Medicaid Redesign: Trialliance RFP Suggestions

Introduction

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

Over this period of time the Trialliance began and maintained a consistent dialogue with Georgia's Care Management Organizations (CMOs), and many problems have been addressed. In retrospect it is clear that earlier communication with the CMOs would have been quite beneficial in securing a smoother transition to managed care. Nevertheless, some problems still remain, sometimes leading to denied services to children; missed sessions, and children regressing, which causes medical complications.

The Triallinace is pleased to be represented on the Medicaid Provider Task Force and Children's Task Force as DCH moves toward redesign of Georgia's Medicaid program, and it offers the recommendations in the section below in response to DCH's solicitation of recommendations of requirements to be included in requests for proposals to implement the prospective redesigned Medicaid program in Georgia. The recommendations in this paper are made from the experience and dialogue referenced in the above two paragraphs and from a realization that there have been many "bumps in the road" for children with disabilities, their parents, and pediatric therapy service providers. In light of the possible significant increase of children moving from the ABD fee for service program administered by DCH to managed care, it is crucial to learn from past experience.

The format below is one of listing program requirements in specific areas of concern (e.g. prior approval of services, credentialing of providers). In instances in which it may not be obvious why requirements are being listed, explanations are given in italics. The Trialliance is aware that some of these recommendations may be specific enough to better warrant their inclusion in contracts between DCH and the CMOs. Nevertheless, the Triallinace feels that all of the points addressed below are significant enough that a minimum the RFP will need to address them.

RFP/.Contract Provisions

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

(A) Centralized PA process (submission, review and approval) administered through a "neutral" agency (e.g., Georgia Medical Care Foundation). *This practice would ensure a consistent level of care across all CMO's*.

(B) Require electronic approval/denial of PAs and a means of communicating questions/concerns electronically. *CMOs, current and some prospective, do not have this capacity. The lack of consistent electronic communication adds significant time to the consideration and resolution of PA requests.*

(C) Approval/denial of PA requests within five days. *At least one current CMO has a 24hour turnaround*

(D) Approval of request for services should "follow the child." *There should not be a delay in services if a patient sees a similarly credentialed therapist, (e.g., one in the same practice or a different CMO).*

(E) Children with Deeming Waiver, SSI should be allowed eight units of therapy without prior approval. *This is the current case in the ABD program.*

(F) Allow commencement of PA process upon CMO receipt of physician's signature without waiting for signed Plan of Care POC). *At least one current CMO allows services in the first 30 days, with payment for services pending receipt of the POC.*

2. Inclusion of EPSDT Law/Standards in Contracts: All contracts with CMOs should contain:

(A) Definition of Medical Necessity/"Correct or Ameliorate, including a statement that an EPSDT patient cannot be denied services because the child has not shown progress. *These definitions are contained in GA Code Section 49-4-169.1, and the standards have neither been consistently applied by the CMOs nor enforced by DCH.*

(B) Notation of Distinction between Individual Education Plans (IEP) and Medical Goals. Review of services must be based on specific goals, the method of service delivery and the child's need for therapy to meet all identified goals. *Students frequently have different goals for "educational" and EPSDT purposes. CMOs have frequently denied services, citing a federal prohibition on duplication of services if a special education student has an IEP. The receipt of therapy services in the school system does not automatically indicate a duplication of services under EPSDT.*

(C) Family of Codes/General Areas of Treatment: Georgia Code 49-4-169.3(e) requires that prescriptions and prior approval for services shall be general areas of treatment, treatment goals, or ranges of specific treatments or processing codes." *CMOs sometimes create a delay in treatment because the y frequently grant PAs for specific services and require providers to resubmit information part way through treatment when other specific services are more appropriate to advancing the child's treatment*

(D) Requirement that Approval of Services be for a six-month period when prescribed as medically necessary. *The current law contains a provision of "up to six months" so as not to require six months for acute patients who may only require therapy for a short duration. However, CMOs have used this provision to reduce services for children with chronic conditions, in contravention of the intent of the law.*

3. Creation of a Uniform Manual of Policies and Procedures: *Currently CMOs all utilize different policies, procedures and forms, creating delays in treatment and increased administrative work for providers.*

4. Credentialing: *The lack of timely processing of provider credentials is a problem which has led to delays to children and the lack of a sufficient network of providers to serve children.*

(A) Centralized credentialing in which providers send complete application for credentialing a therapist to one entity and that entity credentials for all CMO's.

(B) Credentialing that follows the provider i.e., (from one practice to another). *This credentialing should at least be within a shortened time frame, as it only involves updating of information*

(C) Credentialing should all be electronic using CAQH

(D) The time to process a provider's credentials should be significantly less than is currently the case, perhaps one month.

(E) Approval of a provider's credentials should be retroactive to date of application. *Currently the ABD Medicaid program approves provider credentials back to date of application, which allows the therapist to serve children while credentialing is being completed. This should be allowed by the CMO's so that services to children are not delayed when one provider leaves and another provider is hired to take their place.*

5. Development of Provider Networks: Contracts should require that a CMO accept all applicant providers who meet CMO qualifications. *This will both improve access to services and assist in the development and maintenance of adequate networks of pediatric providers.*

6.. Collection and Submission of Outcome Measures to DCH and an Independent Oversight Agency (see # 7 below)

(A) Improved data regarding PAs/Claims:

(i) Collection of data distinguishing between approvals/partial approval of services (e.g. approval of services at a lesser amount than requested. *Currently CMOs track approvals versus denials.*
(ii) Average turnaround time for PA approvals.
(iii) Claims adjudication errors. *Currently CMOs make frequent errors, which leads to delays in services and significant administrative provider effort to resolve claims.*

(B) Length of time to be credentialed – This data should take track the number of total applications submitted. *CMOs currently only report "clean" applications even when all the paperwork was submitted appropriately by the provider and the CMOs make an error (e.g. lose information).Currently CMOs report an average processing time that is significantly less than the actual time involved.*

(C) Tracking of problems with missing paperwork. *Since the CMOs are not all" electronic", providers must continually resubmit information, and claims/attachments do not show up in system or are lost.*

7. Creation of Independent Oversight Organization: *DCH currently lacks the resources to effectively monitor CMOs, and frequently both parents and providers of EPSDT patients have had a very difficult time "navigating" the Medicaid system, (e.g. receiving timely information and services and resolving problems.* As a result an independent agency should perform the following functions:

(A) Serve as an intermediary for:

(i) patients/parents
(ii) providers

(B) Maintain and respond to requests for data on outcome measures

(C) Review CMO compliance and DCH enforcement of CMO compliance

8 Transitional Provisions Related to Children moving from ABD to CMOs or from one CMO to Another CMO: *The continuation of care for medically fragile children and those with chronic disabilities is particularly important.* Contract provisions should ensure:

(A) Continuation of treatment under the existing PA for the full time granted. *There is currently a transition of care within the CMO's and Medicaid. They will all cover services approved by each other for time span of at least 30 days- some of them cover full span of previous auth from other CMO or Medicaid.*

(C) Development of a consistent payment plan to providers during the transition process. *The previous transitions to CMOs resulted in long periods without payment.*

9. Payment Requirements

(A) Clean claims must be processed within seven days and checks mailed within 48 hours of processing. *At least one of the current CMO's is holding checks for up to a month after processing, leading DCH to believe providers are being adequately reimbursed.*

(B) All CMO's should be required to allow submission of claims and payment of funds electronically. *This method would help alleviate delays caused by lost paperwork and holding of claims, since electronic allows tracking of dates received, processed and paid.*

(C) Reimbursement of services should be at rate set by Medicaid. *CIS rate should be set as minimum rate to ensure provision of a sufficient provider network. Provider administrative cost of operating with the CMO's is higher and must be considered when setting reimbursement rate.*

10. Requirements for Appeals Process: Beneficiary and provider appeals are one assurance of fairness and full, appropriate services, not the brake or disincentive to care. They need to conform to state and federal law and proceed with fairness and promptness:

(A) CMO and subcontractor agreements should not require nor permit providers to waive nor compromise state or federal law provisions, including EPSDT standards for medical necessity and utilization, precertification insurance standards, and state and federal disclosure and timing requirements.

(B) Any otherwise legally permissible limitations on or requirements for utilization documentation, appeal rights or procedures should be fully disclosed in provider agreements and CMO or subcontractor manuals.

(C) CMO contracts should require warranties of good faith pursuit of administrative reviews and appeals

(D) Retroactive reviews should be limited to judgments about medical necessity or quality of care standards and not office management or employment patterns.

(E) DCH and the independent oversight organization (#7 above) should monitor appeal practices and results and permit providers to review reports of their performance filed by CMOs with DCH.

(F) Wrongful terminations that reduce access or punish providers and bad faith performance of appeal procedures should incur penalties, including per claim fees, interest, and attorney's fees.

(G) Authorized services to beneficiaries should continue during appeals.