

Public Health Medicaid Participation Agreement Proposal

Over the past year, the Georgia Department of Community Health has been examining the state Medicaid Managed Care program as part of a comprehensive Medicaid Redesign initiative. Georgia Medicaid has been gracious and comprehensive in their efforts to assemble feedback from the various entities that administer Medicaid services throughout the state including the public health departments that administer care in every county.

Public health services are an essential part of our healthcare landscape in Georgia. We are well positioned to provide essential services efficiently and effectively. Because of the changing landscape of healthcare, Georgia may well need a stronger public health safety net to accommodate healthcare services for what will be an increasing Medicaid population but without an expected increase in the number of healthcare providers accepting Medicaid. In addition, Public health is uniquely positioned to be a viable player in lowering disease specific costs for Medicaid.

The Georgia Department of Public Health (DPH) is proposing the formation of a Guaranteed Participation Agreement between the Medicaid Care Management Organizations (CMOs) and the local public health departments and state public health laboratories.

DPH Proposal

1. **Participation Agreement and Coverage of Preventive Health Services** - The contract would guarantee that the CMOs offer contracts to each local health department as essential Medicaid providers for the coverage of Medicaid-reimbursable public health services.
 - Local public health departments currently provide a variety of different Medicaid-eligible preventive health services, many of which fall under at least three main categories – Diagnostic, screening, and preventive services (DSPS), Health Check services, and Family Planning. DSPS includes lab services/tests, adult immunizations, chronic disease prevention and control services, and communicable disease prevention and control services, all of which are grouped under the Category of Service (COS) code 790. Health Check services includes all childhood immunizations. This agreement would bring consistency across the CMO's for covering public health services.
 - The agreements would alleviate administrative burdens for billing and reimbursement for local health departments and the state Medicaid program by establishing contracts that were consistent among the CMOs in terms of contractual obligations, protocols, and services covered.
 - The Georgia DPH proposal is modeled closely after a similar contractual agreement between CMOs and the local Public Health Departments in Kentucky (see Attachments). In Kentucky, the participation agreement was implemented to strongly encourage and cultivate significant collaboration between the CMOs and local health departments to achieve

improvements in priority health-related areas. For Georgia, that could include closer collaboration and coordination with the CMOs to improve local case management efforts, assisting with eligibility assessments, or connecting consumers with appropriate providers and services.

2. **Public Health’s Role in Tomorrow’s Medicaid Program: Collaboration leading to cost-saving initiatives** –Public Health, both at the state and local levels, can be a major player in assisting DCH in improving both the cost and effectiveness of our state’s Medicaid program. Through these participation agreements, Public Health’s assets could be more fully utilized in pursuing public-private collaborative health efforts. In both Kentucky and Texas, for example, state public health departments in conjunction with private partners and their respective state Medicaid programs, worked together to develop initiatives to reduce the number of preventable preterm births over the past few years. Through these efforts, both states have implemented elements that incentivize healthier behaviors in targeted high risk Medicaid populations which have lead to a reduction in the number of preventable pre-term births. Kentucky had preliminary findings last year that showed a decrease of nearly 10% in preterm births over a three year period, while Texas is estimating that if it achieves an 8% decrease in two years, over \$7.2 million in Medicaid savings would be possible. In both these cases, a targeted collaborative initiative, focused on high-cost populations, utilized public health’s resources in a successful effort to produce healthier outcomes, more appropriate use of resources and potential cost savings for the state Medicaid programs.
3. **Standard and Customary Reimbursement Rates** – The agreement would require Medicaid reimbursement rates for public health services that are standard across the contracts and commensurate with private healthcare provider rates.

Additional Supporting Information:

Health Departments, located in every county in Georgia, serve as essential providers for Medicaid members by operating as Network Providers of Medicaid Services. Every County Health Department is a qualified provider for Medicaid Programs.

A participation agreement would ensure that there is a strong linkage between the managed care organizations and the local health departments. The continued development of collaborative relationships between the CMOs and Public Health will be critical in achieving improvements in priority health areas:

- The presence of Public Health in each county allows for the provision of local clinical and case management services that enhance the Medicaid member’s resilience and ability to better utilize Medicaid services in a cost effective manner. Public Health’s ability to coordinate such local services with the efforts of the CMOs will provide great value to the state’s Medicaid program.

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- The local health departments and districts can become an even more complementary piece to the state's efforts in expanding and enhancing managed care. A stronger partnership with the Managed Care program will enable the state to better serve many of its more vulnerable and patients who tend to fall into the healthcare gaps between private insurance and Medicaid due to serious health and economic conditions, which in turn could ultimately lead to lower utilization for the Medicaid program.
- DPH utilizes specific grant funding to support this population. Closer collaboration with the CMOs will allow us to maximize the use of these funds and reduce duplication of services. Through these grants, Public Health can provide services that wraparound Medicaid-reimbursable services as well as services that reach populations or treat conditions in ways that will ultimately reduce Medicaid utilization and improve healthcare across the state.
- A guaranteed public health services Medicaid contract with the health departments will also reduce the administrative burden on both the health districts and the Medicaid administrative staff by enabling the local departments to bill for regular Medicaid reimbursable codes instead of through complicated, specialty "packages" like DSPS.
- Public health, at both the state and local level, has significant expertise and data related to population-based health analyses. Closer collaboration between the health departments and the CMOs will lead to more robust data and analyses of both the population and the health needs of Georgia's citizens.
- A guaranteed contractual relationship with local health departments will help ensure that essential preventative health services are accessible, especially in rural areas of the state, where there are increasingly limited numbers of Medicaid providers. Not only is there is a health department in each county, but a majority of the health districts are now on track to be able to deliver services via telehealth. The inclusion of Public Health's telehealth services into the Medicaid program would fit squarely into DCH's increasing support of telemetry as a health delivery option.

Attachments:

Sample Contract Language from Kentucky's CMO contracts:

Sec. 28.1

Contractor shall enroll the following types of providers who are willing to meet the terms and conditions for participation established by the Contractor: physicians, advanced practice registered nurses, physician assistants, birthing centers, dentists, primary care centers including: home health agencies, rural health clinics, opticians, optometrists, audiologists, hearing aid vendors, pharmacies, durable medical equipment suppliers, podiatrists, renal dialysis clinics, ambulatory surgical centers, family planning providers, emergency medical transportation provider, non-emergency medical transportation providers as specified by the Department, other laboratory and x-ray providers, individuals and clinics providing Early and Periodic Screening, Diagnosis, and Treatment services, chiropractors, community mental health centers, psychiatric residential treatment facilities, hospitals (including acute care, critical access, rehabilitation, and psychiatric hospitals), **local health departments**, and providers of EPSDT Special Services.

Sec. 28.7 [page 119]

The Contractor shall attempt to enroll the following Providers in its network as follows:

- A. Teaching hospitals;
- B. FQHCs and rural health clinics;
- C. The Kentucky Commission for Children with Special Health Care Needs; and
- D. Community Mental Health Centers

If the Contractor is not able to reach agreement on terms and conditions with these specified providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in this Contract shall be provided to meet the needs of its Members without contracting with these specified providers. ***In consideration of the role that Department for Public Health, which contracts with the local health departments play in promoting population health of the provision of safety net services, the Contractor shall offer a participation agreement to public health departments. Such participation agreements shall include the following provisions: A. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360. B. Provide reimbursement at rates commensurate with those provided under Medicare.***

Related Kentucky Regulations:

907 KAR 1:360. Preventive and remedial public health services.

Section 1. Definitions. (1) "Add-on code" means a designated CPT code which may be used in conjunction with another CPT code to denote that an adjunctive service has been performed.

(2) "CPT code" means a code used for reporting procedures and services performed by physicians or other licensed medical professionals which is published annually by the American Medical Association in Current Procedural Terminology.

(3) "Department" means the Department for Medicaid Services or its designated agent.

(4) "Incidental" means that a medical procedure:

(a) Is performed at the same time as a more complex primary procedure; and

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(b)1. Requires few additional physician resources; or

2. Is clinically integral to the performance of the primary procedure.

(5) "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.

(6) "KenPAC" means the Kentucky Patient Access and Care System.

(7) "KenPAC PCP" means a Medicaid provider who is enrolled as a primary care provider in the Kentucky Patient Access and Care System.

(8) "Medically necessary" or "Medical necessity" means a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(9) "Mutually exclusive" means that two (2) procedures:

(a) Are not reasonably performed in conjunction with one (1) another during the same patient encounter on the same date of service;

(b) Represent two (2) methods of performing the same procedure;

(c) Represent medically impossible or improbable use of CPT codes; or

(d) Are described in current procedural terminology as inappropriate coding of procedure combinations.

(10) "Relative value unit" or "RVU" means the Medicare-established value assigned to a CPT code which takes into consideration the physician's work, practice expense, and liability insurance.

(11) "Screening" means the evaluation of a recipient by a physician to determine:

(a) The presence of a disease or medical condition; and

(b) The necessity of further evaluation, diagnostic tests or treatment.

Section 2. Participation Requirements. (1) The Department for Public Health shall comply with the terms and conditions established in the following administrative regulations:

(a) 907 KAR 1:005, Nonduplication of payments;

(b) 907 KAR 1:671, Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions; and

(c) 907 KAR 1:672, Provider enrollment, disclosure, and documentation for Medicaid participation.

(2) The Department for Public Health shall comply with the requirements regarding the confidentiality of personal medical records as mandated by 42 U.S.C. 1320d to 1320d-8 and 45 C.F.R. Parts 160 and 164.

Section 3. Covered Services. The following medically-necessary preventive, screening, diagnostic, rehabilitative and remedial services provided by the Department for Public Health directly or indirectly through its subcontractors shall be covered:

(1) A chronic disease service;

(2) A communicable disease service;

(3) An early and periodic screening, diagnosis, and treatment (EPSDT) service;

(4) A family planning service;

(5) A maternity service; or

(6) A pediatric service.

Section 4. Service Limitations. (1) A laboratory procedure shall be limited to a procedure for which the provider has been certified in accordance with 42 C.F.R. Part 493.

(2) A service allowed in accordance with 42 C.F.R. 441, Subpart E or Subpart F shall be covered within the scope and limitations of these federal regulations.

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(3) Coverage for a fetal diagnostic ultrasound procedure shall be limited to two (2) per nine (9) month period per recipient unless the diagnosis code justifies the medical necessity of an additional procedure.

(4) Except for a service specified in 907 KAR 1:320, Section 10(3)(a) through (q), a referral from the KenPAC PCP shall be required for a recipient enrolled in the KenPAC Program.

Section 5. Reimbursement. (1) Payment for a preventive health service specified in Section 3(1) through (6) of this administrative regulation shall be calculated by multiplying the current Medicare conversion factor for Kentucky by the nonfacility relative value unit weight for the procedure code.

(2) For a service covered under Medicare Part B, reimbursement shall be in accordance with 907 KAR 1:006.

(3) If a copayment is required in accordance with 907 KAR 1:604, reimbursement shall be reduced by the amount of the copayment.

(4) If performed concurrently, separate reimbursement shall not be made for a procedure that has been determined by the department to be incidental, integral, or mutually exclusive to another procedure.

(5) Except for an applicable add-on code, reimbursement for an anesthesia service shall be limited to one (1) CPT code and one (1) unit of anesthesia per operative session.

(6) Reimbursement for a surgical procedure shall include the following:

(a) A preoperative service;

(b) An intraoperative service;

(c) A postoperative service and follow-up care:

1. Within ninety (90) days following the date of major surgery; or

2. Within ten (10) days following the date of minor surgery; and

(d) A preoperative consultation performed within two (2) days of the date of the surgery.

Section 6. Audits. (1) The Department for Public Health or subcontracting local health departments shall provide to the Department for Medicaid Services or a representative of an agency or office listed in subsection (2) of this section, upon request:

(a) Information maintained by the provider to document the service provided;

(b) Information regarding a payment claimed by the provider for furnishing a service; or

(c) Information documenting the cost of the service.

(2) Access to provider or subcontractor records relating to a service provided shall be required for:

(a) A representative of the United States Department of Health and Human Services;

(b) The United States Centers for Medicare and Medicaid Services;

(c) The United States Attorney General's Office;

(d) The state Attorney General's Office;

(e) The state Auditor's office;

(f) The Office of the Inspector General; or

(g) An agent or representative as may be designated by the Secretary of the Cabinet for Health Services.

Section 7. Appeal Rights. (1) An appeal of a department decision regarding a Medicaid provider based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:671.

(2) An appeal of a department decision regarding a Medicaid recipient based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563.

(3) An appeal of a department decision regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560