

Facts about Georgia Families: Medicaid & PeachCare for Kids Managed Care

GEORGIA FAMILIES: Updated News about the Statewide Roll Out

General Information:

- Georgia Families is the new managed care delivery system for Medicaid and Peach Care for Kids members
- Managed care focuses on the right care, at the right time, in the right setting
- The program rolled out statewide September 1, 2006
- The total number of Medicaid and Peach Care members eligible for GHF is 1,057,297
- This number differs from the original quote from two years ago of an average monthly enrollment of 1.2 million because eligibility is changing daily. The reasons vary from people falling off the rolls to people being in their choice period—resulting in a constant state of fluctuation
- Any transition of this magnitude will have challenges; however, managed care is working. Teams of health care professionals involved are working every day to ensure access to quality health care services for our members

Medicaid & PeachCare for Kids Members:

- **Prevention and early intervention is the focus in comparison to the predominance of acute care prevalent under fee for service Medicaid**
- Patients/members are receiving care and have available to them new services and options they did not have before
- All call centers involved in GHF address inquiries from members and providers. There are five call centers monitoring calls—one for each of the CMOs, one for Maximus (the enrollment broker), as well as the original call center for the Medicaid program
- The Department of Community Health monitors all centers and has a call tracking system in place for calls coming in from other departments and the Governor's office

- **There is NO evidence from the call center metrics that members are having difficulty accessing or receiving the necessary medical care**
- Member calls have mostly centered around inquiries on how to change plans and/or doctors
- **Members are receiving care and are doing so with the ability to choose their doctor and health plan**
- Members can change their CMO and/or physician for 90 days after the program begins
- After 90 days members can still choose and change their physician within their health plan
- After this initial enrollment period, members will be able to change their health plan (CMO) once a year similar to commercial health plans

Care for Members:

- **There have been NO reports of clinical adverse events**
- Each time an anecdotal story about difficulties with access for members has been communicated to us we have asked for case specific information in order to follow up with the member/patient.
- In fact, even during conversations with physicians expressing their concerns about managed care in general, all have stated that they provided the care to the patients
- **All providers contacting us have been urged to provide details and information immediately if there are any care issues.**
- We have requested from medical associations such as the Academy of Pediatrics, Medical Association of Georgia, and the Atlanta Medical Association that any instance where there has been a problem with access or quality of care be reported to us immediately with member or case specific information that will allow us to intervene on behalf of the member.
- There is no barrier to physicians/providers sharing this info – They would do so in a HIPAA compliant manner similar to the way information sharing is already done

- DCH will respond immediately to any patient care issues that come to our attention. Our first priority will be to contact the member and ensure they are receiving the care they need

Access to Specialists:

- **Availability of Specialists in Georgia**
 - **In some areas of Georgia, there are inadequate numbers of specialists regardless of the type of insurance**, especially in the pediatric specialties
 - **The CMOs have contractual requirements that require them to pay a non-participating provider if, at the time of medical need, a CMO provider is not available**
 - All CMOs continue efforts to expand their provider networks to increase the participation of specialist

Provider Networks:

- **Fee For Service vs. Managed Care:**
 - Provider networks that have developed over the 40 years since the Medicaid program started are being compared to provider access networks developed in under a year by the new CMOs
 - Under fee for service, some specialists limited the number of Medicaid patients they were willing to accept. Under managed care, participating specialists are contractually obligated to see the patients/members
- **Referrals to Emergency Rooms:**
 - In the Fee For Service program, while some specialists enrolled as providers, they did not always accept Medicaid members. Primary care providers reported instances of having difficulty getting patients seen and resorting to sending them to hospital emergency rooms in hopes of specialist seeing patients there as “emergencies.” This is an old practice and one we hope to eliminate over time with the education of providers on the alternatives
- **CMO Coverage of Participating/Nonparticipating Specialists:**
 - Through the CMOs, access to specialists has to provide by either participating providers who are under contract to accept the patient and provide the care or by non-participating specialists that the CMOs must work with the primary care physician to identify

Outreach to Providers:

- In addition to extensive, ongoing outreach by each of the CMOs and Maximus (the enrollment broker), there have been and continue to be by DCH:
 - **Regularly scheduled meetings and teleconferences with provider groups** including the Georgia Chapter of the American Academy of Pediatrics, the Georgia Academy of Family Physicians, the Georgia Hospital Association and Hometown Health (Rural Hospitals).
 - Outreach to the Association representing the speech, occupational and physical therapists, the TriAlliance is also underway

Payments to Providers:

- **Providers are being reimbursed for care delivered**
- **517,649 claims were received by all three CMOs as of 8/11/06**
These are claims for Professional services (Physicians), Facilities, Therapists and Ancillary Services.
(Does not include Behavioral Health, Dental, Pharmacy and Vision Claims)
- **89.4 % of received claims were processed and dispositioned (paid or denied)**
- **96% of clean claims were processed in under 15 days as required**
- **41,675 claims were duplicate claims submitted by providers**
- **A Claims Processing Dashboard displaying the status of the CMOs efforts is available on the DCH Web site at www.dch.georgia.gov http://dch.georgia.gov/00/channel_title/0,2094,31446711_61700694,00.html**
- **The total amount of claims expenditures previously paid by Medicaid under fee for service per service category should not be expected. Utilization management and the prevention of fraud and overpayments will have an impact. The shift in focus from acute care delivery to preventions and appropriate maintenance care will also be reflected**
- **All providers have the ability to negotiate their rates with the CMOs. Physicians and Hospitals have negotiated rates on average equivalent to 100 – 110 % of current Medicaid ffs rates. Some providers have negotiated higher rates**

Earlier Claims Processing Delays:

- Claims submission and processing delays because of problems at **both** the CMO level and at the provider level
- CMO Delay: During the second month of transition there were 3-4 weeks of claims processing delays experienced by the CMOs – predominately by Peach State. **During that time some physicians were advanced interim claims payments**
- **ALL 3 CMOs are able to electronically process claims since 8/8/06**
- **Claims Submission Process in Summary:**
 1. Provider completes and sends claims thru their own claims software system to their EDI vendors (private companies serving as claims clearinghouses)
 2. EDI Vendors transmit the claims to the CMOs
 3. CMOs receive and process claims
- **CMOs are required to pay an 18% penalty fee to providers for any clean claim paid late**

Provider Claim Errors:

- **NUMBER ONE reason for delayed claims processing continues to be incorrect or incomplete filing of a claim by a provider office**
- The other top reasons for delayed claims payments are:
 - **Provider's own office claims management software not interfacing well with EDI vendors (private claims clearing house companies).**
 - Providers were urged to test their systems prior to the rollout – few did
 - **Provider offices still trying to submit claims directly to ACS despite education not to.**
 - **Providers have sent over 100,000 claims in error to ACS**
 - A list of the most common coding errors and claim submission issues is posted on the DCH Web site and has been shared with providers

- To assist providers during this implementation period, the CMOs have reduced some of the PA requirements and are strengthening their educational outreach to providers
- Providers are submitting supporting documents as they learn the claim submission criteria

Choice & Auto-assignment of Members:

- **Medicaid members are individuals who have a choice of who their doctor will be**
- The choice made by a Medicaid or Peach Care member prevails over any past assignments made under the old fee for service program and the past primary care case management program
- Medicaid members are not the exclusive property of certain providers. They are encouraged to make health care decisions that best meet their individual needs or those of their family
- **When members do not state a choice they are auto assigned to a health plan based on:**
 - **Previous relationship with a primary physician as evidenced thru claims history**
 - **Efforts to keep them together with a family member if a family member is already in a CMO,**
 - And finally to a random plan if the two conditions above do not exist
- **Medicaid members continue to have the ability to change their health plan for 90 days after their program effective date and can change annually after that similar to what is available to people in commercial health plans**
- **Members are able to change their primary care physician within their health plan at any point in time**

Contracting & Credentialing of Providers:

- **Despite early and proactive outreach to providers, some providers did not contract with CMOs until right before implementation or after CMOs began providing health care to Medicaid and PeachCare for Kids members**
- Provider must be properly credentialed by the respective CMOs before they are considered a network provider with the ability to submit claims for reimbursement

- In the early stages of building provider networks, CMOs focused heavily on recruiting hospital facilities and credentialing primary care providers
- Participation as a Medicaid provider under the CMO networks is not a given
- These are not “any willing provider” programs
- **Application to participate as a CMO provider does not guarantee acceptance.** Acceptance of a provider into any of the CMOs is based on a number of factors: 1) clinical expertise and history of quality care; 2) business decision based on network need, 3) contractual agreement, and 4) completion of credentialing process
- Credentialing is carried out by both hospitals and managed care organizations to ensure that only qualified practitioners with current demonstrated competence have practice privileges at the hospital or other type of health care facility and they practice within the range of their expertise and abilities₁
- **All CMOs have implemented an “interim” credentialing process to expedite the participation of providers in the Georgia Families.** The “interim” plan is in place on a temporary basis and does not negate any of the requirements to meet full credentialing

Quality Care with Utilization Management:

- **Managed care is about providing the right care at the right time by the right provider.** This means ensuring access to preventive and acute care in a coordinated environment. It does not mean cutting costs at the expense of the patient’s medical needs
- Unless individuals are considered private pay, some aspect of your care is managed whether you are in a public or commercial health plan. Georgia’s Medicaid program has included a form of managed care, Georgia Better Health Care, for this same population statewide since 1998
- Per the contract terms with DCH, all CMOs are required to be accredited by a recognized national accrediting body, such as the National Committee for Quality Assurance (NCQA) within 3 years of operating in Georgia. To meet the minimum standards to be considered for selection as a CMO in Georgia Families, these organizations must have been accredited in other states

- DCH requires all CMOs to achieve performance improvement directly related to improved patient outcomes:
 - Improving health check screening rates
 - Improving the rate of immunizations
 - Improving the rate of blood lead screening
 - Improvement in the screening or detection of chronic kidney disease
 - Improvement in the treatment and management of asthma
- CMOs as part of their health strategy have quality initiatives in place for their respective members. These quality initiatives include:
 - Kidney disease
 - Asthma
 - High risk pregnancies
 - Sickle cell anemia
 - HIV/AIDS
 - Major depression
 - Schizophrenia

Georgia Families – The Transition to Managed Care:

- **Transition of care from one delivery system (FFS) to managed care provider networks has required both advanced planning and ongoing flexibility** to address quickly each arising situation. Most provider groups have been working with us to ensure each member receives the care they need
- Advance planning began in 2005 and involved the development of communications processes and system requirements as well as outreach and education for the members and providers
- Organized and regularly scheduled meetings and teleconferences with providers group including the Georgia Chapter of the American Academy of Pediatrics, the Georgia Academy of Family Physicians, the Georgia Hospital Association and Hometown Health (Rural Hospitals)
- Outreach to the Association representing the speech, occupational, and physical therapists, the TriAlliance is also underway

Care Management Organizations Experience:

- The three CMOs that provide health care services to our members all operate Medicaid managed care delivery systems, including claims payments to providers, in a combined total of 17 states and the District of Columbia

- While there may be unique aspects specific to certain states, these organizations are experienced in processing and reimbursing claims for health services provided
- Each of the 3 Care Management Organizations (CMOs) maintains its own Web site which provide additional information
 - Amerigroup:**
<https://www.amerigroupcorp.com/members/>
<https://www.amerigroupcorp.com/providers/ProviderPortalWeb/publicpages/GA/>
 - Peach State:**
<https://www.pshpgeorgia.com/pshp/>
 - Wellcare**
<http://georgia.wellcare.com/>