rate escalation for both the IPPS base rate and weights.

Question: **With the upcoming changes in the payment methodology, how is Amerigroup planning to accommodate/handle CMS code additions and deletions?**

Answer: CMS updates of new or deleted DRG codes will be reviewed by Amerigroup on an ongoing basis and will be updated accordingly. Any new DRG or APC codes added will be paid at the rate submitted for that fiscal year.