

**Georgia Department of Community Health
Georgia Medicaid Management Information System
(GAMMIS)
Interim Payment Contingency Guide**

Version 1.5

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Attachments

Attachment A: Interim Provider Payment Request Form
Attachment B: Interim Payments Quick Reference Guide
Attachment C: Interim Provider Payment CTMS Tracking Report
Attachment D: Interim Payment Letters

1.0 Introduction

For the purpose of Business Contingency Planning the definition of a “disaster” is any condition that prevents an organization from performing their critical business functions in an acceptable period of time. Business continuity is the set of procedures that may be followed during an emotional and highly disruptive event. The objective is to simplify as much of the decision making as possible during such an incident and give guidance to management in executing a comprehensive and documented approach to recovery back to the production environment. While Hewlett-Packard Enterprise Services (HP) is working closely with each of its partners to ensure business continuity preparedness and expects these systems and services to be available, the Department of Community Health (DCH) is taking additional internal precautions to ensure that business processes continue in the event of project failure or system un-readiness to ensure business continuity.

The Department recognizes that even with extensive testing and planning no system or facility can be totally immune from crisis and may experience unanticipated problems during cut-over. Additionally, during the start up period of system implementation there may be issues that will need to be addressed and resolved in an expedient manner. Prompt resolution of these issues will be critical to preserve customer confidence and to ensure that health care services are not interrupted. Therefore during this critical transitional period, DCH and HP will work jointly to triage the issues and communication the solutions to its health care community beginning and up until the production environment becomes stabilized.

A Joint DCH/HP Management Team has been assembled to execute the overall plan. The comprehensive management tool will mitigate risks and direct services and operational procedures that will be followed if there are start up problems or disruptions during transition.

As part of the Georgia MMIS (GAMMIS) implementation preparation, the Joint DCH/HP Management Team recognized the importance of having a well defined plan surrounding the issuing of Interim Provider Payments. In March 2010, the Interim Provider Payment Workgroup was formed to define the triage, monitoring and communication processes. The workgroup included DCH, HP and GAMMIS Project Management Office (PMO) resources. Their efforts resulted in this **Interim Payment Contingency Guide**, as a supplement to the existing Business Continuity Plan, to safeguard its ability to reimburse Medicaid Providers for valid covered services to Medicaid and PeachCare for Kids (PCK) members when the provider is unable to be paid through the new GAMMIS.

This document is not designed to replace the current DCH Business Continuity Plan, DCH Facility Disaster Recovery Plan or any disaster recovery plans and business continuity plans established.

This document does not reflect the CMO or Fiscal Intermediary Business Continuity Plans.

1.1 Purpose & Goals

The purpose of establishing the Department of Community Health Interim Payment Contingency Guide is to preserve the department's ability to serve its customers.

As the DCH is the largest purchaser of health care in the State of Georgia, DCH has made the continuity of payments to health care providers and suppliers its first priority both in GAMMIS system development and in its contingency planning.

The goal is to identify as early as possible the problems that could cause DCH to invoke the plan by detailing the triage, monitoring and communication processes required to address problems encountered during pre-go-live and the initial start-up phase.

1.2 Objectives

1. Maintain uninterrupted services to members and payment to providers throughout all phases of implementation
2. Provide bidirectional communication with the provider community
3. Pay providers in an accurate and timely fashion to ensure uninterrupted service
4. Keep all vital touch points live and appropriate stakeholders in contact with each other
5. Prior to go-live, establish a methodology to achieve accountability for all payments with reliable, auditable records documenting that transactions are claims based, properly authorized and properly paid

1.3 Use and Scope

This document is intended to provide DCH with the necessary criteria and guidance to

- Identify indicators that may warrant the issuing of Interim Provider Payments
- Communicate to the provider community those issues that may impact and/or delay payments
- Establish communication with providers regarding Interim Payments
- Document the method for tracking and funding Interim Provider Payments
- Document the reporting process for Interim Provider Payments issued and recovered

1.4 Assumptions

The basic assumptions upon which this plan is predicated include:

1. In the event there is a catastrophic situation with the GAMMIS and no claims are able to process, the DCH will work with the Centers for Medicare & Medicaid Services (CMS) and The Office of Planning and Budget (OPB) to determine an overall funding strategy.
2. Key staff has been defined and the number is sufficient to address all identified scenarios.

3. HP will begin operation as DCH's fiscal intermediary on Monday, November 1, 2010.
4. There are certain budgetary constraints.
5. Interim Provider Payment Workgroup Team members are responsible for coordinating DCH plans both at planning and time of interruption.
6. Interim Provider Payment Workgroup Team members will be actively involved in the daily Operations & Transition Support Team Meetings.
7. The issuance of ALL Interim Provider Payments will be approved by the Chief Financial Officer and/or the Chief Medical Assistance Plan.
8. Agency Management has reviewed and agreed on the plan.
9. CMS has reviewed the plan.

1.5 Mitigation Strategies

Mitigation factors are the protection devices, safeguards, and the procedures in place that reduce the effects of the threats. The Department of Community Health recognizes the need to mitigate risk to operations posed by GAMMIS implementation by identifying, assessing, managing, and reducing those risks. Therefore, mitigation strategies will be engaged by DCH prior to go-live to plan to minimize the extent and duration of implementation failures on mission critical business or to circumvent/eliminate the impact altogether. DCH has a plan to address problems related to the inability to process claims, which would interrupt payment to Providers and has taken corrective measures to eliminate or minimize any disruption of cash flow to our Provider Community. The mitigation plan includes the following:

- Interface Tracking - Data transmission among the stakeholders is a key element to a successful implementation. A process has been developed that provides a testing schedule and testing results in order for DCH to easily determine the status of each individual interface.
- Data Conversion - Testing may reveal a significant problem (or problems) in the conversion results scheduled for delivery October 28, 2010.
- EDI Provider Readiness - As it relates to the testing of EDI Transactions a process has been developed to capture the following types of information:
 - Counts of providers, clearinghouses, billing agents, etc. that are approved to conduct transactions with the EDI Gateway. Will include X12 transactions, GAMMIS defined proprietary transactions, and Provider Electronic Solutions (PES) transmission.
 - Counts of transactions received & processed by the EDI Gateway by transaction type.
 - Problem issues and resolution steps for high priority claims submitters (providers, billing agents, etc.) as defined by DCH.
 - Corrective actions for high-risk submitters to mitigate risk of not being able to submit claims for payment.

- Provider Beta Testing – In preparation for the transition, 70 providers will participate in sessions designed to solicit input and feedback on the new GAMMIS. These sessions will allow the selected beta providers to preview the new Georgia Health Partnership Web Portal and will allow testing of critical portal activities.
- Georgia Provider Readiness Portal – A web portal has been established (<http://providerinfo.mmis.georgia.gov/providerprereadiness/home.aspx>) to serve as a means for providing necessary communication to providers. This is to help in the transition period. It will provide information and updates on the following:
 - Dates and Times of Provider Training Workshop
 - EDI Testing
 - Documents on Policy, Billing and Companion Guides
 - Information on Medicaid Training Opportunities
 - Clear communication regarding claim payment volumes that may be different than expected
 - Information about the criteria for interim payments and the procedures for requesting such payments
- Provider Training and Implementation Workshops – HP and DCH will conduct 171 workshops throughout Georgia. The workshop training sessions will be based on provider types
- Additionally, the DCH has:
 - 1) Developed an Interim Payment communication process that defines how
 - a. Calls are routed from providers, members, vendors, and public officials.
 - b. Providers are notified of payment issues.
 - c. Providers request interim payments.
 - 2) Generated Ad-hoc reports to determine
 - a. Provider payment averages so that any disruption to cash flow will be mitigated.
 - b. Those providers submitting the majority of their claims via paper or web so that cash flow will not be interrupted.
 - 3) Developed an interim payment accountability process to limit the creation of audit obstacles.
- Myers and Stauffer LC (M&S) Independent Financial Assessment - The Myers & Stauffer Report will provide an additional level of analysis about the extent to which the claim processing software logic has been properly configured. All parties are aware of the difficulties experienced in the prior implementation as well as problem areas identified in the annual Benefits Testing. After Go-Live, M&S will perform its annual

“Benefit Testing” analysis which will continue to monitor the claim processing functionality, as well as reprocessing activities.

M&S has also been tasked with testing items that may identify data conversion issues. This will be particularly of value in the Member and Provider Areas.

DCH senior management will be responsible for evaluating the results reported by M&S in context of evidence that DCH senior management gathers from all other sources (e.g., parallel testing, system integration testing, user acceptance testing, provider beta testing, member data conversion, provider data conversion, prior authorization data conversion and history, interface success, etc).

1.6 Indicators to be Monitored

Pre and Post go-live indicators which may trigger the plan range from a specific malfunctioning of the entire system, output below minimal level, or disruption in GAMMIS operations. Many of these indicators will be monitored on a daily bases. The indicator is not a guarantee that Interim Payments will be issued. The indicator is simply an alert to the department that additional action is required to determine the root cause of the trend being experienced. The issue will be researched, analyzed, workarounds discussed and determinations made as to the impact on provider payments.

Specific areas are assigned with the responsibility of evoking the plan.

Responsible Area	Indicator
DCH (all)	<p>Pre Go-Live: Prior to implementation there are extensive testing efforts being conducted. When findings are identified, defects are created. DCH will monitor the outstanding defects to identify those affecting provider payments.</p> <p>The ACS/HP cutover plan will identify areas such as paper and/or web claim submissions where DCH will know in advance that specific providers will have payment delays and assess the need for interim payments to these providers.</p>
HP Contact Center	<p>Post Go-Live: Both the HP Provider Contact Center/Written Correspondence Center and Field Service Representatives will monitor provider feedback with regards to payment issues. All information will be logged into the Call Tracking Management System (CTMS). A separate identifier will be created for Interim Payments and daily reports run to assess the calls based on the identifier reason code.</p> <p>The report will be review daily to identify common reoccurring items. The CTMS record will be routed to the appropriate parties to take action. This may be deploying a provider representative, a return call to educate the caller on a</p>

	<p>new process and/or functionality or to the triage unit to research the root cause. In addition, if the issue can not be resolved immediately, the provider may qualify for an Interim Payment if a payment request is received.</p>
<p>HP Claims Operations</p>	<p>Post Go-Live: Monitor the amount of incoming mail, specifically if there is a greater than the average number of 8500 paper claims that may indicate a problem with submitting claims electronically. The 8500 number is based on the historical volumes provided by the current fiscal agent. This may indicate a Web Portal issue or an issue caused by the new SNIP claim level edits moving from 1 and 2 to 1, 2, 3, and 4.</p> <p>Monitor the number of Dental claim Return to Provider (RTP) letters to determine if they are related to the new ADA2006 form not being completed correctly. An RTP rate of 20% and higher on the ADA 2006 may indicate a problem with reduced payments to dental providers. The claims operations team will work with the provider services department and DCH to communicate to the dental providers through the field service representatives, the monthly newsletter, web postings and other approved methods of communication.</p> <p>EDI will be proactive in monitoring files sent to the File Tracking System (FTS) electronically to compare rejection levels of more than 50% and also compare those files accepted to see if what was accepted was processed by the claims engine. The expectation is an acceptance rate of 90% or higher. This system will help us identify high rejection rates of EDI claims and those claims that are not being forwarded to the claims engine because of high rejections levels.</p> <p>Monitor suspense volumes by claim type as well as provider category of service for potential problems with edits and audit suspending claims that should be systematically paid or denied. We will compare the suspense volumes to the current average weekly suspense volumes of 20,000-25,000 per week. If weekly suspense in the new GAMMIS is greater than 20,000-25,000. HP will research the edit and audit failures with the highest failures to determine if edits and audits are suspending claims according to edit and audit criteria</p> <p>Monitor claim denial appeals for an increase in payment related issues. HP has assumed that 25% of the provider correspondence monthly volume is for claim denial appeals which is an average of 1360 based on 2010 correspondence volumes. If the actual volume is twice the assumed volume, HP appeals team will be alert to a potential problems with editing and auditing as the denials are researched</p> <p>Monitor data imaging/OCR processing to ensure claims are processing properly according to the defined business rules through OCR applications within FormWorks and ensure the output file of claims processed from FormWorks to Claims Engine is balanced. If not balanced, we will work with the appropriate</p>

	<p>claims systems team to research and identify the root causes and correct. Claims reports used for research are the daily, weekly and monthly Claims Submission Statistics Report and the FormWorks Processing Volume report.</p>
DCH Claims	<p>Post Go-Live: Monitor the following system generated reports:</p> <p>Claims Processing Daily Report - This daily report lists summary information by claim type and category of service for a claim adjudication cycle. All claims processed during the cycle are reported.</p> <p>Claims Processing Weekly Report - This weekly report lists summary information by claim type and category of service for a claim adjudication cycle.</p> <p>Suspense Analysis by Exception Code-Provider - This report is a list of the occurrences of each exception code in suspense inventory for claims initiated by a provider (through correspondence: 837, web portal (Internet) or paper). The Current Occurrence is the number of times the exception code was set during the current day's adjudication process. The Total Occurrence is the number of times the exception code is set within the whole suspense inventory.</p> <p>Claims Exception Report - This daily report shows how many times each exception occurred by claim type, category of service, and disposition status for a reporting period. The report provides a rolling 5 day view to monitor trends in claim exceptions.</p> <p>Prior Authorizations (PA's) coming into the system will be monitored via interface reports. If a problem is detected, this would prevent providers with claims that require a PA to process their claims.</p> <p>Crossover Claims will be monitored via the Medicare Vendor input files. Indicators of a problem will be low or no electronic claims being submitted and/or high volumes of provider submitted via web or paper.</p>
DCH Finance	<p>Post Go-Live: Review weekly pre-payment reports to determine if the payments are greater than 15% (+/-) the average payment for that period.</p> <p>If the payments are lower, review for any significant accounts receivables that may be causing the decrease. If the payments are higher, review for any significant payouts that may be causing the increase. If neither is present then review additional payment reports by category of service to see which areas have the variances and address with the Interim Payment workgroup.</p>
DCH Web Portal	<p>Post Go-Live: Review reports detailing web transactions for each feature available to providers/member/general public to determine trend variances for problems.</p> <p>Review reports of Prior Authorizations (PAs) /Claims entered via the web and the availability of the web to enter PAs and claims to identify problems.</p>

2.0 Roles and Responsibilities

The **Interim Provider Payment Workgroup** is responsible for coordinating agency activities if business continuity is interrupted as it relates to provider payments. The mission of this team is to provide a rapid response in the event of claim processing or claim payment failures that occur during the transition to the GAMMIS. During the GAMMIS transitional phase, a three-tier organizational structure exists to facilitate the process: **(1) Executive Team, (2) Interim Provider Payment Workgroup and (3) Operations & Transition Triage Team.**

2.1 The Executive Team

The **Executive Team** sponsors the plan and is comprised of key individuals pertinent to the decision-making processes in the event of an interruption. During the planning process, the Executive Team ultimately approves the overall plan implementation. In the event of an interruption, the Interim Payment Contingency Guide facilitates decision-making processes and the conducting of business in a contingency mode. These individuals direct the business recovery processes. The Executive Team will declare the disaster. During incident management they will have the resources and authority to ensure that recovery procedures are executed. For plan activation, the Executive Team is empowered to deploy or re-deploy resources as deemed necessary. They are also responsible for managing public communication during the crisis.

The following table lists the Executive Team members:

Area of Responsibility	Contact Name
DCH Chief DMA	Jerry Dubberly
DCH Interim CIO	Vince Harris
DCH Interim CFO	Scott Frederking
DCH Director of MMIS	Ivan Fleet
DCH Inspector General	Robert Finlayson III
DCH COO	Debbie Hall
DCH Director of Internal Audit & Program Evaluation	John Hankins
DCH Director of Communications	Lisa Marie Shekell

2.2 The Interim Provider Payment Workgroup

The **Interim Provider Payment Workgroup** directs the deployed resources and processes at the business function level. During the planning phase, the Interim Provider Payment Workgroup is responsible for overseeing the development of the Interim Provider Payment plan and related processes. While in recovery mode, the Interim Provider Payment Workgroup will direct recovery activities and coordinate the business recovery teams within the Department as instructed by the Executive Team.

The following table lists the Interim Provider Payment Workgroup team members:

Area of Responsibility	Contact Name
Financial Services	Julie Biel
Financial Services	Iлона Share
MMIS Finance PMO Lead	Jody McHoul
Provider Enrollment	Jackie Koffi
Provider Enrollment	Leslie Austin
Claims /EDI	Sheldia Maddox
Medical Policy	Stacey Harris
MMIS Systems	Tina Hawkins
Communications	Joye Burton
Operations	Shawn Walker
IVR	Wanda Patterson
Member	Yolande Calhoun
Managed Care	Gretser Rush
Interfaces / EDI	Donald Fischer
HP Operations	Mary Ann Barndt-Williams
HP Interfaces / EDI	Frank Martin
HP Operations	Pamela White
HP Operations	Bille L. Frazier
HP Operations	Agnes Beeks
MMIS Claims PMO Lead	David Schuster
Ad Hoc/MAR/SUR	Darryl Dees
HP Operations	Teresa Milline
North Highland – Principal	Patricia Miles
Reference/PA/CTMS	Edwinlyn Heyward
Financial Services	Said Tlemcani
Financial Services	Lisa Robinson

2.21 Team Responsibilities

	Roles and Responsibilities/Areas of Expertise
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<p>Operations / Contact Center</p> <p>Shawn Walker Mary Ann Barndt-Williams Agnes Beeks Pamela White Teresa Milline</p>	<ul style="list-style-type: none"> • Monitor Pre and Post Go-Live Indicators; • Ensure that DCH staff have training on CTMS, the call monitoring tool and any other incident management tools as appropriate; • Monitor CTMS center real-time call reporting software. Report problems when they occur and support development of a plan for resolving performance issues during go live; • Review and monitor CTMS reports daily and report any issues; • Support the triage of issues that are identified to determine which issues require an immediate response or action, which issues require defect notification and tracking ; • Participate in daily conference calls to be aware of any newly identified issues; • Ensure that the Operations & Transition Triage Team is aware of any issues, which need to be escalated.
<p>Provider Relations /IVR</p> <p>Jackie Koffi Leslie Austin Wanda Patterson Bille Frazier</p>	<ul style="list-style-type: none"> • Monitor Pre and Post Go-Live Indicators; • Provide clarification to the HP provider field representative staff related to the referral process and provide clarification for provider training; • Communicate questions and concerns that arise in the field back to the appropriate DCH staff for resolution; • Serve as the main liaison for the department to coordinate all requests for DCH representation at provider training ; • If necessary, work with the field representative supervisor to arrange for ongoing training and education for the field representative staff and help to identify any additional training that they may require; • Identify DCH policy staff that may be appropriate to provide training; • Work with HP to identify providers that may be having claims processing problems that are impacting their payments; • Monitor and report problems associated with web contacts received or IVR inquires; • Support the triage of issues that are identified to determine which issues require an immediate response or action, which issues require defect notification and tracking; • Participate in daily conference calls to be aware of any newly identified issues; • Ensure that the Operations & Transition Triage Team is aware of any issues, which need to be escalated;
<p>Financial Services</p> <p>Ilona Share Julie Biel Jody McHoul Darryl Dees</p>	<ul style="list-style-type: none"> • Monitor Pre and Post Go-Live Indicators; • Provide support to the HP Financial operations area; • Review and provide support to HP in the performance and posting of payments that come in through the lockbox from provider refunds; • Review the weekly claims check cycle to ensure the integrity of the payments being made; • Work with HP to identify on a daily basis if the department’s contingency plans for expediting provider payment needs to be enacted; • Monitor State’s cash flow; • Work with HP and the department’s bank (BOA) to resolve any banking issues that arise; • Report any issues in development to the PMO Team Lead for the respective areas; • Support the triage of issues that are identified to determine which issues require an immediate response or action, which issues require defect

	<p>notification and tracking;</p> <ul style="list-style-type: none"> • Participate in daily conference calls to be aware of any newly identified issues; • Ensure that the Operations & Transition Triage Team is aware of any issues, which need to be escalated.
<p>Member / Managed Care</p> <p>Gretser Rush Yolande Calhoun</p>	<ul style="list-style-type: none"> • Provide support to the Managed Care staff. Check daily for any issues they've identified and problems reported by providers, CMOs, or members directly to them; • Support the triage of issues that are identified to determine which issues require an immediate response or action, which issues require defect notification and tracking; • Participate in daily conference calls to be aware of any newly identified issues that may impact their area; • Participate in daily conference calls to be aware of any newly identified issues; • Ensure that the Operations & Transition Triage Team is aware of any issues, which need to be escalated.
<p>Interim Payment Coordinators</p> <p>Said Tlemcani Lisa Robinson</p>	<ul style="list-style-type: none"> • Receives and logs requests • Compares requests to established criteria • Rejects those that fail criteria & sends explanatory reply to provider • Assembles document package for those appearing to meet criteria • Forwards those appearing to meet criteria for approval • Communicates Cash needs • Coordinates with Financial Services for payment release
<p>Communications</p> <p>Lisa Marie Shekell Joye Burton</p>	<ul style="list-style-type: none"> • Provide support to the Workgroup • Coordinate and Approve Communication Materials • Participate in daily conference calls to be aware of any newly identified issues; • Ensure that the Operations & Transition Triage Team is aware of any issues, which need to be escalated.
<p>Claims / PA</p> <p>Sheldia Maddox Stacey Harris Tina Hawkins Edwinlyn Heyward David Schuster</p>	<ul style="list-style-type: none"> • Monitor Pre and Post Go-Live Indicators; • Support the triage of issues that are identified to determine which issues require an immediate response or action, which issues require defect notification and tracking ; • Participate in daily conference calls to be aware of any newly identified issues; • Ensure that the Operations & Transition Triage Team is aware of any issues, which need to be escalated.
<p>Interfaces / EDI</p> <p>Sheldia Maddox Don Fisher Frank Martin</p>	<ul style="list-style-type: none"> • Monitor Pre and Post Go-Live Indicators; • Support the triage of issues that are identified to determine which issues require an immediate response or action, which issues require defect notification and tracking ; • Participate in daily conference calls to be aware of any newly identified issues; • Ensure that the Operations & Transition Triage Team is aware of any issues, which need to be escalated.

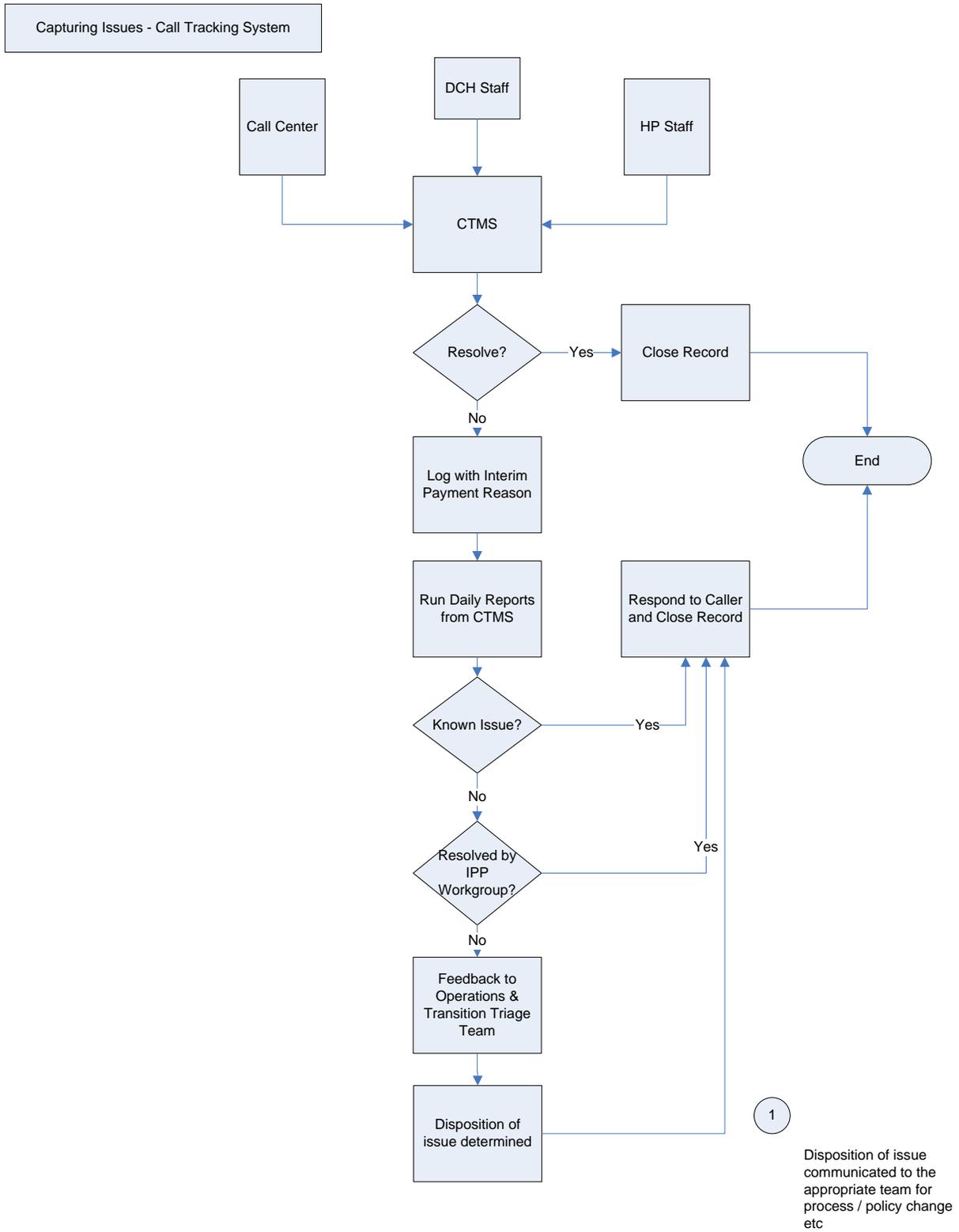
IV&V Patricia Miles	<ul style="list-style-type: none">• Gain an understanding of the Interim Payment Process• Observe the Work Group Sessions
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2.22 Issue Tracking & Escalation

The Interim Provider Payment Workgroup has determined that the HP Call Tracking System, CTMS will be used for call tracking and escalation related to interim provider payment inquiries. In the event DCH staff members are contacted directly, an Interim Payments Quick Reference Guide (see **Attachment B**) has been developed to assist them in the entering of this information into the GAMMIS. Reporting will be generated daily for review (see **Attachment C**).

The CTMS Interim Provider Payment team will be responsible for escalating issues recorded, routing the record to the appropriate team member(s) and following up once the issue has been closed.

See Call Tracking Flow Chart on the following page:



2.3 Operations & Transition Triage Team

In order to facilitate a successful implementation of GAMMIS and the transition from ACS to HP, it is recommended that an Operations & Transition Triage Team be created.

The team would be responsible for the prioritization and coordination of the resolution of ALL issues that arise during the deployment of GAMMIS on November 1, 2010. The Interim Provider Payment Workgroup members should be assimilated in this team to both report on and be informed of issues and resolutions.

3.0 Business Contingency Plan -Payment to Providers

The DCH is the largest purchaser of health care in the State of Georgia and must make provider payments to ensure access to care for Medicaid member. DCH has made the continuity of payments to health care providers and suppliers its first priority both in GAMMIS system development and in its contingency planning. DCH through its business partners is making an unprecedented outreach effort to the provider to make sure that they are informed of the change in fiscal agent so that they are able to respond to training initiatives and changes in systems requirements.

Timely and succinct internal and external communications are imperative to ensure that payment issues are identified quickly and that the provider community is kept informed. Issues must be analyzed and worked in real-time. Appropriate resources must be available for issue consultation and implementation of immediate actions.

The indicators noted in Section 1.6 will be used to determine the type of communication that will be most timely and effective. Prior to Go-Live, DCH system testing, provider beta testing and the cutover plan will dictate interim payments that may be required from the onset. Upon implementation, the Department will monitor the report driven indicators on a daily basis. The HP provider Contact Center and DCH will use CTMS to log all provider calls related to payment issues. Reports will be generated daily to discuss and identify payment issues identified by the providers. When the Department agrees that the need for interim payments exits; DCH will proactively communicate to the affected providers by posting messages on the HP provider website, using the GAMMIS Letter Generator application (see **Attachment D**) and/or including information as a banner message which displays on the provider's remittance advice.

Providers will receive instructions to complete an Interim Provider Payment Request Form (see **Attachment A**) that will be linked to the website. The Form will require information regarding the weekly claim dollar amount submitted and the amount of payment requested. The completed form will be submitted to a DCH email account (Interimpmts@dch.ga.gov), where it will be reviewed and submitted to senior management for approval. There will be predefined criteria used to evaluate the payment request, such as: submission of a claim to the MMIS or DCH, the dollar amount requested, the historical weekly payment average, the dollar amount of the

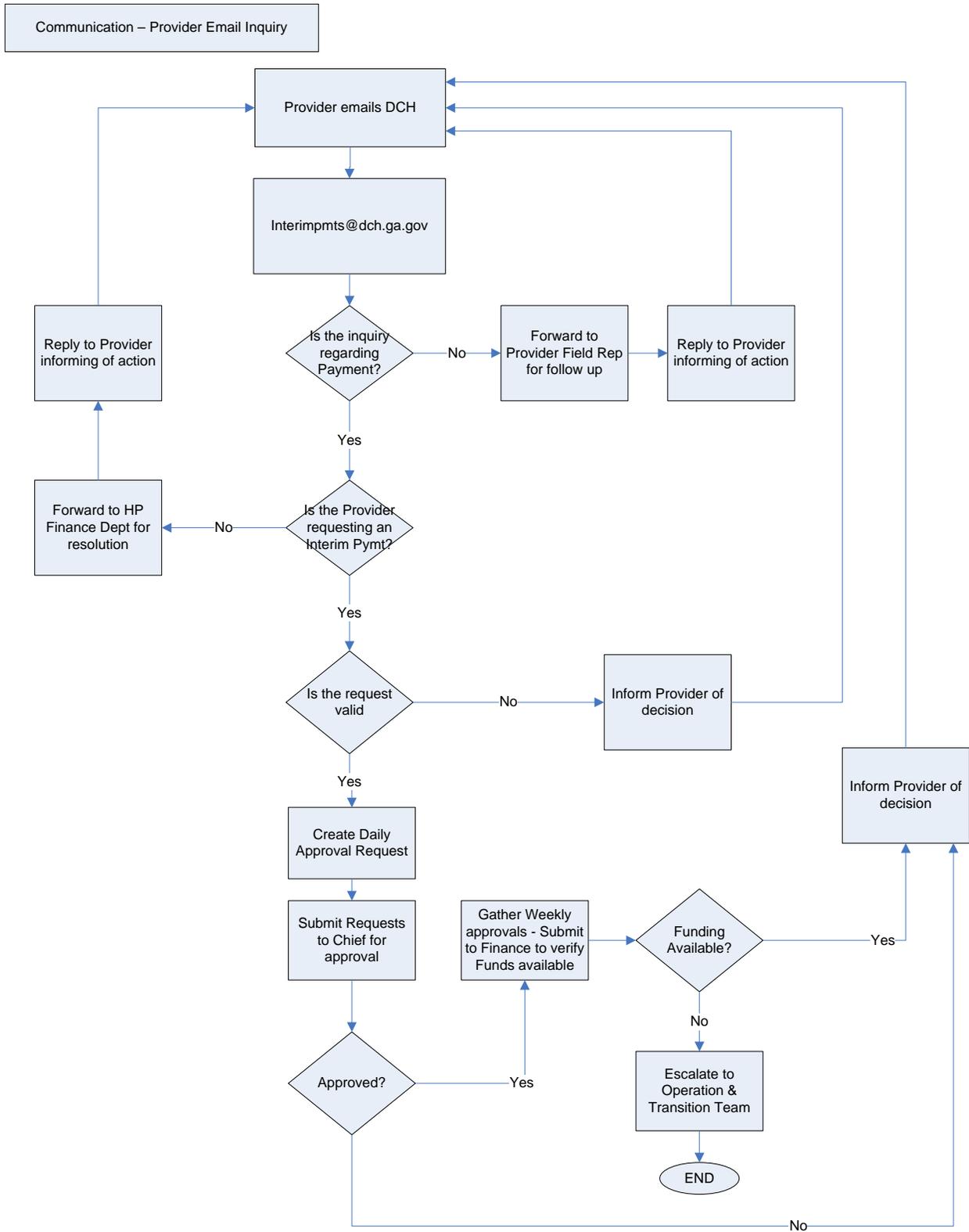
reported claims submitted, etc. If approved, 80% of the lesser amount will be issued in the subsequent payment cycle.

In the event of a catastrophic situation; defined as the GAMMIS not being able to accept any or a significant majority of claims, the Department will take the following action:

- Request CMS assistance to obtain Federal Funds
- Discuss allotment of additional funds from Office of Planning and Budget (OPB)

If these efforts are unsuccessful, the Department will make non claim based payments to the extent state funds are available. The Department will allocate the funds by issuing only the State Share of the historical claims average for each provider and create an estimated payable for the Federal Share.

See Provider Email Inquiry Flow Chart on the following page:



Once a Payment Request Form has been approved, the payment will be issued using **one of two methods**, depending on whether or not the submitted claims can be adjudicated by the GAMMIS.

(1) Lump Sum Payment Method

If a provider has attempted to submit claims electronically and the GAMMIS is unable to accept the claims for processing, the provider would receive a lump sum payment, based on the criteria previously described. Since this type of payment would not be based on an “adjudicated” claim, the Department understands that these payments would be issued using 100% State funds with no Federal Financial Participation (FFP) match. Accordingly, these payments would not be included on the CMS64 Report. These payments would simultaneously be recorded as accounts receivables on the Department’s general ledger (basis for DCH financial statements). Subsequently, when the system has stabilized and adjudicated claims are paid, the accounts receivable will recoup as 100% State funds and the Federal funds will be claimed.

In the event that there is a catastrophic problem with the GAMMIS, the Department and CMS would need to work together to determine an overall funding strategy for provider payments.

(2) Adjudicated Claim Flat Fee Based Payment Method

If a provider has successfully submitted claims, but the DCH senior management is aware of a claim processing or pricing problem with specific claim and/or provider type, the claim will adjudicate using a calculated claim average rate. This will allow the payment to be linked to a specific claim and the provider will be able to post the payment to their Medical Billing records. Reports will be created to identify the claims that have been paid in this manner and track their adjustments when (a) the issue that prevented their initial payment has been corrected, and (b) the claims are reprocessed.

These adjudicated claims will be paid using both State and Federal funds, based on the FFP in effect as of the payment date. The payments will be reported on line 6 of the CMS64 Report, in accordance with the related category of service. At the time that the claims are subsequently adjusted, it will be determined if an overpayment or underpayment has been identified. If an underpayment has occurred, the underpaid amount on the adjusted claim will be paid and reported as a positive adjustment on line 8. If an overpayment is identified when the claim is adjusted, and recovery occurs, the recoupment will be included on line 10b.

If the overpayment is not recouped, an accounts receivable will be created. If the receivable is recouped from subsequent claim activity, the recoupment will be recorded on line 10b. If a refund is received, the entry would be reflected on line 9d. If the accounts receivable ages over 60 days from being identified, the current process for reflecting 60 day receivables will be followed. The 60 day receivable balance will be reported on line 10c. By reporting the 60 day receivable, any increase in the balance will result in the federal portion of the overpayment being returned to CMS. When the 60 day receivable is subsequently recouped, the 60 day receivables will decrease. This will result in a refunding by CMS of the federal portion of the overpayment.

4.0 Communications/Media Plan

DCH’s Communication Office is designed to answer questions during the transition phase from constituents and specified stakeholders in a *centralized manner*. Additionally, the DCH’s GAMMIS Implementation Management Team has through knowledge of Medicaid and PeachCare for Kids® programs. They will deliver the designated message to providers and/or members who call in with issues related the GAMMIS implementation. If the Communications Office cannot address an issue learned from a constituent or media, they will refer the issue back to the appropriate GAMMIS Implementation Management Team member for resolution.

DCH’s internet site will provide information to members and providers in addition to frequently asked questions, how to enroll providers, apply for medical assistance, obtain a replacement id card, how to file a claim, how to appeal a decision and applicable toll free numbers for speaking to a customer service representative.

The signature(s) below denote acceptance of the plan.

Approval Authority		
Name	Title	Signature and Date
Jerry Dubberly	Chief, Department of Medical Assistance	
Robert Finlayson	Inspector General	
Scott Frederking	Acting Chief Financial Officer	
Vince Harris	Acting Chief Information Officer	