MEDICAL CARE ADVISORY COMMITTEE (MCAC) MEETING
February 20, 2013
5th Floor Board Room

Members Present		**Phone Conference**	**Members Absent**
Dr. Michael Brooks	Dr. Lori Paschal	Mr. A. Edward Cockman	Mr. Steven Barber
Mr. Marvell Butts	Dr. Hugo Scornik	Dr. William Kanto	Dr. Jacinto del Mazo
Dr. Hillary Hahm	Dr. Ruth Shim	Dr. Sandra Reed	Dr. Hogai Nassery
Dr. Jennifer Hale	Mr. J. Reid Wilson	Dr. Larry Tune	
Dr. Kim Hazelwood	Mr. Dave Zilles, Advocate		
Dr. John Lue			

The MCAC Committee meeting began at 10:05 a.m. with a welcome by Ms. Patricia Jeter and introductions of the Committee members, DCH staff and guests. Dr. Lue, Chairperson, called the meeting to order. A motion was made to approve the November 7, 2012, minutes. The minutes were approved as written.

The following agenda items were presented:

A. Overview on Medicaid Redesign – Terri Branning—Medicaid Redesign Initiatives

Ms. Branning presented updates on several redesign initiatives that DCH is developing for the Fee-for-Service side of Medicaid involving the Foster Care/Adoption and ABD populations. These initiatives are based on input and feedback from various stakeholders and partner agencies (DHS, DBHDD, DJJ, DPH, and DOE), task forces and work groups (Children and Families, ABD, Provider, Mental Health and Substance Abuse) and advocates. The expected implementation date for the Foster Care/Adoption CMO initiative is January 2014 with pre-implementation activities conducted between November – December 2013. The main objective of the Foster Care/Adoption CMO is to provide medical care coordination with intensive case management under one (1) vendor (one of the three existing CMOs). The chosen CMO will utilize care coordination of health services through a multi-disciplinary team to develop and implement individualized Service Plans for each enrolled member.

Terri also presented the implementation timeline of January 2014 for the Aged, Blind, and Disabled (ABD) initiative. The DCH is looking for vendor experience with the ABD populations to utilize various managed care tools as health assessments, risk stratification and predictive modeling. The chosen vendor will be selected in the second quarter of 2013.

B. Overview on ICD-10 – Joyce Winters—ICD - 10 Compliance

Ms. Winters presented information on the federal mandate from CMS for all HIPAA-covered entities (entities include hospitals, physicians and other practitioners, health insurers, 3rd party payers, electronic transmission firms, clearinghouses, hardware/software vendors, billing practice and management firms, health care administrative and oversight agencies, public and private health care research institutions). All must be ICD-10 compliant on October 1, 2014, which is an extension from 10/1/2013. Transiton to ICD-10 is NOT an option for the health care industry. All health care providers in the United States must transition to ICD-10 code sets to continue to be paid for services.

Some facts on ICD-10 mandated transition are:

- There are 72,000 new ICD-10-PCS for inpatient procedure coding. The PCS codes are associated only with surgical codes. PCS codes must be associated with *any* inpatient hospital service. This is a major change for inpatient UB 04 claims.
- The current ICD-9 system is outdated. It is 30-years old, limited data storage capacity and no longer supports medical science
- ICD-10 is vital to transforming our nation's health care system. The new code sets will evolve in being more robust and expandable and will be used for case management or care coordination for more efficient billing and increase claims processing and payments.

- The ICD-10 transition has no impact on Current Procedural Terminology (CPT) for outpatient procedures and Healthcare Common Procedure Coding System (HCPCS).Without a successful transition to ICD-10, claims will be suspended, rejected or denied.
- Without a successful transition to ICD-10, providers' cash flows, revenues and audit experience with payers will be negatively impacted.
- Reminder: ICD-10 codes with dates of service prior to October 1, 2014 will be accepted; ICD – 9 codes submitted **on/after October 1, 2014 will NOT be accepted.**

C. CMO COMPLIANCE AUDIT—Sasha Green, Provider Services (Managed Care Unit)

Ms. Green presented a slide presentation on the DCH CMO Centralized Credentialing. The CMOs' credentialing process is to streamline their enrollment application process into the Georgia Medicaid Management System (GAMMIS) web portal. The change is a single source application to provide credentialing documentation to each of the CMOs. Beginning **March 29, 2013,** the new single source credentialing application can be submitted to the Georgia Health Partnership Web Portal (https://www.mmis.georgia.gov) as a single source system to complete their electronic Georgia Medicaid enrollment and CMO credentialing via the web portal. The entire credentialing process takes 30 to 45 days for applications with complete documents/documentation. Incomplete applications (e.g. missing documents) will result in an extended processing time (up to 120 days or more). If any questions regarding CMO Contacts, contact the specific CMO's Provider Relations to inquire about its CMO credentialing and contracting status.

Amerigroup	Peach State Health Plan	WellCare of Georgia
1-800-454-3730	1-866-874-0633	1-866-300-1141

Call : 770-325-9600, or
1-800-766-4456 (only if outside local calling area)

D. UPDATES ON Provider Rate Increase—Erica Dimes, Program Director

Ms. Dimes provided the update on providers' rate increase – Patient Protection Act and the Portable Care Act. The CMS mandates a rate increase for certain primary care providers (Primary care physicians, nurse practitioners, and any PAs who are supervised by a physician) effective January 1, 2013 – December 31, 2014. The rate increase allows the primary care provider to receive 100% fee schedule for CY January 2013 and January 2014 with a possibility of a change in 2015. Each affected provider must sign an Attestation Form (which will be forthcoming via HP web portal). Providers will initially have 90 days to enroll – notifications will be sent via Associations, Remittance Advices, and Banner Messages. Supplemental rate increase payments will begin after the initial enrollment period. There will not be retro payments back to January 2013 if the provider's attestation or enrollment is NOT in the initial period.

MCAC Members' Round Table Discussion:

- Dr. Lue – Question regarding babies delivered at a level three nursery. There is a grant for payment for transporting sick babies to tertiary level facilities. The facility the baby is being transferred to gets the full payment. There is no accommodation for splitting up the fee for NICUs at level two or three. Dr. Lue wants to discuss further and make a recommendation that the CMOs look at changing the reimbursement so that babies can go back to the primary institutions once stabilized. Erica and Sasha to collaborate on this issue.
- Dr. Lue suggested that Joyce and Terri comeback to discuss further the ICD-10 and Medicaid Redesign topics further.
- Mr. Wilson – Enrollment question regarding a hospital doctor who does not participate in any of the CMOs. The doctor should receive the first month fee for his rendered service to the member. Follow up was made by Sasha Green on 2/20/13 with the CMO policy (see the separate page of the CMO policy).

- Change reimbursement for vaccine under health care ACA rate increase – providers can get an increase on vaccine administration and primary care evaluation. The provider will bill the specific product code. Georgia will pay for the actual product cost. This falls under Dr. Janice Carson's policy area.
- Dr. Paschal wants to know which Georgia dental patients have a provider. CMO tried to find out with whom the patient is signed up and if certain dental procedures have been utilized for the current year. Dr. Lue suggested that a letter should come from the committee and suggested that Dr. Paschal compose the letter. Lynnette Rhodes will discuss with Dr. Jerry Dubberly and attend the next meeting to respond.

Meeting was adjourned at Noon.

The next MCAC meeting is May 15, 2013 at 10 a.m. 37th Floor War Room.

MCAC future meeting dates for 2013:
August, 21, 2013
November 20, 2013

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED, THIS _____ DAY OF _____, 2013.

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John Lue, MD, FACP, Chairperson

- **Response to Dr. Scornik's question:**

QUESTION: According to my practice manager, if a practitioner sees a newborn and does not participate in the newborn's CMO, he can only get reimbursed the out of network rate. I believe this question came up during the meeting. I would also like to point out that if the mother does not have Medicaid (a very common occurrence), the new baby has to go through eligibility verification which can take 30 days or more. During this time, the newborn technically has no insurance and the family may have difficulty obtaining medicines, labs, or even medical follow-up for the baby.

DCH RESPONSE: There are some instances where the answer to your question may vary. Members are encouraged to go to an in-network provider however if the member chooses to go to an out-of-network provider (non-emergency) then the CMO is not responsible for paying the out-of-network provider. Please see content below which comes from Section 4.8.19.2 of the CMO contract with DCH:

> **4.8.19.2 The Contractor shall coordinate with Out-of-Network Providers regarding payment. For payment to Out-of-Network, or non-participating Providers, the following guidelines apply:**
>
> • If the Contractor offers the service through an In-Network Provider(s), and the Member chooses to access the service (i.e., it is not an emergency) from an Out-of-Network Provider, the Contractor is not responsible for payment.
>
> • If the service is not available from an In-Network Provider, but the Contractor has three (3) Documented Attempts to contract with the Provider, the Contractor is not required to pay more than Medicaid FFS rates for the applicable service, less ten percent (10%).
>
> • If the service is available from an In-Network Provider, but the service meets the Emergency Medical Condition standard, and the Contractor has three (3) Documented Attempts to contract with the Provider, the Contractor is not required to pay more than Medicaid FFS rates for the applicable service, less ten percent (10%).
>
> • When paying out of state providers in an emergency situation: Be advised that the CMOs shall not allow a member to be held accountable for payment under these circumstances.
>
> • If the service is not available from an In-Network Provider and the Member requires the service and is referred for treatment to an Out-of-Network Provider, the payment amount is a matter between the CMO and the Out-of-Network Provider.
>
> 4.8.19.3 In the event that needed services are not available from an In-Network Provider and the Member must receive services from an Out-of-Network Provider, the Contractor must ensure that the Member is not charged more than it would have if the services were furnished within the network.

In Medicaid a newborn is defined as a child that is born to a woman who is eligible for Medicaid on the day the child is born. Based on the example that you provided, the child would be considered a new applicant and Medicaid eligibility does have 30-45days to open the Medicaid case. Medicaid does, however, provide retro-eligibility for up to 3 months.

I hope that I have answered your questions. Please feel free to contact me if I may be of further assistance.

Thanks,
Sasha Green, CMO Compliance Auditor
GA Department of Community Health
404-463-1124