

Suggestions of the Georgia Occupational Therapy Association, Georgia Speech Language-Hearing Association and Physical Therapy Association of Georgia on Requests for Proposals by the Department of Community Health to CMOs

Introduction

About six years ago the Georgia Therapy Trialliance (composed of pediatric therapists from the Georgia Occupational Therapy Association, Georgia Speech-Language Hearing Association, and the Physical Therapy Association of Georgia) began working with the Medicaid staff of the Georgia Department of Community Health (DCH) to address changes made to the Children's Intervention Services (CIS) part of the Aged Blind, and Disabled Medicaid program. When DCH began the managed care program for Low Income Medicaid (LIM), many children with chronic disabilities experienced delays and/or denials of therapy services within the EPSDT (Early Periodic Screening, Diagnosis and Treatment) program. EPSDT is a federally mandated part of Medicaid which requires a different standard in determining the need and duration for treatment than that used by traditional managed care organizations. Its definition of medical necessity was enacted in Georgia law in 2008 along with particular standards for therapy services.

Over this period of time the Trialliance began and maintained a consistent dialogue with Georgia's Care Management Organizations (CMOs), and many problems have been addressed. Nevertheless, some problems still remain, sometimes leading to denied services to children, missed sessions, and children regressing, which causes medical complications. Many problems have resulted from CMOs subcontracting management of therapy services to outside vendors.

In addition to DCH's preparing to issue a new request for proposal (RFP) to CMOs, the Department intends to implement a care coordination program within the Aged, Blind and Disabled (ABD) portion of Medicaid which has been publicly acknowledged to be the first step in moving toward a capitated, managed care approach for all ABD services. In light of the possible significant increase of children moving from the ABD fee for service program administered by DCH to managed care, it is crucial to learn from past experience.

In response to the DCH invitation to provide input, the three associations offer the following suggestions for the Department's RFP for the Low Income Medicaid program. The format below is one of listing program requirements in specific areas of concern (e.g. prior approval of services, credentialing of providers, etc.). The Trialliance has noted some circumstances in which it believes the RFP should specify particular requirements with which CMOs must adhere. In instances in which it may not be obvious why requirements are being listed, explanations are given in italics.

1. **Prior Approval (PA) of Services:** *The length of time and lack of uniformity of approval of therapy services, including type, duration and frequency has been one of the major problems which parents and the pediatric therapists who serve their children have faced. It is particularly important that children with chronic disabilities receive services in a timely and consistent fashion, in order to prevent regression.* With regard to therapy services under Medicaid EPSDT, the DCH/CMO contracts and the RFPs should provide for/require the following:

- (A) Centralized PA process (submission, review and approval) through a single portal that will be monitored by DCH. *This practice would ensure a consistent level of care across all CMO's.*
 - (B) Require electronic approval/denial of PAs and a means of communicating questions/concerns electronically. *CMOs do not all have this capacity. The lack of consistent electronic communication adds significant time to the consideration and resolution of PA requests.*
 - (C) Approval/denial of PA requests within five days.
 - (D) Approval of request for services should “follow the child.” *There should not be a delay in services if a patient sees a similarly credentialed therapist (either in the same company or a different company) or moves to a different CMO.*
2. Inclusion of EPSDT Law/Standards in Contracts: All contracts with CMOs should contain the definition of Medical Necessity/”Correct or Ameliorate”, not simply a reiteration to conform to EPSDT, including a statement that an EPSDT patient cannot be denied services because the child has not shown progress. *These definitions are contained in GA Code Section 49-4-169.1, and the standards have not been consistently applied by the CMOs.*
3. Credentialing: *The lack of timely processing of provider credentials is a problem which has led to delays to children and the lack of a sufficient network of providers to serve children.* DCH should seek to assure:
- (A) Centralized credentialing in which providers send complete application for credentialing a therapist to one entity and that entity credentials for all CMO's.
 - (B) Credentialing that follows the provider (i.e., from one practice to another).
 - (C) The maximum time to process a provider's credentials should be 30 days.
 - (D) Approval of a provider's credentials should be retroactive to date of application. *The ABD Medicaid program approves provider credentials back to date of application, allowing the therapist to serve children while credentialing is being completed. This should be allowed by the CMO's so that services to children are not delayed when one provider leaves and another provider is hired to take his or her place.*
- 4 Provider Networks: CMOs should be required to:
- (A) Accept all applicant providers who meet CMO qualifications. *This will both improve access to services and assist in the development and maintenance of adequate networks of pediatric providers.*

(B) Enroll qualified pediatric providers to provide services to children. *DCH should set same the requirement as is in the current CIS manual: "All providers are required to maintain on file, on site verification indicating they have obtained a minimum of 1/3 of their required professional state licensing board Continuing Education Units (CEU) in pediatrics."* Awards of contracts should consider geo accessor and other quality standards to ensure access to appropriate pediatric providers.

5. Payment Requirements: CMOs should be required to:

(A) Allow submission of claims and payment of funds electronically. *This method would help alleviate delays caused by lost paperwork and holding of claims, since electronic allows tracking of dates received, processed and paid.*

(B) Reimburse services at a level which at least meets a minimum rate set by Medicaid in order to ensure provision of a sufficient provider network, as required by federal rules. *Provider administrative cost of operating with the CMO's is higher and must be considered when setting reimbursement rate.*

6. Oversight of CMOs: *DCH currently lacks the resources to effectively monitor CMOs, and frequently both parents and providers of EPSDT patients have had a very difficult time "navigating" the Medicaid system, (e.g. receiving timely information and services and resolving problems)* As a result DCH should:

(A) Establish a separate system to monitor CMOs when they subcontract for services, including maintenance of financial requirements such as surety bonds; and

(B) Ensure that all reports currently required of CMOs be simultaneously submitted to the House and Senate Health and Human Services Committees and applicable Appropriations subcommittees which make Medicaid budget recommendations.

7. Provider Manuals: DCH should continue to maintain Part II provider manuals (such as CIS, CISS, etc) that set minimum policies to which CMO's must adhere.

8. Duplication of Services: *One particularly troublesome area has been the denial of requests on the basis that there will be a duplication of services, and DCH is developing a policy on this issue.* The RFP and accompanying contract should ensure that criteria for denial based upon duplication of services must be consistent with federal special education and EPSDT laws and Georgia law on children's therapy services.

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