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Medical Association of Georgia

Building a Better State of Health Since 1849

June 29, 2012

Jerry Dubberly, Pharm. D.
Chief, Medicaid Division
Georgia Department of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303-3159

Re: Medicaid and PeachCare Redesign

Dear Dr. Dubberly:

I am writing in response to your request for additional feedback regarding the Navigant Redesign Task Force for the Medicaid and PeachCare programs in Georgia. Thank you for giving us the opportunity to participate in this important initiative as we seek to improve the Medicaid and PeachCare programs and provide health care solutions for the state's neediest populations.

I have attached a letter that the Medical Association of Georgia (MAG) wrote to Commissioner David Cook on February 29, 2012, with MAG's initial findings and suggestions regarding the redesign of Medicaid and PeachCare. I **would like to emphasize that MAG remains committed to resolving all the concerns that were outlined in that letter regarding the current CMOs and Fee for Service programs.** There are several additional issues that are especially important that we would like to address in detail.

MAG remains concerned about the possible **influx of more than 600,000 beneficiaries** into the Medicaid programs in Georgia. Studies reveal that Georgia spent $4,074 per capita on Medicaid patients in 2010, the third lowest in the nation. What's more, Medicaid hospitals and physicians have already been devastated by payment reductions and administrative burdens. The addition of 600,000 new patients is simply unsustainable.

MAG is also concerned about the **lack of standardization** in the Medicaid and PeachCare programs. The administrative burden associated with four different administrative structures for the three CMOs and FFS Medicaid represents an unreasonable burden for physicians. This lack of standardization in the current systems mean that there are four different formularies, four sets of prior authorization rules, four different billing requirements, and four different policies and procedures for virtually every aspect of practice administration. This collectively represents a huge obstacle for physicians.

The attached May 19 letter to DCH Commissioner Cook outlines MAG's assessment of the CMOs and FFS. Addendums 1 and 2 are a compilation of complaints that MAG received from physicians during the week of April 18, 2011. These assessments illustrate the practical difficulties that physicians face with the current Medicaid and PeachCare systems. Examples involve claims processing, secondary claims, credentialing, low payment rates and prior authorization, as well as a integrated delivery and payment model.

- **Claims processing:** Complaints to the CMOs and FFS programs regarding erroneous denials and denial reasons. Several services, in particular, are being denied including preventive wellness, emergency cesarean deliveries, and miscarriage claims. Several other complaints are also included.
- **Secondary claims:** This includes all coordination of benefits (COB) and crossover claims. There have been several complaints in both FFS and CMOs (e.g., COB payment errors, third party liability payment denials, anesthesiology payment denials, and MCR claim denials.)
- **Credentialing:** Delayed physician credentialing processing has been a problem for physicians in both the FFS and the CMOs. Some physicians have waited as long as six months to be credentialed.
- **Low payment rates:** Along with erroneous denials, MAG has received several complaints about extraordinarily low payment rates and erroneous fee schedules.
- **Prior authorization:** This includes complaints related to excessive administrative burdens for prior authorizations and pre-certifications for different procedures. The process should be streamlined, and it should include a reasonable process for emergencies and late requests after 3 p.m. on Fridays.
- **Integrated Delivery and Payment Models:** As detailed in a forementioned May 19 letter, MAG supports integrated delivery systems that include the patient-centered medical home (PCMH), integrated care for Dual Eligibles, enhanced primary care case management, and comprehensive care coordination. MAG further supports a change in emphasis from episodic acute care to prevention by accomplishing more care in one or more integrated delivery system (e.g., Kaiser Permanente) We continue to support the choice of a payment model based at least in part upon capitation/prepayment--thus incentivizing outcomes (i.e.,better health) rather than process,(i.e., coding, billing).

Furthermore, MAG urges the Department of Community Health to follow the guidelines that are included in the *MAG Georgia Model Managed Care Contract* for physician/managed care organization(MCO) contracts. The sections of the contract that warrant particular attention include:

Delivery of Services

2.1: Covered services should be consistent with those covered by Medicare in order to better align the programs and to insure equity for the Medicare-Medicaid dual eligible patient.

2.1: Notes: A covering physician does not have to be a Medicaid participating physician.

2.6: All enrollees should have an ID card with the specific name of the payer; enrollee's name, picture, logo, contact information for prior authorization, the billing address, and any other information consistent

with private payer plans. Except in the case of Emergency services, participating physician shall use, and shall be entitled to conclusively rely on the mechanism, including identification care, MCO web site, or telephone, chosen by MCO designated for such purpose to confirm an Enrollee's status as an Enrollee, eligibility and applicable Covered Services prior to rendering any such services, in order to guarantee payment. (24 hours a day, 7 days per week basis)

NEW: All enrollees' eligibility should extend for a minimum of one year.

NEW: All emergency services will be covered whether or not the physician is enrolled in the Medicaid program.

Access to psychiatrists within 100 miles or allowance for primary care physicians to prescribe psychiatric-only drugs until a psychiatric consult is available.

Compensation and Related Terms:

3.1: Compensation- MCO shall have an obligation to pay Participating Physician the compensation designated on Exhibit B, Attached hereto, for the Covered Services provided by Physicians hereunder.

New: MCO shall pay a fee schedule or capitulated rate no less than the current year payment rates under the Medicare Fee-for-Service Fee Schedule or its equivalent for a capitated rate. (MAG would prefer that there be a single formulary/fee schedule across all MCOs)

3.7: Coding for Bills Submitted. MCO hereby agrees that Claims submitted for services and procedures rendered by Participating Physician shall be presumed to be coded correctly. MCO may rebut such presumptions with evidence that a Claim fails to satisfy the standards set forth on AMA CPT Codes. MCO shall adhere to AMA CPT Codes, including the use and recognition of modifiers. MCO shall not automatically change AMA CPT codes submitted by a Participating Physician. (Payment should be included for preventative medicine counseling, 99401, etc, in the treatment of obesity and obesity prevention, which is currently bundled.)

3.8: Copayments to be Collected from Enrollees. Where the Plan requires Enrollees to make Copayments at the time of service, Participating Physician shall collect such Copayments accordingly. MCO shall pay all co-payments and deductibles owed on Dual Eligible Medicare-Medicaid patients.

3.10: Coordination of Benefits (b) If Payer is deemed "secondary" in accordance with applicable industry COB standards, Payer shall pay Participating Physician the difference between what Participating Physician received from the primary Payer and the additional amount Payer owes Participating Physician as Total compensation under the terms of this Agreement. In the case of Medicare beneficiaries and where the Payer is the secondary Payer, the sum of such payments shall not be less than one hundred percent (100%) of the Medicare allowed fee schedule.

3.11(h) No Payer may conduct a post payment audit or impose a retroactive denial of payment on any Claim by any Claimant relating to the provision of health care services that was submitted within 6 to 18 months of the last date of service or discharge covered by such Claim, consistent with Georgia law.

Participating Physician's Obligations

4.8 Noninterference with Medical Care. (Medical Necessity) Nothing in this Agreement is intended to create (nor shall be construed or deemed to create) any right of MCO or any Payer to intervene in any manner in the methods or means by which Participating Physician and its Physicians render health care services or procedures to Enrollees. Under no circumstances shall MCO or any Payer limit the free, open and unrestricted exchange of information between Participating Physician and/or its Physicians and Enrollees regarding the nature of the Enrollee's medical conditions or treatment and provider options and the relative risks and benefits and cots to the Enrollee of such options, whether or not such treatment is covered under the Enrollee's Plan, and any right to appeal any adverse decision by MCO or any Payer regarding coverage of treatment that has been recommended or rendered.

MCO's Obligations

5.1 MCO shall include as part of Exhibit C a list of each Payer and shall promptly update Exhibit C upon the addition or deletion of Payers. The Parties acknowledge that the intent of Sections 5.1 is to provide a mechanism for assuring that "rental networks" and similar arrangements do not accede to this Agreement or avail themselves of the discounts and arrangements established by the Parties through this Agreement.

5.5 Cooperation in Credentialing. MCO and Participating Physician agree to cooperate in credentialing and re-credentialing Physicians in accordance with the process set forth on Exhibit D of this Agreement. Notwithstanding the foregoing, MCO and Payer agree that Participating physician shall not be charged or assessed any amount associated with the credentialing and recredentialing Physicians. MCO shall permit Physicians to submit applications prior to the time when the Physician(s) becomes actively employed or engaged by a participating physician group. MCO agrees to make final physician credentialing determinations within thirty (30) calendar days of receipt of an applications and to grant provisional credentialing pending a final decision if the credentialing process exceeds thirty (30) calendar days. If a Physician is successfully credentialed, MCO shall retroactively compensate such Physician for services rendered from the date of his/her credentialing submission. The MCO agrees to use data from the NCQA if the physician participates in that process and desires that it be used.

5.8 Quality Improvement. Evidence-based clinical quality of care measures are the primary measures used, and outcome measures are subject to the best available risk-adjustment for patient demographics and severity of illness. The reporting process is voluntary for the Physician. MCO provides Physicians the opportunity to review and appeal the accuracy of their personal data and data analysis. MCO's current Quality Improvement Initiatives are listed on Exhibit H. In the event any of these initiatives require Participating Physician to submit data, MCO agrees to provide Participating Physician with at least ninety (90) days advance written notice of all information that must be submitted, including any deadlines. This should include adequate payment for developmental screening, AMA CPT Code 96110, at "Well Child" and "ADHD" visits, which often require more than one screening at a single visit.. MCO agrees to pay physician a 10% monthly bonus payment of all services paid for patient information being reported.

Records and Confidentiality

6.2 Access to Records. MCO must make a written request for medical records and allow for ten (10) business days to receive such records. However, any review of the medical records by MCO must be narrowly tailored to the specific purpose for which the MCO seeks the information and must be in compliance with applicable state and federal laws, including but not limited to the federal regulations

promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. The MCO will request no more than 20 medical records at a time from any one practice, at no more than one time per year.

MAG is hopeful that the Department's Medicaid redesign will be a critical step toward improving and coordinating the overall system of care in our state. This will, in turn, ensure that physicians are able to attain the optimum care for their patients and the state of Georgia will have a healthier population now and in generations to come.

Sincerely,

Sandra B. Reed, M.D.
President

Attachments
DP/cg

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Medical Association *of* Georgia

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February 29, 2012

David A. Cook, Commissioner
Department of Community Health
2 Peachtree Street, NW
40th Floor
Atlanta, GA 30303-3159

Re: Medicaid and PeachCare Redesign

Dear Commissioner Cook:

We are writing to you on behalf of a diverse cross-section of physicians and hospitals in Georgia. We would like to address the report that Navigant prepared for the Georgia Department of Community Health (DCH) as it makes plans to redesign the Medicaid and PeachCare programs in the state. With the release of the Navigant report, the Medical Association of Georgia (MAG) convened a working group representing solo physicians, multispecialty large group physicians, health system physicians, specialists, rural and urban hospitals, as well as an academic teaching institution. We want to thank you for the opportunity to participate in this very important initiative as we seek to find health care solutions for the state's neediest populations. We also look forward to working with you throughout the process.

As Navigant pointed out in its report, a number of states are looking at managed care models as they brace for the Patient Protection and Affordable Care Act-driven influx of Medicaid beneficiaries – including more than 600,000 in Georgia – in 2014, especially those with the chronic conditions. But we still view managed care, including the CMO system that is currently in place in Georgia, as largely experimental and unproven (i.e., it hasn't delivered substantial value or cost savings). It was, indeed, unsettling to learn that Navigant discovered that dramatic cost overruns and deferred payments have been the norm among the 12 state managed care models it evaluated.

According to the latest information from the Henry Kaiser Foundation, the amount of money that Georgia currently spends on Medicaid patients per capita ($4,074) is already the third lowest in the nation. That means it is unlikely and unreasonable to think that we can squeeze much more out of the system, especially when you consider that both hospitals and physicians have already been decimated by the payment reductions and administrative burdens that have been imposed on them by the CMOs in the state.

Some important caveats notwithstanding – and in light of the fact that it is improbable that the Georgia legislature will abolish the CMO system in the state – we nevertheless view the fee-for-service and CMO systems that are currently in place in the state as the best-available option. We also believe that DCH should conduct several pilot programs to evaluate alternative models that physicians believe hold some promise. These models should be evaluated from a number of perspectives, including cost and benefits, practical implications, and the implications for unique areas and populations. This dual-pronged approach

will give physicians and other key stakeholders a chance to evaluate the concepts without disrupting the entire Medicaid program in the state in a permanent, wholesale way.

We believe that DCH should test 1) a Patient-Centered Medical Home (PCMH) model for children and adults who have chronic diseases or who have critical care needs that require more careful management and 2) a private, free-market care model (e.g., health savings accounts, defined private benefit plan), which might be a good fit for the new working-class beneficiaries who will become Medicaid eligible in 2014.

In redesigning the Medicaid and PeachCare programs, MAG also believes that DCH should…

- Use models that are diverse enough to account for the different Medicaid populations, geographic nuances, and disease nuances.
- Maintain the fee-for-service system for the aged, blind and disabled patient populations given their need for unhindered care. Children with chronic health conditions and disabilities would benefit from a PCMH based system rather than straight fee-for-service.
- Be cautious when it comes to co-pays, which can 1) discourage patients from getting the care they need and 2) result in financial losses for physicians and hospitals.
- Prohibit "all products clauses" in all physician contracts.
- Employ state-managed models rather than those that rely on contractors since the corresponding administrative costs increase from about three percent to nine percent or more.
- Adopt policies that will result in patients assuming more responsibility for their own care.
- Increase physician payments for Saturday and evening care to reduce the need for more costly hospital emergency room care.
- Increase the use of telemedicine.
- Reinstate the 20 percent copayment for dually eligible Medicare and Medicaid patients, and allow physicians to collect co-pays from patients who have private insurance as their primary insurance and Medicaid as their secondary insurance.
- Improve the uniformity of the "quality of care" reporting requirements for physicians. Reporting requirements for pediatricians should be specific to the care that they provide to children.
- Employ a clear and graduated formula for payments for physician office-based or clinic case managers under the "Patient-Centered Medical Home" model that is based on the severity of the patient's disease and/or the extent of the management that is required.
- Create community-based, hospital, clinic, or physician service models that can be implemented at the local level and replicated in other areas.

- Form community-level adult and pediatric advisory groups that can oversee how the system operates at the local level and offer advice on ways to enhance Medicaid and PeachCare services.

- Standardize the provider contracts that are used by the CMOs so they have the same non-financial terms.

- Standardize the precertification and prior authorization requirements among the CMOs.

- Require CMOs to adopt one set of rules for claims auditing.

We also believe that DCH must simultaneously modify the current Medicaid/PeachCare programs in a number of ways, including credentialing, quality of care reporting, administrative efficiency, patient access, payment levels, patient education, and service denials.

The credentialing process should employ: a single, uniform, paperless process – one that pays physicians on a retroactive basis once the requisite credentialing information has been submitted; a process that lasts no more than six weeks; a single physician identification number vs. one per practice location; better, clearer instructions; a better way to contact administrators; more timely updates; and, finally, a confirmation.

If we look at the bigger picture, it is important to point out that physician pay for Medicaid in Georgia has remained flat for 10 years – despite rising costs and ever-increasing administrative burdens. The Medicaid fee-for-service payment rate, which is 86.5 percent of the Medicare rate, simply doesn't cover the cost of providing the care. And matters have grown worse under the CMOs, which have phased out the majority of case management fees while significantly increasing the administrative demands. Change notwithstanding, the future looks especially bleak for primary care physicians in rural areas who have a disproportionately high number of Medicaid patients.

There is, of course, a relationship between physician pay and the number of physicians who participate in the Medicaid program. So it is no surprise that the DCH Board of Directors has reported that the number of physicians who participate in the Medicaid program in Georgia has dropped by more than 15 percent in the last five years. We consequently believe that DCH should establish a minimum/base level physician fee schedule for Medicaid to provide some stability.

Other factors that discourage physicians from participating in the Medicaid program in Georgia include excessive numbers of prior authorizations, required reports, and medical necessity reviews, as well as the overall complexity of Medicaid rules. What's more, services are often fragmented due to interruptions in treatment that are caused when more expensive, though necessary, services like radiology, physical therapy, and other testing are denied. It is important for DCH to take steps to address these issues.

We are concerned about the accuracy and usefulness of quality reporting by the CMOs since it's not standardized or easily accessible for review and tracking by health care clinics and physicians.

We also believe that the Medicaid/PeachCare system in Georgia needs to be better aligned with other children's care programs in the state to avoid duplicity and facilitate better coordination of care.

Finally, we would like to see DCH put better controls in place (e.g., annual/one-year enrollment terms) to reduce the frequent eligibility changes that plague today's system to ensure that patients get the best possible care (i.e., continuity). For example, enrolling all eligible children in Medicaid at birth and keeping kids enrolled in the appropriate program as family income levels change.

It is imperative for physicians in Georgia to secure some peace of mind and budget certainty as they assess whether it is feasible for them to participate in the Medicaid and PeachCare programs in the future. Therefore, we are encouraging DCH to address that gap in confidence as a deliverable to ensure that the state's neediest patients continue to have access to the physicians and the medical care they need.

Please contact Donald J. Palmisano Jr. with MAG at dpalmisano@mag.org or 678.303.9250 in the event you have comments or need additional information.

Sincerely,

Sandra B. Reed, M.D., President
Medical Association of Georgia

Quentin R. Pirkle, M.D.

Quentin R. Pirkle, Jr., M.D., Chair,
Piedmont Clinic Board of Directors,
a subsidiary of Piedmont Healthcare

Richard J. LoCicero, M.D., President
The Longstreet Clinic, P.C.

Steven M. Walsh, M.D., President
Georgia Society of Anesthesiologists

Jose M. Tongol, M.D., President
Georgia Society of Clinical Oncology

Matthew J. Watson, M.D., President
Georgia College of Emergency Physicians

Robert N. Vincent, M.D., President
Georgia Chapter, American College of Cardiology

Leland C. McCluskey, M.D, President
Georgia Orthopedic Society

Howard M. Mazier, M.D., President
Georgia Psychiatric Physicians Association

Harold L. Kent, M.D., President
Georgia Society of American College of Surgeons

Michael Sharkey, M.D., President
Georgia Society of Dermatology and Dermatologic Surgery

Marvin A. Rachelefsky, M.D., Treasurer
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Malcolm S. Moore ("Sid"), Jr., M.D.,
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Michael D. McEachin, M.D., President
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CC: Jerry Dubberly, Pharm. D., Chief, Medical Division, DCH
Terri Branning, Executive Medicaid Business Analyst, DCH

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Medical Association *of* Georgia

Building a Better State of Health Since 1849

May 19, 2011

David A. Cook, Commissioner
Georgia Department of Community Health
2 Peachtree Street, N.W., 40th floor
Atlanta, Georgia 30303

Dear Commissioner Cook:

Per your request, the Medical Association of Georgia, the Georgia Academy of Family Physicians, the Georgia Chapter of the American Academy of Pediatrics, Georgia College of Emergency Physicians, Georgia Chapter, American College of Physicians, the Georgia Obstetrical and Gynecological Society, Georgia Neurological Society, the Georgia Society of Anesthesiologists, Inc. , and the Georgia Society of Clinical Oncology prepared the following comments to address the Medicaid Care Management Organizations (CMO) in Georgia. In addition, we took the liberty to detail some of the key problems that surround the Medicaid "Fee-For-Service" program in the state – issues MAG discussed with Medicaid Director Jerry Dubberly, in a meeting on April 15.

Following a tumultuous introduction in June 2006, we have noted some gradual improvements in the administration of the CMOs in Georgia. However, many substantial problems remain. It's inevitable that there's going to be system volatility with any massive public program change, such as the transition of most of the Medicaid population to a HMO system. But it is troubling to physicians that so many serious problems remain, even as the fifth anniversary of CMOs in Georgia approaches.

The fact that physicians must contend with three different administrative structures for CMOs – four if you include regular FFS Medicaid – is inherently problematic and creates an unreasonable administrative burden. This means four formularies to follow, four sets of prior authorization rules to follow, four different billing requirements, four different policies and procedures for virtually every aspect of practice administration.

We are also concerned that none of the savings, which the CMO's claimed to have produced, have filtered down to the physician practices, who actually provide Medicaid patients with care. Most of these physicians are in small private practices that don't have the size or scale to continue to absorb the kind of losses associated with low CMO payments, which have remained flat despite the effects of inflation.

Exacerbating matters is a shortage of physicians in the system, both in primary care—family medicine, pediatrics and internal medicine; obstetrical care, and specialists—most acutely in pediatrics but also in adult care. This represents a real obstacle for large numbers of Medicaid patients when it comes to finding an appropriate physician to deliver their care. Further, Medicaid patients still aren't always assigned to the

physician of their choice – an issue that often takes a long time to resolve. That such a fundamental and basic system feature is still flawed five years into the launch of CMO's is almost incomprehensible.

When it comes to specific issues, the attached addendum provides a chronicle of the problems practices continue to face, including examples such as attending physicians who go unpaid when they assume care for reassigned newborns; physicians paid at rates inconsistent with the fee schedules; patients being assigned to obstetricians in counties that don't have hospitals with adequate capabilities; unreasonable prior authorization requirements often represent a considerable burden for obstetrical and high-risk patients, lengthy times to credential physicians who want to serve these patients, anesthesia specialists and other providers routinely paid at improper rates, etc. etc.

These are just a few of the issues that need to be addressed to improve the Medicaid/CMO system in Georgia. With that in mind, we have also prepared the attached addendums. Addendum 1 contains a list of the most pressing Georgia Medicaid CMO issues, while Addendum 2 addresses important Medicaid Fee-For-Service issues.

In terms of CMO priorities, we believe that the single most pressing issue is the payment rate for physicians; Medicaid pay must keep pace with the cost of running a medical practice. While we understand that the General Assembly pays a major role in setting Medicaid payment rates, we are disappointed that in five years the CMO's have not sought to address any facet of this issue, whether it be rate increases of their own, reducing administrative burdens, shared savings programs to broad groups of physicians, incentive programs, and so forth.

While the challenges that physicians face in the CMO arena are no doubt considerable, nevertheless, we believe the problems associated with the current Medicaid Fee-For-Service system that's administered by HP Enterprises are also profound. We urge you to address those issues, some of which have worsened since the HP conversion in November, which have been detailed in Appendix 2, as soon as possible.

In closing, the physician members of the undersigned organizations would like to express our sincere thanks for the opportunity to comment on some critical issues and we look forward to working with you and the Department of Community Health in the future. We genuinely appreciate your efforts to strengthen the Medicaid program in Georgia to ensure we can collectively care for the state's neediest patients.

Sincerely,

E. Daniel DeLoach, M.D., President
Medical Association of Georgia

Harry S. Strothers, III, M.D. MMM, FAAFP,
President, Georgia Academy of Family Physicians

Kathryn K. Cheek, M.D., President
Georgia Chapter, American Academy of Pediatrics

Robert J. Cox, M.D., President
Georgia College of Emergency Physicians

Jacqueline W. Fincher, M.D., Governor
Georgia Chapter, American College of Physicians

Cynthia A. Mercer, M.D., President
Georgia Obstetrical and Gynecological Society

Marvin Rachelefsky, M.D., Representative
Georgia Neurological Society

Timothy N. Beeson, M.D., President
Georgia Society of Anesthesiologists, Inc.

Jose M. Tongol, M.D., President
Georgia Society of Clinical Oncology

/cg
Enclosures
Appendices 1 and 2

Addendum 1

Georgia Medicaid CMOs Assessment

April 28, 2011

Medical Association of Georgia
Georgia Academy of Family Physicians
Georgia Chapter, American Academy of Pediatrics
Georgia Chapter, American College of Physicians
Georgia College of Emergency Physicians
Georgia Obstetrical and Gynecological Society
Georgia Neurological Society
Georgia Society of Anesthesiologists, Inc
Georgia Society of Clinical Oncology

The following is a compilation of complaints received from MAG physicians during the week of April 18, 2011 and from other primary care and specialty physician organizations during March 2011. The topics are broken down by major program/function areas and references are provided if examples were noted with the complaint.

A. Claims Processing/Payment

1. *Complicated Claims Processing Requirements:*
   Large multi-specialty clinics report that Wellcare requires that "dates of service" for all services be filed under one claim number. This is particularly difficult for large practices to prepare and highlights a deficiency in the CMO payment system. **(Reference E-1)**

2. *Improper NDC Reporting Requirements:*
   Although DCH agrees that NDC numbers are no longer required for vaccines that are provided to children reenrolled in Medicaid, Wellcare and Amerigroup continue to require them. **(Reference G)**

   OB-GYN practices report that Wellcare and Amerigroup require NDC code reporting in different formats, which is an administrative burden. **(Reference C-1)**

3. *Improper Fees Paid for Rural Health Clinic Specialists:*
   Physician group approved as a federally-designated rural health clinic, fails to be paid by Amerigroup at the correct Medicaid specialist's services PFFS rate. Amerigroup insists it only has to reimburse at the practice's current private payment service rate. Billing rule is difficult to explain to non-educated personnel, and lowered rates continue to be paid. **(Reference J-1)**

4. *Payment Inconsistent with Contracted Fee Schedule:*
Anesthesia practices report that Wellcare claims are underpaid per applicable fee schedule. **(Reference B-1)**

5. *Improper Reduction of Anesthesia Assistants:*
Anesthesia practices report that payments for anesthesia assistants are being incorrectly reduced by 10 percent--DCH reports Wellcare logic is incorrect, but errors remain. **(Reference B-2)**

6. *Place of Service Code Denials:*
Large practice reports inappropriate denials by Wellcare for "place of service" codes, unable to get problems resolved.
(Reference A-3)

7. *Administrative Difficulties with Paper Claims:*
Practices reports that Wellcare is inconsistent with the other CMOs in requirements for submission of paper claims, instead requiring manual entry of the taxonomy information and removal of the NPI information. Requirements represent an administrative burden. **(Reference D)**

8. *Improper Bundling of Ultrasounds with Evaluation and Management Services:*
Practices reports that Wellcare denies all ultrasounds performed when billed with an evaluation and management service on the same day. The rational is that the review of the radiology exam or study is already included in the E & M payment based on CMS guidelines. CMS guidelines state that they can be bundled unless a **complete written report** is made. In these cases, a complete written report was made.
(Reference E-3)

9. *Improper Denials Contrary to Coding Guidelines:*
Emergency physician practices indicate that Wellcare is still denying some claims for reasons contrary to accepted coding guidelines. Even though they are usually overturned after an appeal (except for EKG interpretations, which are flatly denied), it is an unwieldy process. **(Reference H-1)**

10. *Incorrect Bundling of Certain Procedures:*

    a. Physicians report that Wellcare payments are often inconsistent with Rural Health PPS Rates/Rules, failing to make the distinctions for unbundled payment as contained on "carve-out" lists established by DCH. **(Reference J-2)**

    b. When the physician bills for an office visit, a procedure and a test (i.e. office visit, pulse, oximetry or pulmonary function tests), the CMO frequently just pays the multiple charges submitted.

11. *Payments Inconsistent with Contracted Fee Schedules:*
Practices report that they are often unable to get their claims paid according to their contracted rate. In the example offered, a practice had asked Wellcare to make a correction for over a year. The practice states it recently met with a Wellcare representative, Dora Wilson, who was "helpful" and it believes the issue can be quickly resolved. **(Reference L-2)**

12. *Overly long lag-times for Recoupment's of Physician Services:*
Many of the CMO recoupment efforts occur well past a reasonable time period and are often inconsistent with Georgia law, which allows the reviews to take place for up to one year or 18 months, depending on the service and/or billing time periods. These recoupments often result in budget and tax implications for the practice, which are difficult to address, and that don't allow enough time to rebill primary insurance. **(Reference H-2)**

13. *Unresponsive CMO Plan Representatives:*
Practices report that CMO representatives frequently do not respond to communications in a timely manner or do not respond at all. They are often not knowledgeable about Medicaid policies, and they are unable to solve problems for physician offices.

14. *Failure to Recognize Standard Modifiers Numbers 58 and 59:*
Wellcare has refused to recognize modifier 58 (staged or related procedure or service by the same physician during the post-operative period), making it difficult to get full payment. **(Reference K).** Wellcare has also refused to recognize modifier 59 (distinct procedure service), which is recognized as a "Fee for service" by Medicaid and all other major payers. (Neurological Associates, Rome, Georgia)

B. Primary Care Physician (PCP) and/or Patient Assignment Problems

1. *Improper denials for PCP "Not on record":*
Large practices report primary care physician (PCP) claim denials by Wellcare because physicians aren't listed as the PCP "on record." This often occurs when newborns are reassigned to new primary care physicians and the plan is slow in formally recording this change. Plans should better track these changes and update them in a timely manner. The issue remains unresolved. **(Reference A-1)**

2. *Patient Classification Delays:*
Problems occur when patients change classification from "standard Medicaid" to CMO or vice versa, resulting in delays in care. Shifting pregnant patients from regular Medicaid to a CMO plan often delays prenatal care and/or results in poor pregnancy outcomes, increasing costs for the entire system.

3. *Improper Default Mechanism:*
OB-GYN practices complain that when a patient fails to elect a CMO, the default CMO is sometimes one with the least number of patients and hospitals in the area. In

the example provided, Wellstar Kennestone and Wellstar Cobb hospitals are the only two hospitals in the county that have OB delivery services that are non-par with Peach State. **(Reference C-2)**

C. Coordination of Care/Secondary/Crossover Claims

1. *Incorrect Identification of Other Insurance by CMO:*
Large practices report denials for "Coordination of Care" when patients are often mis-identified as having other insurance, i.e., Blue-Cross. **(Reference A-2)**

2. *Incorrect Payment of Secondary Claims for Capitated HMO Plans:*
Since the advent of the Georgia CMOs, Wellcare has not correctly paid secondary claims when the primary claim is a capitated HMO plan. This is even true when the paper claim is sent with the appropriate Medicaid TLP form. In the example offered, the practice had to obtain special intervention by the CMO representative to get the claim paid. **(Reference E-2)**

D. Prior Authorization/Precerification

1. *Inefficiencies for practice-based surgery Prior Authorizations:*
Surgical practices complain that Wellcare, unlike all other private insurers, requires a prior authorization when patients on referral to the surgery practice for diagnoses and treatment could have surgery on the same visit. Since the prior authorizations are not timely, a second costly visit is required for the surgery**. (Reference F)**

2. *Overly Broad, Complex, and Time-Consuming Prior Authorization Process:*
In general, practices report that prior authorizations of drugs, procedures, clinical services, and referrals are much too broad, complex, and time-consuming—particularly for obstetrical services, including ultrasounds, IUDs, medications in pregnancy (Rhogam)**. (Reference I)**

3. *Lengthy Precertifications for Out-Patient Testing:*
Practices report that precertifications can take 20 to 45 minutes each on the telephone, and final approval can take from two to 28 days.

4. *Improper Denial of Secondary Drug When Initial Drug Is Not Working:*
Physicians report that at the first level of prior authorization, they are unable to receive a prior authorization for a new drug when the reason given is that the initial drug failed. This is perplexing and difficult for physicians. In addition, the drug formulary does not include Zolair treatment for asthma, a unique drug without an adequate alternative on the drug list.

5. *Inadequate Number of Specialists Visits Allowed Authorization by PCPs:*
The primary care physician is often limited to requesting no more than three specialist visits, making it difficult to manage ongoing care for certain diagnoses particularly oncology services.

E. Physician Credentialing

1. *Lengthy Credentialing Process:*
The physician credentialing process continues to be time and labor-intensive as physicians must apply to be Medicaid "Fee for Service" program providers, as well as a credentialing program for the CMO programs. There are also long delays by Amerigroup in practices obtaining dedicated provider numbers, resulting in provider payments that fail to cover the full time period in which services were actually provided. **(Reference H-3)**

2. *Complicated Credentialing Process:*
The credentialing process for the CMOs isn't allowed until the physician (provider) has a Medicaid number. There should be a simple single or unified credentialing process. In the example provided, a practice states it had five new doctors since January 1, 2011 and that they have been unable to get the physicians credentialed in a timely manner by Wellcare. **(Reference L-1)**

F. Adequacy of Network

1. *Inadequate Specialists in network for Referral:*
Physicians report a generally-deficient specialty physician network, making it difficult to make specialty referrals, which sometimes delays care and can have adverse effects on patient care.

G. New Programs

1. *Delayed or Lack of Promotion of Family Planning Waiver Program:*
The family planning waiver was approved in last year's state budget. A waiver was reportedly submitted and approved some six to eight months ago. Although the Public Health office shifted some $250,000 to the Department of DCH to promote the availability of the waiver, state medical and specialty societies have seen little to no communications to promote this new service/benefit to Medicaid patients. The Georgia Academy of Family Physicians (GAFP) has requested this information from DCH, but has not received a response.

2. *Abrupt End of Georgia Better Health Care (GBHC) "Case Management of Special Needs Patients" to Primary Care Physicians:*
The Georgia Academy of Family Physicians reported that GBHC abruptly dropped some 34,000 children from its program about two months ago for "case management services to special needs patients," stating that GBHC was a managed care system and required a waiver for any special needs child in the plan. This resulted in the sudden and dramatic end of the $2 or $3 case management/extra service fees paid monthly to primary care physicians.

This has had an unplanned and unwarranted financial effect on primary care physician practices and their patients. Questions arise as to why GBHC did not know from the beginning that the program required a waiver, and why it was necessary to abruptly end the program without adequate notice and proper planning to physicians. GAFP and other medical groups would like to be appraised of the status of the waiver request and DCH's plans to address this unexpected reduction in service payment.

3. *Lack of Clarity on the Status of the Dental Varnish Program:*
In 2010, DCH was given approval for the payment of dental varnish for children, whether the care is provided by a physician or dentist. DCH and CMOs have been reticent about promoting these additional services to Medicaid providers and their patients. The medical community believes that the service is important to child health and would like to receive an update on the issue.

Addendum 2

Georgia Medicaid Fee for Service System Assessment

April 29, 2011

Medical Association of Georgia
Georgia Academy of Family Physicians
Georgia Chapter, American Academy of Pediatrics
Georgia Chapter, American College of Physicians
Georgia College of Emergency Physicians
Georgia Obstetrical and Gynecological Society
Georgia Neurological Society
Georgia Society of Anesthesiologists, Inc.
Georgia Society of Clinical Oncology

This is a compilation of problems that were reported to MAG by physician practices during the week of April 12, 2011, in response to a MAG e-mail request. The topics are broken down by major program/function areas; references are provided when examples were provided with the complaint.

A. Web Portal

1. *Inadequate Eligibility Search Engine:*
   Hewlett-Packard/Medicaid's (HP) Website eligibility search engine limits the date range of eligibility inquiry to the dates included in the inquiry. Previous eligibility search engines provided the effective and end date range for the active plan, including any retro-eligibility period, Georgia Families (managed care), and any prior GBHC enrollments information that is useful when determining a patient's eligibility for a certain date of service. **(Reference L)**

2. *Slow Web Site Response:*
   The Web portal is "extremely" slow and often requires multiple login attempts-even during the evening hours when traffic should be light. This is important since physician practices often handle hundreds to thousands of claims per day. **(References H-2 and J-3)**

3. *Inadequate Claim Adjustment Mechanism*:
   When voiding or adjusting a claim on the portal, the system does not show the negative amount-just zero. It is also difficult to tell what was voided versus what was denied. **(Reference H-3)**

4. *Incorrect Payment of Primary Payment:*
Physician offices are receiving a number of primary payments from HP when the claim should be a secondary payment. This causes practices to have to void the payment and resubmit the claim-causing a delay in payments. **(Reference H-4)**

5. *Inaccurate Eligibility Search Engine:*
A practice reported checking eligibility for a patient two times on the same day and received two different answers. (Patient 111541537046 had FFS Medicaid and then had Amerigroup.) **(Reference H-11)**

B. Claims Processing/Payment

1. *Erroneous Denial Reasons:*
Claims submitted prior to 11/01/10 are paid, while identical claims submitted after 11/01/10 are often not paid. Denial reasons are numerous and unclear. Most denial reasons are erroneous and leave billing personnel unable to know how to resolve. **(Reference L-3)**

2. *Electronic Enrollment Errors:*
Providers that had been enrolled as a Medicaid provider and enrolled to file electronic claims are having claims denied on the basis they're not enrolled for electronic billing (Denial #3600). **(Reference L-4)** Claims not processed due to a "provider not enrolled for electronic billing," error message which are then submitted on paper and returned from HP with cover sheet indicating that the provider's Medicaid ID must appear on the paper claim form. **(Reference L-5)**

3. *Preventative Wellness Claims Denials:*
Preventative Wellness claims deny stating that there are "Health Check Referral codes present on a non-health check claim." (Denial #2657) **(Reference L-6)** Preventative Wellness claims also deny stating that the diagnosis is invalid for the category of service (Denial 3423) **(Reference L-7)**

4. *Erroneous Provider Type Denials:*
Claims deny stating that "this provider type/provider specialty may not bill this service (Denial #N95). **(Reference L-8)**

Surgical physicians report that they are not being paid if a service is provided at the hospital, because the practice is listed as Physician/Osteopaths. The practice example's physicians have been surgeons since they were approved as providers of Medicaid services. They have not been able to get this problem corrected by Provider Relations. **(Reference T)**

5. *Incorrect Urodynamics Denials:*
A practice reported not getting paid for the urodynamics performed on patients for stress urinary incontinence. Medicaid denied the claim, stating that the procedure

needs to be done at the hospital on an outpatient basis. The hospital does not schedule these types of procedures; they are done in the physicians' offices. **(Reference M-2)**

6. *Emergency Cesarean Delivery Only Denials*:
Obstetrician offices report that HP/Medicaid is incorrectly denying EMA Cesarean Delivery Only, 59514, for exception edit 5554, "Global fee has been paid for this pregnancy." One practice reported that its HP representative, ("Donna") (Reference #2513176) told them it is an internal issue and there is no estimated time for the issue to be resolved. **(Reference H-7)**

7. *Specialty Type Denials:*
Medicaid/HP is incorrectly denying claims for exception edit 149, "Procedure Restricted to certain specialty(ies). Provider not enrolled for necessary specialty." HP/Medicaid provided no estimated time for correction. When one practice questioned its HP representatives, Shemekia Terrell and Bille Frazier, they were told to go to the "Transition Updates" section of the Website-but the information was not listed. **(References H-8 and H-9)**

8. *Assistant Surgeon Denials in C-Sections:*
HP/Medicaid continues to fail to pay assistant surgeon fees for C-sections. The few times it paid the assistant surgeon fee, it denied the surgeon fee. HP says it's a system issue which they have not been able to resolve. **(Reference C)**

9. *Improper 3-Day Hospital Limit Denials:*
HP/Medicaid is reportedly not paying for all dates of service associated with a hospital stay. It pays for the initial history and physical exam and discharge, but will only pay for one subsequent day physician visit. HP states that this procedure is limited to one per 280 days. For example, if the patient is in the hospital for four days they will pay as follows:
   - Day 1 H & P.....Paid
   - Day 2 Subsequent day.....Paid
   - Day 3 Subsequent day.....Denied
   - Day 4 Discharge.....Paid

   HP states that it is denying 99214 because the information submitted does not support this level of service. They give no further reason for the basis of the denial. **(Reference D-1)**

10. *Improper Urinalysis Test Limits:*
HP/Medicaid will only pay for one urinalysis per rolling month. Physicians have patients that require repeat urinalysis to ensure the urinary tract infection is gone or because they saw an abnormal result and want to recheck a first morning void. **(Reference D-3)**

11. *New CPT Codes Not Updated in System:*
New CPT codes 92133 and 92134 were implemented in January 2011, but they still have not been input into the system. The practice has to keep rekeying the claims on the Web portal to keep them current so that they will eventually be paid. The claims are accumulating. **(Reference F)**

Ophthalmologists report that a frequently used code, Ocular Tomography, previously listed as CPT code 92135, was updated on January 1, 2011 by the AMA to three separate codes. Medicaid has failed to update this in their payment system, forcing practices to refile the claims every 30 days to keep their current. All private insurance companies have updated the codes. **(Reference S)**

12. *Frequent Primary Care Physician Changes Slow Referrals:*
Generating referrals is an issue because PCPs appear to change at random and recently have dropped out altogether. **(Reference D-4)**

13. *Serious and Widespread HP Problems:*
One large management company that handles a lot of claims says that "the system and service issues are so bad; trying to get these issues solved in an efficient and timely manner will not be possible." **(Reference I)**

14. *New Emergency Physician Denials:*
A large emergency physicians group states that some of its Medicaid primary claims are being denied for various and sundry reasons which they have never experienced before. They want to know if the coverage rules have changed. **(Reference G-3)**

15. *Denials of Miscarriage Claims Due to HP's Confusion With Abortion Claims:* HP frequently denies OB/GYB practice claims for miscarriages, CPT Code 59812, with ICD-9 Code 632, 634.91, with remark code 4012, stating that AB Certification of Necessity is missing—This is DMA-311 form which is titled Certificate of Necessity for Abortion. These procedures are not abortions. This was an issue with ACS about three years ago, then corrected. It has now again a problem with HP. **(Reference U)**

C. Coordination of Benefits(COB)/Secondary (Crossover) Claims

1. *Insufficient HP Primary Insurance Listings on Website:*
If the patient has primary insurance and it's not listed on Medicaid's Website, HP will not pay any secondary claims—even though the practice faxed in a required form (DMA-410: EB-TPL) and sent in a copy of the insurance card and a eligibility print out from the Website of the primary insurance company; the patient is also attempting to get Medicaid to accept the primary insurance. **(Reference M-1)**

2. *HP COB Payment Error:*
HP/Medicaid often does not correctly calculate the primary health plans payment on COB cases and pays the wrong allowable amount to the physician. **(Reference M-4)**

3. HP System Cannot Distinguish Patient Deductibles in COB:
Claims are being returned, indicating the Medicare payment is zero when it is applied to the patient deductible. **(Reference N-1)** Practices report problems on Medicare crossover claims when the whole allowed amount is applied to the deductible. In these cases, HP/Medicaid is denying the claims because it says the Medicare deductible amount exceeds the allowable—so they are not paying the physician for the balance of the claim. This was reported to field representatives on February 28, and no resolution has been reported. **(Reference F-2)**

4. *Third Party Liability (TPL) Payment Denials:*
Medicaid denies payment for TPL, stating the payment doesn't match the claim information when it does. **(Reference N-2)**

5. *HP Paper Claim Keying Denials:*
When entering the secondary claims that are submitted by paper; Medicaid/HP leaves the first three numbers off of the patient ID number and denies the claim as incorrect. **(Reference M-5)**

6. *HP Overpays Medicare Primary:*
HP is paying more than the Medicaid allowable on Medicare primary charges, causing additional work for physicians by voiding the payments—not to mention the state losses. **(Reference H-5)**

7. *Multiple HP Crossover Errors:*
One practice detailed the ongoing Medicare Crossover problems that occur when claims are denied: the practice must correct the claims and resubmit them via the HP Web portal. This must be done weekly since the claims continue to be incorrectly denied. The errors: 1) Medicaid ID numbers are entered in the system by HP with the first three digits missing; 2) Medicare claims are being denied for "invalid modifiers," and 3) Medicare claims crossing over on patients that do not have coverage for Medicare premiums but not deductible/coinsurance. **(Reference B)**

8. *HP Denies Anesthesiology Payments Due to Reading Units, not Minutes*:
There are problems with crossover claims from Medicare to Medicaid where HP sees fractional units, not total minutes. The claim balance is then denied. Practices are eventually able to be paid by going to the Web portal and converting the fractional units into minutes, as was billed. This has created a large and unnecessary workload for practices. **(Reference E)**

9. *Anesthetists Payments Incorrectly Denied:*
Anesthesiologists report that with the advent of HP/Medicaid, the doctor claim is paid when they bill code D9242QX claims for MAC anesthesia, but the anesthetists are denied for "invalid specialty." They are unable to get the balances paid, even under

the Web portal, so the claims are accumulating. **(References E-1 and E-2)** This may be related to the way the Category of Service for anesthetists (431) is set up under this code (D9242) in the HP system. If you pull up this code under COS431 on the Web portal, the modifier scenario does not list "Including 1-1 from QX" nor "Including 1-1 from QZ." It appears that this might determine which modifiers are paid under each procedure code. Since the above scenarios are not included under Category of Service 431, the claims are denied to "invalid specialty." In this case, a simple correction in the HP system would remedy this problem. In this case, the practice manager attempted to use the "Contact Us" feature on the Web portal and tried to reach her provider representative but has not yet received any response. **(Reference K)**

10. *Anesthetists Crossover claims denied due to patient classification SLGl1:*
Anesthesia practices report that Anesthesia crossover claims are being denied with the edit, "not payable per coverage restrictions," which HP explains is a special patient classification SLGl1. HP states that physician practices cannot bill the patient for their Medicare co-insurance as Medicaid will not cover it. The practice is not acquainted with this patient classification and no clear explanation is offered. **(Reference R)**

11. *Unworkable and Non-paying Emergency Physician Secondary Payment System:*
ER physicians report problems surrounding secondary claims processing. They state the Medicare/Medicaid auto-crossover interface is not working correctly. Medicare normally sends primary payment information to Medicaid electronically so it can pay any secondary amount due. Medicaid is also requiring providers to wait 45 days from Medicare processing to submit an alternative paper, which slows the process down. Outstanding Account Receivables continues to grow. It also takes HP Enterprises a long time to process secondary paper claims. One practice reported sending numerous secondary paper claims to HP that haven't been loaded into their system for one to two months. **(Reference C)**

12. *MCR Claim Denials:*
MCR crossover claims are denied on the basis that Medicaid should be the tertiary payer. An inquiry request results in a response that the patient has MCR Part A, B, C and D. The eligibility search engine can't determine if the patient is enrolled in an MCR Advantage plan. The claim has crossed over with the Explanation of Benefits from the MCR Advantage carrier. **(Reference L-2)**

D. Medical Review

1. *Unclear Suspended Claims for Medical Review:*
Medicaid suspends claims for medical review for no apparent reason. What's more, the customer service representatives cannot provide a reason. **(Reference M-3)**

E. Provider Representative/Education

1. *Unavailable Provider Representatives:*
   Practices continue to report that they cannot reach a provider representative for help. When practices finally reach HP, it appears the representatives are reading from a script and have no understanding of the billing system or of the problem. **(References M-6 and O-1)**

2. *Ineffective Provider Representatives:*
   HP representatives are generally reluctant to assist practices with claims resolution. They repeatedly refer them to the Web portal or to administrative manuals, which is often not helpful. Only after strong insistence are the HP representatives willing to retrieve the claims or research why codes were used to deny the claim, and the remittance advice often does not match the detailed explanation the representative finally provides. One practice stated that effective HP Enterprises field support is non-existent. **(References A, J-1, and N-3)**

3. *Insufficient Provider Education Meetings:*
   Practices report that HP/Medicaid has not scheduled any provider meetings since the introductory meetings in 2010. **(Reference A)**

F. Consent Forms

1. *Black Hole Consent Forms:*
   Medicaid continues to report that it has not received a consent form, even when they are sent by registered mail or fax. This involved more than $5,000 in claims for one practice. **(Reference M-7)**

G. Failing to Recognize Modifiers

1. *HP Fails to Recognize Modifiers 58 and 78*:
   HP does not recognize modifiers 58 and 78, even when they have been approved by Medicare. HP says the practice should be using modifier 24, 25, 59, 29, 54 or 55, even though this is inconsistent with the AMA CPT coding book. Practices do not want to submit false bills. **(Reference O-1)**

2. *HP Unable to Differentiate Physician Bill from Hospital Bill:*
   When a patient has an out-patient procedure performed at the hospital and HP receives the hospital bill before the physician bill, the hospital/facility portion of the bill is paid and the professional (physician) component of the bill is denied. HP is unable to differentiate between the facility portion of the bill and the professional portion—they improperly identify the physician bill as a duplicate. **(Reference O-2)**

H. Physician Credentialing

1. *Delayed Credentialing Process:*
   One practice has been waiting since January 2011 just to have a location change for a physician. **(Reference H-13)**

I. Paper Claims Processing

1. *Delayed Paper Claims Processing:*
   Paper claims for both primary and secondary claims are taking up to 10 weeks to be processed, although HP reports that it should take between three and four weeks. **(Reference H-6)**

2. *Erroneous Messages on Paper Claims Delays:*
   Practices report having paper claims returned with notices explaining that the claims have not been processed for various reasons. The claims were mailed on 12/27/10 and the notices were dated three months later (3/31/11). **(Reference H-10)**

3. *HP Denials of Paper Claims of Patient Names:*
   Practices report receiving denials on paper claims (secondary, EMA) for patient names. HP acknowledges that the names are being entered incorrectly by HP staff. **(Reference H-1)**

J. Prior Authorizations/Pre-certifications

1. *Excessive Administrative Burdens of Prior Authorizations:*
   Obstetrical practices report that Medicaid and the CMOs create an excessive administrative burden for their high risk OB patient regarding precerts for ultrasounds. **(Reference A)**

K. Patient Assignment to Health Plan

1. *HP's Failure to Recognize Patient Choice of CMO Assignment:*
   Since the change to HP/Medicaid, practices report numerous patients have reported to them that they have informed their caseworker and/or Medicaid they want to enroll in another plan, i.e., Peach State. By the time they are switched from "Right from the Start Medicaid," where they were initially enrolled, they have been enrolled in another CMO, i.e., Amerigroup or Wellcare. **(Reference A)**

L. Physician Payment Audits and Recoupment

1. *HP Recoupments Seven Years After Payment and Services Provided:*
   Practices report HP/Medicaid has been recouping payments from some seven years ago on "primary care physician gatekeeper fees" of $2 and $3, stating that the patient was not eligible at that time—past the time that the physician could collect the money

from the patient or from another insurer. In addition, there were a lot of system errors that occurred at that time, particularly in 2003 when the CMOs conversion took place and when a lot of primary care providers were given inaccurate patient lists. Georgia law limits recoupment "look backs" at no greater than 18 months. **(Reference P)**

M. Problems Unique to Clinical Oncology

1. *HP Standards do not match up to ACS in areas of provider enrollment, referral processing and provider communication and service:*
The Georgia Society of Clinical Oncology states that provider enrollment, referral processing and provider communication and service do not meet the former standards established by the former contractor ACS. In addition, the one area where oncology has a singularly serious area of concern is in the management of the Physician Injectable Drug List. The Medicaid fee schedule updates continue to be seriously less than the actual acquisition costs of drugs as of early 2011. Oncology and infectious diseases are seriously affected by these lowered drug fees. **(Reference Q)**

N. Problems Unique to Physician Dispensing

1. The Division of Medicaid Services, through their Pharmacy Advisory Committee, made a change to the Pharmacy Manual that prevents physicians from dispensing medications. This appeared to have been done summarily, without notice, and in conflict with physicians licensing rules in Georgia, which allow physicians to dispense medication. In addition, the Georgia Care Management Organizations appear to be following suit in conformance with Medicaid's Pharmacy rules. A copy of the April 2010 change is contained in the case examples attached. **(Reference V)**