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GOVERNOR

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INTERIM SECRETARY

October 7, 2016

Statewide Medicaid Managed Care (SMMC) Policy Transmittal

Policy Transmittal: 16-27

Applicable to:
- ☒ Comprehensive Long-term Care (LTC) Plan
- ☒ Managed Medical Assistance Health Maintenance Organization
- ☒ Managed Medical Assistance Provider Service Network
- ☒ Managed Medical Assistance Specialty Plan
- ☐ Children's Medical Services (CMS) Plan

Applicable to enrollees in:
- ☒ Managed Medical Assistance (MMA)
- ☐ Long-term Care (LTC)

Re: Obstetrical Delivery Kick Payments

Effective September 1, 2016, managed care plans will be paid for obstetrical delivery services through a kick payment by the Agency for Health Care Administration (Agency). The Agency has adjusted capitation rates to reflect this change for the rate year beginning September 1, 2016. The purpose of this policy transmittal is to inform the managed care plan of the process by which the plan may request a kick payment from the Agency for coverage of obstetrical delivery services.

The Agency will make kick payments to the managed care plan for covered obstetrical delivery services provided to an enrollee (excluding dually eligible enrollees) in the amounts specified below:

Region	Rate Year 16/17 Maternity Kick Payment
1	$5,125.96
2	$4,970.54
3	$4,670.68
4	$4,665.94
5	$4,879.64
6	$5,393.96
7	$4,802.25
8	$4,552.37
9	$4,474.13
10	$5,064.39
11	$5,271.57

For kick payment purposes, an obstetrical delivery includes all births resulting from the delivery; therefore, if an obstetrical delivery results in multiple births, the Agency will make only one kick payment. The kick payment amount is the same, regardless of the delivery outcome (live or still birth), the mode of delivery (vaginal or cesarean), or the setting in which the delivery occurs (hospital, birth center, or in the home).

To receive a kick payment for obstetrical delivery services, the managed care plan must adhere to the specific requirements listed below:

(1) The managed care plan must have provided the covered service while the recipient was enrolled in the managed care plan.

(2) The Managed Care Plan must submit an X12 837 Professional (837P) (non-encounter) transaction, or through the direct data entry or trade files option on the Medicaid Provider Web Portal, within the required Medicaid FFS claims submittal timeframes.

(3) The managed care plan must use one of the following procedure codes on the claim form to request the kick payment:

CPT CODE	DESCRIPTION
59410	Vaginal Delivery with Post-Delivery Care
59515	Cesarean Delivery with Post-Delivery Care

(4) The managed care plan must submit any required documentation to the Agency upon its request in order to receive the kick payment.

(5) The managed care plan must list itself as both the pay-to and the rendering provider on the transaction or claim.

If you have questions, please contact your Agency contract manager at (850) 412-4004.

Sincerely,

Beth Kidder
Assistant Deputy Secretary for
Medicaid Policy and Quality

BK/sr
Attachment: Tip Sheet