

**Georgia Hospital Association Comments<sup>1</sup>**  
**To the Georgia Department of Community Health regarding**  
**2015 Re-procurement for the Georgia Families and Georgia Families 360° CMOs**

**Section I. Summary of Discussion Points for Consideration by DCH**

**Statutory Compliance Issues**

1. **Out of Network Emergency Payments** - Contract Section 4.8.23.2.4 is in conflict with O.C.G.A § 33-21A-4(c) which states that an out-of-network provider must be paid 100% of the Fee For Service (FFS) Medicaid rate for emergency or post-stabilization services. GHA requests a revision of the language to meet the requirements set forth in Georgia law.
2. **Prohibition Against Rescinding Prior Authorization or Pre-Certification** - Due to historic non-compliance by the CMOs with state law prohibiting a plan from denying payment for a service it has authorized, GHA requests that DCH add a provision expressly requiring that the CMOs comply with O.C.G.A. §33-20A-7.1(b) and O.C.G.A. §33-20A-62(f) by paying for Pre-Authorized or Pre-Certified Services unless an enrollee is no longer eligible, benefits are not covered or there exists substantiation of fraud.
3. **Mental Health Emergencies** – Although mental health emergencies are clearly included in the definition of an Emergency Medical Condition in the Contract, some CMOs and their subcontractors apply different standards to mental health emergencies than to medical emergencies, in some cases even requiring prior authorization of emergency evaluation and stabilization services. GHA requests the addition of language to clarify the responsibilities of both the CMOs and their subcontractors to apply utilization management policies consistently to both medical and mental health emergencies. In addition, at least one CMO subcontractor takes the position that the contractual requirements in Contract Section 4.6.1 related to emergency services are not applicable in freestanding psychiatric hospitals because they do not have emergency departments. For this reason the subcontractor requires prior authorization for evaluation and stabilization services regardless of the severity of the member’s condition. GHA requests the addition of language to clarify that these requirements apply whether or not the hospital where the member is located has an emergency department.
4. **Call Center Availability for Authorization Inquiries** - O.C.G.A. §33-20A-7.1(c) and Contract Section 4.9.5.5 require that plans provide call centers 24/7 with personnel to respond to prior authorization and pre-certification requests and questions. In spite of that requirement, many CMOs or their subcontractors do not have personnel readily available that can respond to such inquiries. GHA requests the addition of language to strengthen these standards, and to ensure fairness and accountability.

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<sup>1</sup>All comments are intended to apply to the applicable Sections of both the Contract and the Georgia Families 360° contract. Contract, as used herein, means the Georgia Families CMO Contract (Attachment I of the RFP). Contract Sections referenced herein have comparable sections in the Georgia Families 360° contract (Attachment J of the RFP), although numbering may differ.

## Clarification of Existing Provisions

5. **Utilization Management (“UM”) Terminology** – The distinction between “Prior Authorization” and “Pre-Certification” is not clear in the Contract’s definitions, and it is unclear which requirements in the Contract are applicable to each process. As noted below, most of the requirements are written to apply only to prior authorization, and in many cases no standards are included for pre-certification or other aspects of UM. If all requirements in the contract applicable to prior authorization also apply to pre-certification, it would be much clearer to use a single term throughout, such as “Authorizations”. If that is not the case, GHA recommends a review of these terms throughout the Contract to ensure both are included when a provision is intended to apply to both. Further, there is no definition of “concurrent review,” a required part of the UM process that has historically created significant challenges for providers and been handled inconsistently, even within a single CMO and its subcontractors. For this reason, GHA recommends adding that term to the definitions of “Prior Authorization” and “Pre-Certification” to clarify that the requirements applicable to each also apply to concurrent review. In addition, in order to ensure that the CMOs implement UM policies and procedures that facilitate appropriate and medically necessary care for members without unnecessarily increasing administrative expense to Providers, GHA requests that DCH add additional reporting requirements and performance guarantees to the Contract.
6. **Authorization Timeframes** – Contract Sections 4.11.2.7.1 and 4.11.2.7.2 specify the timeframes within which authorization decisions must be made and give the option for extending those timeframes as necessary. However, Contract Section 4.11.2.7.1 addresses only prior authorizations, not pre-certifications, and there is no other provision that would establish timeframes for pre-certifications. As discussed above, GHA requests clarification to reflect the Department’s intent. In addition, inclusion of the phrase “or other established timeframe” could be interpreted to allow the CMOs to contractually, or through policy, establish longer timeframes and circumvent the Department’s intent. GHA requests the elimination of this language. Finally, to avoid unintended administrative denials that would otherwise result from the CMOs’ responses to the shorter timeframes established in this Contract, GHA also requests clarification that the timeframes begin with the submission of clinical information by the provider to support the request.
7. **Consistent Application of Valid Medical Necessity Criteria** –The CMOs have historically failed to consistently apply industry standard medical necessity review criteria. Excessive use of non-industry standard criteria, inconsistent application of these standards and the lack of expertise of CMO reviewers is a very significant problem for providers. Contract Section 4.11.1.3 requires consistency in such reviews. However, given the problems providers have experienced with the CMOs regarding medical necessity determinations, GHA requests the addition of language to ensure the validity of non-industry standard criteria and reviewer expertise.
8. **Accountability for Subcontractors** - Although Contract Section 18.1 specifies that the CMOs are solely responsible for all work contemplated and required, whether performed directly or through a subcontractor, the subcontractors do not always comply with the

Contract's requirements. In addition, providers have suffered major financial losses due to inadequate vetting and oversight by the CMOs of subcontractors engaged in service delivery, authorization or payment. For this reason, GHA requests that the language in Contract Section 18.1 be expanded to clarify that subcontracts must adhere to the same contractual requirements applicable to the CMOs and to strengthen the CMOs' accountability for the actions of their subcontractors.

9. **Claims Payment for Continuous Inpatient Stays** – Providers have historically experienced both authorization and claims payment delays due to a lack of clarity regarding the CMOs' responsibility when enrollment changes occur during a continuous inpatient stay. GHA has recommended changes to the Contract to provide needed clarification.
10. **Incorrectly Paid Claims** – Historically, the CMOs have taken long periods of time to correct configuration errors within their claims systems that result in incorrectly paid claims, and even longer periods of time to reprocess and appropriately pay such claims. In recognition of this issue, the Contract includes a requirement that claims processing issues causing incorrect payment of claims must be resolved within 45 days. GHA requests the addition of language providing that such resolution must also include reprocessing and correct payment of affected claims.
11. **Centralized Credentialing** - DCH has communicated verbally and through email that the requirement to use the CVO for credentialing will be waived for health systems with delegated credentialing with the CMOs in the same way that requirement is waived for IPAs and PHOs. To avoid confusion and ensure consistent interpretation of the CVO requirements, GHA requests that such a provision be added to DCH notices regarding the CVO and specified in the Contract.
12. **Provider Loading & Effective Dates** - Claims system loading requirements are included in the Contract for some scenarios, but not all. GHA has identified all of the scenarios requiring loading of provider information and has suggested loading timeframes and effective dates for each. Please see the attached Exhibit 1. The current CMOs recently received these recommendations and Wellcare has acknowledged their reasonableness and agreed to voluntarily comply with them going forward. GHA requests the addition of language in the Contract to address each scenario to ensure fairness and consistency across the board, and to prevent the payment delays and significant administrative costs that flow from long loading delays.

## **Requests for Expanded/Additional Requirements**

13. **Reduced (Triage) Payment for Emergency Services** – GHA believes stronger enforcement measures are needed for Contract Section 4.6.1.6 which stipulates that the CMO may not deny or inappropriately reduce payment for emergency services. GHA requests that DCH require the CMOs to adhere to defined standards and reporting requirements to ensure consistent and appropriate payment for emergency services.
14. **Peer-to-Peer Review Standards** - Although widely utilized as part of the CMO utilization management programs, there are no standards defined in the Contract for peer-to-peer review, resulting in current widespread variation and misuse of the process. GHA requests that DCH require the CMOs to adhere to defined standards to ensure consistent and appropriate utilization management.

15. **Distinction between Provider Complaints and Claims Adjustments** – Historic inconsistency among the CMOs in the interpretation and application of defined procedures for provider complaints and claims adjustments warrants more specific requirements and definitions of timeframes for response and/or payment. In addition, historic handling of these complaints and requests indicates the need for the addition of requirements for timely reprocessing and payment of such claims, expansion of the time period for providers to respond to notices of incomplete claim requests to allow for necessary research, and the addition of a defined response period for the CMO to make determinations and issue additional payments when applicable.
16. **Appeal by Provider of Authorization Denial for Services Already Rendered** - Because the CMOs currently have varying interpretations of the rights of providers to challenge prior authorization and pre-certification decisions for services already rendered, GHA requests the addition of Contract language that allows providers to appeal authorization denials for services already rendered as part of the provider complaint process.
17. **Add-On Services and Families of Codes** - The Contract currently contains no requirements for CMOs to cover medically necessary services that may not have an approved authorization because they are not anticipated prior to the rendering of a related service. GHA requests the addition of provisions which provide for coverage under an existing authorization or notification, with retrospective review by the CMOs as necessary.
18. **Delay in Discharge to Lower Level of Care** - Historic delays in discharge of a patient to a lower level of care due to CMO network or authorization process inadequacies have a negative financial impact on providers when they are unable to safely discharge a patient without appropriate post-discharge care. Therefore, GHA requests that the CMOs be required to cover continued care at a higher level in such cases.

## **Section II. Detailed Discussion of Requested Changes**

### **Statutory Compliance Issues**

#### **1. Out of Network Emergency Payments**

Contract Section 4.8.23.2.4 states that “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%).” This provision is in direct conflict with O.C.G.A § 33-21A-4.(c) which states that “If a provider that has not entered into a contract with a care management organization provides emergency health care services or post-stabilization services to that care management organization’s member, the care management organization shall reimburse the non-contracted provider for such emergency health care services and post-stabilization services at a rate equal to the rate paid by the Department of Community Health for Medicaid claims that it reimburses directly.” Therefore, GHA requests that Contract Section 4.8.23.2.4 be modified as follows:

If the service is available from an In-Network Provider, but the service meets the Emergency Medical Condition or Post-Stabilization standard, ~~and the Contractor has three (30 Documented Attempts to contract with the Provider, the Contractor shall is not required to pay the non-contracted Provider the rate paid by DCH for more than Medicaid FFS claims. rates for the applicable service, less ten percent (10%).~~

## 2. Prohibition Against Rescinding Prior Authorization or Pre-Certification

O.C.G.A. §33-20A-7.1(b) states that “When an enrollee, provider, facility, or home health care provider obtains precertification for any covered health care service, the managed care plan is liable for such pre-certified services at the reimbursement level provided under the health benefit plan for such services where rendered within the time limits set in the precertification unless the enrollee is no longer covered under the plan at the time the services are received by the enrollee, benefits under the contract or plan have been exhausted, or there exists substantiation of fraud by the enrollee, provider, facility, or home health care provider.” This is reiterated in O.C.G.A. §33-20A-62(f) which states “Notwithstanding any other provision in this article to the contrary, when precertification has been obtained for a service, the insurer, carrier, plan, network, panel, or agent thereof shall be prohibited from contesting, requesting payment, or reopening such claim or any portion thereof at any time following precertification except to the extent the insurer is not liable for the payment under O.C.G.A. 33-20A-7.1.”

In recognition of these state law requirements, and to provide DCH with the authority to take action in the event of non-compliance by the CMOs, GHA requests the addition of the following Section to the Contract:

4.11.2.9 If the Contractor or its agent communicates approval of a requested Prior Authorization or Pre-Certification, the Contractor is liable to the Provider for such services at the applicable reimbursement level where such services are rendered within the time limits set in the Pre-Certification or Prior Authorization unless the Member is no longer covered by the Contractor at the time the services are received, benefits have been exhausted or there exists substantiation of fraud by the Member or the Provider. Furthermore, the Contractor shall be prohibited from contesting, requesting payment, or reopening such claim or any portion thereof at any time following Pre-Certification or Prior Authorization except to the extent the Contractor is not liable for payment as described herein.

## 3. Mental Health Emergencies

Although the definition of an emergency medical condition (EMC) in the Contract clearly includes mental health emergencies, some CMOs and their subcontractors require authorization for specialized psychiatric care of such patients and, not infrequently, deny

authorization for inpatient care based on an initial admission assessment, even in cases in which the patient clearly has an emergency medical condition.

For example, even where a 1013 Emergency Evaluation Certificate (“1013”) has been issued and remains in effect, the CMOs may require authorization of services. A 1013 authorizes transport of an individual that “appears to be a mentally ill person requiring involuntary treatment in that he/she appears to be mentally ill AND: (A.) presents a substantial risk of imminent harm to self or others as manifested by recent overt acts or recent expressed threats of violence which present a probability of physical injury to self or to other persons; OR (B.) appears to be so unable to care for his/her own physical health and safety as to create an imminently life- endangering crisis.”

We believe the CMOs should expressly be required to comply with the prohibition against requiring authorizations when a member has a mental health emergency, including but not limited to situations in which a 1013 is in effect for the member. While the Emergency Medical Treatment and Labor Act (EMTALA) is not directly applicable to the CMOs, it is clear that both the Department and Congress considered hospitals’ EMTALA obligations when developing requirements for Medicaid CMOs related to emergency services and it is therefore instructive when considering the breadth of the CMOs’ obligations.

The State Operations Manual Appendix V – Interpretive Guidelines, Part II, Interpretive Guidelines for EMTALA provide as follows:

§489.24(d)(1)(i): “In the case of psychiatric emergencies, an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an EMC.”

In addition, at least one of the CMOs’ subcontractors for mental health services takes the position that emergencies can only exist at hospitals that have emergency departments and therefore it can require prior authorization for any services provided in a psychiatric hospital that does not have an emergency department, even when the examining physician has determined that the patient has an emergency medical condition. This position is inconsistent with the terms of both the Contract and EMTALA, neither of which tie the existence of an emergency medical condition to an emergency department and both of which provide that the examining physician makes the determination of whether an emergency medical condition exists.<sup>2</sup>

In addition, EMTALA provides that when a patient is referred to a psychiatric hospital for an EMC by a facility that does not provide mental health services, the receiving hospital must accept and treat the patient until stabilized in accordance with 42 CFR§ 489.24(f) which states that “A participating hospital that has specialized capabilities or facilities may not

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<sup>2</sup> 42 CFR §489.24(a)(1)(i) states “Once an individual has presented to the hospital seeking emergency care, the determination of whether an EMC exists is made by the examining physician(s) or other qualified medical personnel of the hospital.”

refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual. This requirement applies to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.”

In order to ensure that the CMOs appropriately recognize psychiatric EMCs and apply the applicable emergency services standards as intended, GHA requests the addition of the following provisions to the Contract:

4.6.1.3.1 The provisions of Section 4.6.1 shall apply to Emergency Services provided by participating hospitals, whether or not the participating hospital has an emergency department.

4.6.1.3.1.1 The provisions of Section 4.6.1, shall apply to a Member with a mental health Emergency Medical Condition until the patient is medically stable. Where a 1013 Emergency Evaluation Certificate (“1013”) has been issued for a Member, the Member shall be treated as an individual with an Emergency Medical Condition until the Member is stabilized in accordance with Section 4.6.1.8.

#### **4. Call Center Availability for Authorization Inquiries**

Call center use in the utilization management process is addressed in Contract Section 4.9.5.5 which requires that the CMOs operate a call center around the clock which has staff to respond to prior authorization and pre-certification requests. While the current CMOs all offer call centers, they do not necessarily staff the centers with personnel who can address authorization of services. Some current CMOs or their subcontractors have call centers with staff who consistently tell callers that no utilization review representative is available so they must take a message, even during regular office hours. The representatives then may not return the provider’s call for hours or days, sometimes calling after hours and leaving a voice mail message for the provider to call back, starting the cycle over. This structure likely ensures technical compliance with the CMOs’ contractual obligations related to call centers, such as the speed of answering calls, the abandoned call rate, and hold times, but it does not comply with Georgia statutes or with the spirit of the Contract.<sup>3</sup> In order to avoid situations in which providers are unable to

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<sup>3</sup> OCGA §33-20A-7.1(c) states that “Any managed care plan which requires precertification shall have sufficient personnel available 24 hours a day, seven days a week, to provide such pre-certifications for all procedures, other than non-urgent procedures; to advise of acceptance or rejection of such request for precertification; and to provide reasons for any such rejection. Such acceptance or rejection of a precertification request may be provided through a recorded or computer generated communication, provided that the individual requesting precertification has the clear and immediate option to speak to an employee or representative of the managed care plan capable of providing information about the precertification request.”

request and receive timely authorizations, GHA requests the following change to the first sentence of this Section and addition of a second sentence, as follows:

- 4.9.5.5 “Pursuant to O.C.G.A. §33-20A-7.1(c), the Call Center shall be staffed twenty-four (24) hours a day, seven (7) days a week, to ~~respond to Prior Authorization and Pre-Certification requests.~~ advise of acceptance or rejection of Prior Authorization and Pre-Certification requests; to provide reasons for any rejection of such requests and to identify additional information required to make a determination. The individual requesting Prior Authorization and Pre-Certification must have the clear and immediate option to speak to an employee or representative of the CMO who is capable of providing such information.”

In order to ensure compliance with this provision, GHA also requests that a call center standard relative to this provision be added, as well as a performance guarantee, as follows:

- 4.9.5.6.7 Immediate access to a person who can advise of acceptance or rejection of Prior Authorization and Pre-Certification requests, provide reasons for any rejection of such requests and identify additional information required to make a determination shall occur: Ninety-five percent (95%) of calls related to Prior Authorization or Pre-Certification requests shall be immediately connected with a representative who is capable of providing the information identified herein. “Immediately” shall mean within two (2) minutes of the time the call is initially answered by any Call Center representative.

- 25.6.1.6.4 One thousand dollars (\$1,000) for each percentage point that is below the target of ninety-five percent (95%) of calls related to Prior Authorization or Pre-Certification in which the caller is given immediate access to a person who can advise of acceptance or rejection of Prior Authorization and Pre-Certification requests, provide reasons for any rejection of such requests and identify additional information required to make a determination.

## Clarification of Existing Contract Provisions

### 5. Utilization Management (UM) Terminology

The Contract does not clearly distinguish between prior authorization and pre-certification. It appears that pre-certification may be intended to refer to inpatient care and prior authorization to outpatient care, but this is not clear from the definitions or usage.<sup>4</sup> In

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<sup>4</sup> Of 27 uses of the term pre-certification, it is used in conjunction with prior authorization in all except 5. Only 2 seem to indicate any distinction between the two: 4.6.1.14 states “Once a



addition, in some cases the language in the contract refers only to one term, yet the provision appears intended to apply to both. For example, Contract Section 4.11.2.7 contains the requirements for CMO notification to providers of determinations. This Section references only prior authorization, yet there are no other provisions in the Contract establishing notification timeframes for pre-certification and it is unlikely that DCH intends to limit this requirement to prior authorization only. In addition, the Contract includes a definition for the term "Prior Authorization Portal" that references only prior authorizations and not pre-certifications, yet it appears that DCH intends for both prior authorizations and pre-certifications to be communicated via this portal. If all requirements in the contract applicable to prior authorization also apply to pre-certification, it would be much clearer to use a single term throughout. If there is a reason to keep both terms, GHA requests DCH add references to pre-certification throughout Contract Section 4.11.2.7, add a reference to pre-certifications to the definition of the portal and search the Contract for any references to either of these terms to ensure they are used in a manner that accurately reflects DCH's intent. The suggested changes, include, but are not limited to, the following:

In Section 1.4, Definitions

Prior Authorization Portal: The electronic web-based system through which Providers and the CMOs communicate about Prior Authorization and Pre-Certification requests submitted by Providers.

4.11.2.7 The Contractor shall notify the Provider of Prior Authorization or Pre-Certification determinations via the Prior Authorization Portal in accordance with the following timeframes.

See also the comments regarding Section 4.11.2.7.1 below.

In addition, concurrent review, a major component of utilization management, is not separately defined and very few standards related to its use are included in the Contract. Concurrent reviews (review of care which is already underway) often create unique challenges for providers and may involve members urgently in need of continued services, especially in the area of mental health. GHA requests that the DCH incorporate this term into the definitions of prior authorization and pre-certification in Section 1.4 of the Contract in order to ensure that the standards related to pre-certification and prior authorization apply to concurrent review, as follows:

Pre-Certification: Review conducted prior to or during (concurrent review) a Member's admission, stay or other service or course of treatment in a hospital or other facility.

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Member's Condition is stabilized, the Contractor may require Pre-Certification for hospital admission or Prior Authorization for follow-up care" and 4.11.5.4 requires that pre-certification be used for back transfer cases which are inpatient transfers to a lower level of care.

Prior Authorization: Authorization granted in advance of the rendering of a service or during an episode of care (concurrent review) after appropriate medical review. Also known as Pre-Authorization or Prior Approval.

In order to ensure that the CMOs implement utilization management policies and procedures that facilitate appropriate and medically necessary care for members without unnecessarily increasing administrative expense to providers, GHA requests that DCH add the following reporting requirements and performance guarantees to the Contract:

4.11.1.3.11.2 The Contractor shall submit quarterly reports to DCH which summarize all authorization requests, as follows:

- A list of requests for Standard, Expedited or retrospective Pre-Certification or Prior Authorization for inpatient services, including request type, service type, bed type and Provider, as well as the following metrics:
  - Total number of completed requests for Standard Service Authorizations for inpatient services;
  - Total number of completed requests for Expedited Service Authorizations for inpatient services;
  - Percent of completed requests within timeliness standards for inpatient services;
  - Total number and percent of completed requests authorized on initial request;
  - Total number and percent of completed requests denied on initial request;
  - Total number of Medical Necessity denials issued which meet industry standard utilization review criteria, such as Interqual, but were denied based on utilization of Contractor's custom utilization review criteria.
  - Total number and percent of authorizations denied initially that are overturned on appeal, arbitration or settlement; and
  - Patterns and aggregate trend analysis.
- A list of requests for Standard, Expedited or retrospective Pre-Certification or Prior Authorization for outpatient services, including request type, service type and Provider, as well as the following metrics:
  - Total number of completed requests for Standard Service Authorizations for outpatient services;
  - Total number of completed requests for Expedited Service Authorizations for outpatient services;
  - Percent of completed requests within timeliness standards for outpatient services;

- Total number and percent of completed requests authorized on initial request;
- Total number and percent of completed requests denied on initial request;
- Total number of Medical Necessity denials issued which meet industry standard utilization review criteria, such as Interqual, but were denied based on utilization of Contractor’s custom utilization review criteria.
- Total number and percent of authorizations denied initially that are overturned on appeal, arbitration or settlement; and
- Patterns and aggregate trend analysis.

## 6. Authorization Timeframes

Contract Sections 4.11.2.7.1 and 4.11.2.7.2 specify the timeframes within which authorization decisions must be made and give the option for extending those timeframes as necessary. GHA appreciates and supports the new provision requiring the CMOs to make prior authorization decisions for non-urgent services within three (3) business days and for urgent services within twenty-four (24) hours. However, inclusion of the phrase “or other established timeframe” for standard authorizations may render this important requirement meaningless, depending on its interpretation. For example, if the CMO’s provider manual establishes a seven day timeframe and the contract requires providers to comply with the terms of this manual, is the timeframe established by the CMO an “other established timeframe”?

In addition, as written, the timeframe begins when the provider requests authorization, not when the provider submits the clinical data to support the request. This may have unintended negative consequences for providers, especially in the case of inpatient admissions for which the provider issues notification immediately but may not have the utilization management personnel available until the first business day following the admission to follow up with clinical information. In response to this requirement, Amerigroup has already issued a notice that they will soon begin requiring that clinical information be submitted with the notification of inpatient stays and will issue administrative denials when it is not because they must complete the determination within 24 hours. It is reasonable to expect the turnaround time for the CMOs to begin when they have sufficient clinical information to make a decision. Starting the turnaround time with the initial notification will be an open invitation for the CMOs to issue administrative denials, needlessly reducing and delaying hospital reimbursement for services provided in good faith and increasing administrative expense.

In light of the fact DCH has already established a process by which the period can be extended when necessary, GHA recommends that the provision be modified as follows (as also shown in item #8):

- 4.11.2.7.1 Standard Service Authorizations. Prior Authorization and Pre-Certification decisions for non-urgent services shall be made within three (3) Business Days, ~~or other established timeframe,~~ of the request when supporting clinical information is submitted on the same day (generally submitted one week prior to the service or procedure), or within three (3) Business days of the date of supporting clinical information is provided if such information is not submitted on the same day as the request. An extension may be granted for an additional fourteen (14) Calendar Days if the Member or the Provider requests an extension, or if the Contractor justifies to DCH a need for additional information and the extension is in the Member's best interest.
- 4.11.2.7.2 Expedited Service Authorizations. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, Contractor must make an expedited authorization decision within twenty-four (24) clock hours of the time supporting clinical information for the request is submitted and provide notice as expeditiously as the Member's health condition requires and no later than three (3) Business Days after receipt of the request for service and its supporting clinical information. The Contractor may extend the twenty-four (24) clock hour period for up to five (5) Business Days if the Contractor justifies to DCH a need for additional information and how the extension is in the Member's best interest.

## 7. Consistent Application of Valid Medical Necessity Criteria

Contract Section 4.11.1.3 requires the CMOs to have written utilization management policies and procedures that include protocols and criteria for evaluating medical necessity and include mechanisms to ensure consistent application of review criteria. However, the utilization management guidelines in the Contract do not go far enough to ensure that providers have the information they need to determine in advance of providing care what criteria a CMO will use to determine whether the care meets its medical necessity criteria. It is not reasonable to allow the CMOs to use secret criteria to make medical necessity determinations after care has been provided. GHA recommends that the utilization management guidelines in the Contract be expanded to include the following provisions:

- 4.11.1.3.6 In the event Contractor intends to utilize any custom utilization review criteria in addition to, or in place of, industry standard utilization review criteria, such as Interqual, Contractor shall submit such criteria, along with supporting evidence, to DCH for approval prior to implementation, shall post such custom criteria on its website and shall make such criteria available to a Provider in writing upon request.

#### 4.11.1.3.11 Reporting Requirements

4.11.1.3.11.1 The Contractor shall submit quarterly reports to DCH which show the number of Medical Necessity denials issued which meet industry standard utilization review criteria, such as Interqual, but were denied based on utilization of Contractor's custom utilization review criteria.

Add to Category 4 Performance Guarantees:

25.5.1.15 Failure to comply with authorization management requirements, as follows:

25.5.1.15.1 Denial of medical necessity for greater than five percent (5%) of service authorization requests for cases which meet industry standard utilization review criteria, such as Interqual criteria.

## **8. Accountability for Subcontractors**

The RFP and Contract Section 18.1 specify that the CMOs are solely responsible for all work contemplated and required, whether the CMOs perform the work directly or through subcontractors. Further, it requires that all contracts entered into between a CMO and any subcontractor related to this Contract contain provisions which require the CMO to monitor the subcontractor's performance on an ongoing basis and subject the subcontractor to formal review. The use of subcontractors in the GA Families program in the past has resulted in extraordinarily high administrative costs to providers and left many providers with unpaid claims for services they provided in good faith. In order to ensure that the CMOs accept responsibility for the performance of any subcontractors they engage, GHA requests the following modification:

18.1.8 All Subcontractors that enter into agreements with Providers for the provision of and payment for services covered by this DCH Contract, ~~All Provider contracts~~ shall be required to comply with all relevant provisions of this Contract, including the requirements and provisions as set forth in Sections 4.9, 4.10 and 4.11 of this Contract. In the event that a Subcontractor fails to process authorization requests, claims payments or appeals within sixty (60) days of the date required in the above referenced Sections, Contractor shall take over such administrative function, including processing and payment, as applicable, of any outstanding claims due Providers. In the event a delay in processing of an authorization request by a Subcontractor beyond the timeframes required in the above referenced Sections is likely to delay medically necessary care for a Member, Provider may immediately report such delay to the Contractor and Contractor shall ensure that such Provider receives a response to the request within twenty-four (24) hours.

## 9. Claims Payment for Continuous Inpatient Stays

RFP Section I.L.4 and Contract Section 4.11.4.2.1 stipulate that members enrolled in a CMO that are hospitalized in an acute inpatient facility will remain the responsibility of that CMO until they are discharged from the facility even if they change to a different CMO or become eligible for coverage under FFS Medicaid during the stay. However, if a member is placed in foster care during an inpatient stay, he immediately transitions to GF 360. Additional explanation is needed for some aspects of the payment policy for continuous inpatient stays, as follows:

- i. If the GA Families CMO is different from the GA Families 360° CMO, how will payment for the inpatient stay, including outlier payments, be coordinated?
- ii. Currently, a stay is considered to be a continuous inpatient stay covered by the payor in effect at the time of initial admission even if the member is transferred between inpatient acute care facilities during the stay, although that policy isn't stated in the RFP or Contract. To ensure an understanding of this requirement by new entrants, GHA requests the following modification of this Contract Section:

4.11.4.2.1 “Members enrolled in a CMO that are hospitalized in an acute inpatient hospital facility will remain the responsibility of that CMO until they are discharged from inpatient acute care ~~the facility~~, even if they change to a different CMO, or they become eligible for coverage under FFS Medicaid during their Continuous Inpatient Stay. For the purposes of this Section, Continuous Inpatient Stay shall mean a continuous period during which the Member is hospitalized as an inpatient in an acute care hospital, including any periods during which the Member is transferred to another acute care facility for services that cannot be provided at the transferring facility or for a Back Transfer as defined in Section 4.11.5.”

## 10. Incorrectly Paid Claims

Contract Section 4.16.1.1 requires that the CMOs resolve any claims processing issues caused by them within forty five (45) days but does not address reprocessing of affected claims. Historically, reprocessing and payment of such incorrectly paid claims has taken extremely long periods of time, in some cases more than a year. To address this longstanding issue, GHA recommends that the third sentence of Section 4.16.1.1 be modified as follows: “Any claims processing issues caused by the Contractor will be resolved, incorrectly paid claims reprocessed and payment issued to the provider within a forty-five (45) Calendar Day limit.” GHA also recommends that the following sentence be added to the end of that paragraph: “If a claims error affects payment for more than two

hundred (200) claims or more than fifty-thousand dollars (\$50,000), the Contractor shall work in good faith with the provider to agree on a method of payment, such as claims reprocessing or settlement without individual claims processing.

## 11. Centralized Credentialing

GHA would like to thank the Department for implementation of the CVO, which should alleviate many of the past delays in credentialing by the individual CMOs. As implemented, the CVO process is somewhat different from that described in Contract Section 4.8.21 in that organizations with delegated credentialing contracts with the CMOs are not required to use the CVO. As the delegated credentialing process in and of itself is working fairly well and is certainly much simpler for providers than completing individual online applications for each provider, that decision was certainly welcome by health systems and other provider organizations that contract for large numbers of providers. DCH has communicated verbally and through email that the requirement to use the CVO for credentialing will be waived for health systems with delegated credentialing with the CMOs in the same way that requirement is waived for IPAs and PHOs per DCH policy. To avoid confusion and ensure consistent interpretation of the CVO requirements, GHA requests that the Contract be modified to reflect the process as implemented, as follows:

Add to Section 1.4, Definitions:

Delegated Credentialing: A formal process by which a CMO gives a provider organization, including a hospital, health system, independent practice association (IPA), or physician hospital organization (PHO), or other provider organization with which the CMO has a delegated credentialing agreement, authorization to perform credentialing functions on its behalf.

1.1.5.3.2 DCH is implementing a Credentialing Verification Program to simplify the Medicaid and Georgia Families Enrollment process for Providers and improve efficiencies by reducing administrative burden. Providers who do not participate through a Delegated Credentialing arrangement with a CMO will submit electronic applications and other required materials to a Credentialing Verification Organization (CVO) contracted by DCH. The CVO will process the Provider credentialing or re-credentialing information to apply to the fee-for-service and managed care delivery Systems. Except in those cases in which a Delegated Credentialing agreement is in place, the CMOs will not conduct separate credentialing and recredentialing processes.

4.8.1.2 The Contractor shall include in its network only those Providers that have been appropriately credentialed by DCH or its Agent or through a Delegated Credentialing arrangement with a provider organization, that maintain current license(s), and that have appropriate locations to provide the Covered Services.

4.8.21.1 DCH is contracting with a single Credentialing Verification Organization (CVO) to conduct credentialing and re-credentialing of Providers for Medicaid and the contracted CMOs. Unless included in a Delegated Credentialing arrangement between the CMO and a provider organization, Providers must enroll with Medicaid and/or Georgia Families or Georgia Families 360° by submitting an electronic application and supporting documentation through the CVO's web-based Provider Credentialing Portal. Except in the case of Delegated Credentialing, the Contractor will not conduct its own Credentialing processes and shall accept the CVO's credentialing and recredentialing determinations. The Contractor cannot appeal the CVO credentialing decision. The Contractor cannot require Providers to submit supplemental or additional information for purposes of conducting a second credentialing process by the Contractor. See Attachment V, Provider Credentialing Process.

4.8.21.2 The Contractor shall coordinate with DCH's contracted CVO to confirm the status of applicable Providers who are requesting to enroll with the Contractor and to confirm recredentialing status. The Contractor shall report to DCH any instances of which it is informed a determination has not been made by the CVO within thirty (30) Calendar Days of application. See Attachment W, Provider Credentialing Timelines. DCH reserves the right to modify the credentialing timelines as needed.

4.8.21.3 The Contractor shall refer providers to the CVO website to complete the credentialing process prior to enrolling with a CMO, unless such providers will be covered by a Delegated Credentialing agreement between a provider organization and a CMO. The Contractor shall also provide information about the re-credentialing process to all network Providers. The Contractor will refer all Providers to the CVO who are not Medicaid providers and requesting to enroll.

In addition, Attachment V, appended to the Contract, includes a flow chart which should be updated to note the exclusion of providers covered by a delegated provider organization from the CVO process for individual providers.

## 12. Provider Loading and Effective Dates

The final step of provider credentialing for health plans is the loading of provider files and rates into their claims systems. This step has historically been problematic for all of the CMOs. In addition, there are many events that trigger the need for loading provider information that do not relate to credentialing. Problems occur with the loading of new providers and contracts, new locations, and updates to providers, contract rates and Medicaid rates. Not infrequently, it takes months or even years for provider files and rates to be correctly loaded in the CMOs' systems. The primary consequence of these errors and



delays is the tremendous disincentive to providers to participate in the CMOs. Lack of payment or incorrect payment for services provided in good faith further erodes the already low reimbursement under the Medicaid program. And when new providers join a group or provide coverage for another location in which there is insufficient capacity of providers that accept Medicaid, excessive loading delays prevent those providers from offering care to members who need it.

Provider loading and the overall credentialing process were investigated by the Senate Study Committee on Medicaid Managed Care Credentialing in 2014. In its final report, the Committee included among its recommendations two that directly address provider loading processes and effective dates, as follows:

- DCH's contract with the CMOs should set forth a timeframe within which a CMO is required to upload a credentialed provider into its claims payment system.
- CMOs should continue to issue retroactive payments under their policy and be diligent in making sure retroactive payments are issued automatically without undue burden on the providers.

There are multiple scenarios that may arise in provider file and contract loading, and each may require different timeframes for loading and different effective dates depending upon the circumstances. To simplify discussion, those scenarios are shown in the attached Exhibit 1, along with definitions of terms used. GHA appreciates the fact that the Department has recognized the need for increased oversight of the provider file and rate loading functions and the assignment of effective dates, as evidenced by the inclusion of requirements for timely file loading and assignment of effective dates for providers. Those scenarios which have already been addressed in the contract are also indicated on Exhibit 1. GHA requests that current Contract Sections be modified or provisions added to address the other scenarios, as follows:

Add to Section 1.4, Definitions:

**Credentialing Date:** The date on which the CVO or Delegated Credentialing entity approves the Provider's credentialing application.

4.8.18.2 The Contractor shall ensure that all executed Provider contracts or amendments to contracts to add new entities or change rates are processed and loaded into all systems including but not limited to the Contractor's Claims processing system, within thirty (30) Calendar Days of receipt by the Contractor or its designated subcontracted vendor.

4.10.1.4.34 [...the Contractor's Provider Contracts shall:] Require the Contractor to notify the Provider in writing no less than thirty (30) Calendar Days prior to any adjustments to the Provider's contracted reimbursement rates and receive written notification from the Provider of acceptance of the new

reimbursement rates, and such rates shall become effective thirty (30) Calendar Days after the date of the Provider's written acceptance of the rate change or on the date of loading in the CMO claims system, whichever is later;

4.10.4.5 When the Contractor negotiates a contract with a FQHC and/or a RHC, as defined in Section 1905(a)(2)(B) and 1905(a)(2)(C) of the Social Security Act, the Contractor shall pay the PPS rates for Core Services and other ambulatory services per Encounter. The rates are established as described in §1001.1 of the Manual. In the event there is a change in the PPS rates for Core Services and other ambulatory services, the Contractor shall make such change effective thirty (30) Calendar Days after the date of submission of the notice of such change by the FQHC or RHC to the Contractor and shall ensure that such rate is loaded prior to its effective date. At Contractor's discretion, it may pay more than the PPS rates for these services. Payment Reports must consist of all covered service claim types each month, inclusive of all services provided by the Contractor.

4.10.4.7 The Contractor shall adjust its negotiated rates with Providers to reflect budgetary changes to the Medical Assistance program, as directed by the Commissioner of DCH, to the extent such adjustments can be made within funds appropriated to DCH and available for payment to the Contractor. The Contractor's Provider Contracts shall contain a provision giving notice of this obligation to the Provider, such that the Provider's execution of the Contract shall constitute agreement with the Contractor's obligation to DCH. In the event the Commissioner of DCH so directs the Contractor to adjust its rates, the adjusted rates shall be loaded in the Contractor's claims system prior to the effective date if notice from the Commissioner of DCH is given more than thirty (30) days prior to the effective date, otherwise within thirty (30) Calendar Days of the date of such notice. The Contractor shall recognize and honor the adjusted rates for payment of Provider claims with dates of service on or after the effective date assigned by DCH, if given, otherwise the date of the DCH notice. Change in the terms of the Provider's reimbursement rate methodology must be agreed to by the Provider. Contractors are not permitted to simply send a notice advising as to a reimbursement rate methodology change. Once a rate change is agreed to in writing by the Provider, such new rate shall become effective on the date specified in such contract, amendment or other writing and must be loaded into the Contractor's claim system prior to the effective date or within thirty (30) days of the date the executed contract or amendment or other writing is received, whichever is later. This does not prevent routine and necessary adjustments to Maximum Allowable Charge rates. In the event that a Contractor's contract with a Provider indicates that payment will be made on the basis of the Medicaid rate or Maximum Allowable Charge, Contractor shall load any adjustment to such rates prior to the effective date or within

thirty (30) days of the date the new rates are published by DCH, whichever is later.

- 4.10.4.8 For a newly credentialed Provider, the Contractor shall recognize and honor for payment consideration any Provider claims with dates of service on or after the Provider Credentialing Date or the Provider contract effective date, whichever is later, irrespective of the date the Contractor loads the Provider into its claims processing system.
- 4.10.4.9 Where a Provider that has already been credentialed by a CMO changes practice location or adds a practice location that will require both a new Medicaid Provider number and a new contract or an amendment to an existing contract, the Contractor shall recognize and honor for payment consideration any claims for services by the Provider at such new location with dates of service on or after the applicable Medicaid Provider number effective date or the Provider contract or amendment effective date, whichever is later, irrespective of the date the Contractor loads the Provider into its claims processing system.
- 4.10.4.10 Where a Provider that has already been credentialed by a CMO changes practice locations or adds a practice location that will require a new Medicaid Provider number but will not require a new contract or an amendment to an existing contract, the Contractor shall load such new location and Medicaid Provider number into its claims system within thirty (30) Calendar Days of the date it is notified of the new location and new Medicaid Provider number, and shall recognize and honor for payment consideration any claims for services by the Provider at such new location with dates of service on or after the first day of the month in which the Provider submitted a complete Medicaid enrollment application, irrespective of the date the Contractor loads the Provider into its claims processing system.
- 4.10.4.11 In the event the Contractor fails to load new or revised rates within the timeframes described in this Section 4.10 or in Section 4.8.18.2, Contractor shall waive any timeframe limitation for submission of claims for dates of service prior to the date Contractor notifies the Provider that claim system loading is complete, whether such claims have been held by Provider pending notification of loading, rejected by Contractor's claim system or EDI vendor, paid incorrectly or denied.

## Requested Expansion of or Additions to the Contract

### 13. Reduced (Triage) Payment for Emergency Services

Inappropriately reduced payments for emergency services by some CMOs has been a significant issue since the implementation of Medicaid managed care in Georgia in 2006. In many cases the CMOs contractually agree to pay providers for emergency services at 100% of the FFS rate. FFS Medicaid has two rates for services provided in emergency departments, one for emergency services, i.e., services provided to individuals deemed to have emergency medical conditions, and a much lower “triage” rate for individuals with non-emergent conditions. The problem relates to the manner in which the CMOs have programmed their automated claims payment systems to identify claims for emergency medical conditions.

The current legal standards and contractual requirements provide little meaningful guidance regarding how to identify an emergency medical condition based on the information submitted on a claim.<sup>5</sup> As a result, there is no consistency in the way in which the CMOs actually program their systems to recognize emergencies and to pay claims accurately. Numerous hospitals report that some CMOs are paying the majority of emergency department claims at the triage rate, rather than the emergency services rate, even when the condition is determined by the attending physician to be an emergency and there is ample information on the claim to identify the services as emergent. To make matters worse, the data collected by DCH to help assess the extent of the problem fails to capture much of the relevant claims data and significantly underrepresents the scope of underpayments. The CMO flash reports posted on the DCH website, summary graphs & 2015 reports attached as Exhibit 2, show the self-reported volume of emergency claims, claims paid at the triage rate and triage payments overturned on appeal. Peach State and Wellcare reported that between 42% and 60% of their emergency department claims were paid at a reduced rate between January 2014 and June 2015. In addition, prior to a GHA inquiry in March 2015 regarding their reporting methodology, Wellcare reported an average of 60.5 appeals a month when, in fact, they acknowledge that they receive several

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<sup>5</sup> Both federal law and the DCH/CMO contract require that the CMOs use the “prudent layperson standard” which means that the determination of whether a service is emergent must be based on whether a prudent layperson would believe that the patient’s symptoms at the time the patient presents at the emergency room constitute an emergency, not whether a medical emergency actually exists. This standard, without specific implementation criteria, provides insufficient guidance regarding how the CMOs should operationalize this determination.

Contract Section 4.6.1.6 stipulates that the CMO may not deny or inappropriately reduce payment for emergency services and that a CMO must configure its automated claims processing system to process emergency room claims based on consideration of certain specified criteria. However, this too falls short of the type of clear criteria required to address this problem.

thousand requests each month to reconsider these payments.<sup>6</sup> It is of note that in the four months since GHA's inquiry, Wellcare has reported an average of 426 appeals a month, seven times the number reported on average previously.

Whatever terminology you use to describe them, appeals are extremely costly for hospitals, and many smaller hospitals simply do not have the staff to seek appropriate payment for this volume of inappropriately paid claims, even when the higher emergency services rate is clearly justified.

Due to the magnitude and longstanding nature of this issue, GHA requests that DCH include language in the Contract to implement the recommendations made by Myers and Stauffer back in 2008 when it audited the CMOs payments for emergency services and confirmed the significant percentages of inappropriate payments for emergency services. Specifically, Myers and Stauffer recommended that DCH:

- Require CMOs to use a standardized approach for reimbursement, based on CPT or diagnosis. If diagnosis based, DCH should provide a minimum list of presumed conditions and require the CMOs to program their claims payment systems to recognize these claims as presumptive emergencies and pay them accordingly;<sup>7</sup>
- Evaluate and update such list of presumed diagnoses on an annual basis; and
- Require CMOs to evaluate policies and modify based on reconsideration and overturn rates.

GHA also requests that DCH require the CMOs to:

- Treat initial requests by providers for reconsideration of triage payment as claims adjustment requests rather than provider complaints. Claims adjustments may be submitted by a provider within three (3) months of the end of the month in which payment was received, while provider complaints must be filed within a much shorter 30 day timeframe. Given the number of inappropriate emergency room payments, 90 days is a much more reasonable and fair timeframe for providers; and

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<sup>6</sup> A great deal of confusion exists among providers generally regarding the applicability of the Claims Adjustment process as opposed to the Provider Complaints process. This confusion is exacerbated by the fact that two of the CMOs treat hospitals' requests to reconsider lower triage payments as Provider Complaints and one treats them as Claims Adjustment requests. See Section 14 below regarding the distinction between these two processes.

<sup>7</sup> While it is not appropriate to "limit" the definition of an emergency medical condition by creating a list of diagnosis codes and refusing to recognize any other codes as emergencies, it is entirely permissible to create list of codes that constitute "presumptive" emergencies and to require that the CMOs program their claims payment systems to pay them as such, as long as providers are allowed to make the case that other codes also constitute emergencies on a case by case basis.

- Report specific information related to these claims adjustment requests to ensure an accurate count of all emergency department claims that require additional administrative effort to secure appropriate payment.

To address these issues GHA recommends that the following new provisions be added to the Contract:

4.6.1.5.1 In the event that Contractor issues payment at a reduced rate, including a triage rate, to a qualified provider of Emergency Services, the Provider may submit a request for Claim Adjustment within three (3) months of the end of the month in which such payment was received and the Contractor shall reprocess such claim in good faith in accordance with the provisions of Section 4.6.1. In the event the decision to issue payment at a reduced rate is upheld by the Contractor, the Provider may appeal the decision in accordance with the Provider Complaint process.

4.9.9.3 The Contractor shall submit to DCH monthly Emergency Services reports which include the following data:

- Number of Emergency Department (ER) claims submitted;
- Number of ER claims initially paid at a reduced amount (such as the triage rate);
- Number of requests for Claims Adjustments for ER claims initially paid at a reduced amount;
- Number of Claims Adjustment requests for ER claims initially paid at a reduced amount which resulted in additional payment;
- Number of Appeals for ER claims initially paid at a reduced amount;  
and
- Number of Appeals for ER claims initially paid at a reduced amount which resulted in additional payment.

#### **14. Peer to Peer Review Standards**

Contract Section 4.11.2.7.3 requires that the CMOs' policies and procedures for authorization include consulting with the requesting provider when appropriate, although there are no other stipulations for the manner in which such communications should occur. Particularly when performing concurrent review, if a CMO does not initially authorize the requested care, the case is typically referred for "peer-to-peer" review so that the member's physician can discuss the case with an expert physician reviewer for the CMO. GHA member hospitals, especially those providing mental health services, report that some current CMOs or their subcontractors use an excessive number of peer-to-peer reviews, and their reviewers are often unfamiliar with treatment of similar types of patients. In addition, they often do not communicate their decisions at the time of the peer-to-peer discussion, as is the industry standard, but instead defer to the CMO to make a decision.

GHA member hospitals report that the expert reviewers frequently fail to call at the scheduled time; fail to call the mobile number provided by the member's physician; call after hours and leave a voice mail message then close the case because they were unable to reach the attending or other designated physician; are often unfamiliar with evidence-based treatment protocols appropriate for the age of the member; and frequently do not inform the physician of their decision at the end of the call but indicate that they will instead "take it back to the plan." If the decision is truly based on medical necessity, an expert should be able to ask all necessary questions to make a determination of the appropriateness of the treatment at the time of the call and explain their rationale if they deny the request. These tactics often result in denial of care hospitals have rendered in good faith to patients who cannot be safely discharged. Due to inconsistencies and inequities in the expert review process, GHA recommends the addition of the following provisions to the Contract:

Add the following definition to Section 1.4:

**Peer to Peer Review:** A discussion between a Contractor's physician or other licensed clinician with expertise in treatment of the condition in question, and a Provider regarding the Medical Necessity of the services for which the Provider is seeking Prior Authorization or Pre-Certification.

**4.11.1.3.7** When a request for Pre-Certification or Prior Authorization of a service is denied or pended and Peer to Peer Review is requested, the Contractor shall provide reviewers with expertise in the applicable condition, including co-morbidities, and age group of the Member. The Contractor shall require its Peer to Peer reviewer to schedule an agreed upon time for the call with the Provider, be available to take or return calls within twenty (20) minutes of the scheduled time and advise the Provider of his or her decision and the basis for it prior to the conclusion of the call. A Peer to Peer review shall not be considered to have been completed if the reviewer of the reviewer fails to comply with any of these requirements.

Add to Category 4 Performance Guarantees:

**25.5.2.15.2** Failure to complete Peer to Peer calls in at least ninety five percent (95%) of the cases in which a Peer to Peer call is requested.

## **15. Distinction Between Provider Complaints and Claims Adjustments**

The current Contract language does not provide sufficient guidance regarding the types of claims that are subject to the provider complaint process versus those that are subject to the claims adjustment process.

The current CMO's have different interpretations of these processes and of the types of claims issues that go through the provider complaint process (which must be filed within 30 day of the incident) and the claims adjustment process (which must be filed within 90 days from the end of the month in which the claim was processed).

In addition, there is no timeframe in which the CMOs must respond to a provider complaint and the 30 day limit on filing a provider complaint generally makes it impossible for a provider to submit multiple claims with the same issue.

In order to clarify the rights of providers and make it feasible for providers to challenge multiple claims for which payments have been reduced or denied in a single submission, as allowed by O.C.G.A. § 33-21A-7, GHA recommends the following changes to the Contract related to provider complaints :

- 4.9.7.2 The Contractor shall submit its Provider Complaint System Policies and Procedures to DCH for review and approval quarterly and annually and as updated thereafter. The Contractor shall include its Provider Complaint System Policies and Procedures in its Provider Handbook that is distributed to all network Providers. This information shall include, but not be limited to, specific instructions regarding how to contact the Contractor’s Provider services to file a Provider complaint, the types of claims subject to the Provider Complaint process and those subject to the Claims Adjustment process, and which individual(s) have the authority to review a Provider complaint. In no event shall the Contractor require consent of the Member in order for the Provider to submit a Provider Complaint.<sup>8</sup>
- 4.9.7.4.1 Allow Provider thirty (30) Calendar Days from the date of the incident to file a written complaint for a single claim or incident;
- 4.9.7.4.2 Allow Providers ninety (90) Calendar Days from the date of the last occurrence of multiple incidents to consolidate complaints or appeals of multiple Claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment Claims included in the bundled complaint or appeal;
- 4.9.7.4.5 Add the following sentence at the end of the current provision: “The Contractor shall complete reprocessing of such Claims and issue additional payment and interest to the Provider within thirty (30) Calendar Days of the Provider Complaint decision.”

Add Section 4.9.7.4.12, as follows:

The Contractor shall complete its review of a Provider Complaint within thirty (30) Calendar Days of submission of the Provider Complaint and ensure that Provider receives written documentation of such decision and the basis for it within five (5) Calendar Days of such decision.

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<sup>8</sup> One subcontractor for a current CMO has instituted a requirement for a Provider to have the Member’s written consent in order to file a Provider Complaint and does not allow Providers to request an Administrative Law Hearing when a denial is upheld after the internal Provider Complaint process is exhausted.



- 4.11.1.3.5 Provide for the appeal by Providers, Members, or their representative, of authorization decisions, and guarantee no retaliation will be taken by the Contractor against the Member for exercising that right.

Furthermore, RFP Section I.J.9 and Contract Section 4.9.8 specify that a provider may submit a claims adjustment request within 3 months from the end of the month of payment and the contractor must respond within 15 days of receipt. However, if the CMO determines that the request is incomplete, it may return the request to the provider without taking further action and the provider then has 10 days to resubmit the request. With mailing delays and the need for the provider to investigate the CMO's contention that the claim was incomplete, the ten day period may not allow sufficient time for a provider to respond. In addition, although the CMO is required to respond to the adjustment request within 15 days, it is not clear that any additional payment due must also be made during that timeframe. Therefore, GHA requests that the provider response period be increased and the CMO response period be clarified through the following modifications to the Contract:

- 4.9.8.1.1.1 Change the fifth sentence to read "The Contractor may return incomplete requests without further action provided it notifies the Provider of the basis for the incomplete status and allows the Provider ~~ten (10)~~ thirty (30) Calendar Days to resubmit the adjustment request."
- 4.9.8.2 The Contractor shall respond to all adjustment requests and issue any additional payment due within fifteen (15) Calendar Days of receipt.

## **16. Appeal of Authorization Denial by Provider for Services Already Rendered**

Currently, the CMO's have different interpretations of providers' rights to challenge denials of prior authorization or pre-certification requests in cases in which the provider has already rendered services. Some CMOs consider any appeal of a denial of an authorization request to be only the member's right, even though the member has no incentive to dispute the denial when the services have already been rendered. While the Contract indicates that the provider can initially dispute a notice of proposed action on behalf of the member with the member's authorization, there is no recourse for the provider if the denial is upheld in that providers are prohibited from representing patients at the ALJ level.

Authorization denials for care already rendered most often occur when hospitals provide care to inpatients that they believe cannot be safely discharged. The CMO may not make a decision on authorization of the service for several days after they are notified of the admission. If the CMO ultimately denies the request for authorization, the hospital has already provided services in good faith for which it is not paid and is disadvantaged by the excessive delay created if it cannot pursue an appeal at that point and must, instead, wait until the claim has been submitted, processed and denied before a provider complaint can be filed. Some current CMO's consider an appeal of a denied authorization for services

already rendered to be an administrative review rather than a provider complaint, although authorization denials would appear to be included in the definition of that term that states “any aspect of a CMO’s administrative functions.” In order to ensure clarity and protect the rights of providers under such a process, GHA recommends that the hospital be allowed to appeal authorization denials as part of the provider complaint process through the following additions and modifications to the Contract:

Modify the Definition of Provider Complaint in Section 1.4 and Section 4.9.7.1 by adding “...including, but not limited to, denial or underpayment of claims and denial of authorization for services that have already been rendered.”

## 17. Provisions for Add-On Procedures and Families of Codes

Historically, providers have been subject to administrative denials of payment by the CMOs when they have provided medically necessary procedures not anticipated prior to the performance of a different planned procedure. In such cases, it is often in the best interest of the patient to have the unanticipated procedure or service performed at that time, particularly if the patient has had to undergo extensive preparation or is anesthetized. Add on services and family of codes are commonly used by commercial plans in recognition that it is impossible to predict each and every test, procedure or service that may be required in advance of an outpatient visit or a surgical procedure. It is not uncommon for a member’s condition to require a radiology service or surgical procedure that is similar to, but not the same as, the service or procedure that was anticipated at the time the procedure was originally scheduled. Where this occurs it is not reasonable or feasible to require patients to go home, wait three days for the provider to obtain authorization for something that is so similar to the previously authorized service that it will always be authorized. Similarly it is not acceptable to open up a patient originally believed to need one surgical procedure, find the patient needs a different procedure and then close the patient up until authorization can be obtained and then open them back up again.

In order to ensure high quality, appropriate and timely care for members, it is critical that there be a process by which such care can be authorized, either through inclusion in an existing authorization or by allowing the provider to request authorization after the procedure has been performed. Most CMOs, like the majority of commercial health plans, already have a process in place by which they pay claims for procedures included in the same family of CPT/HCPCS codes. However, unlike most commercial plans, the CMOs often refuse to share this information with providers, putting the provider at risk for an administrative denial because they have no idea whether a separate authorization is required. To address these issues, GHA requests inclusion of the following language in the Contract:

4.11.1.3.8 The Contractor shall program its Claims Payment system to recognize families of CPT/HCPCS codes so that if a valid Prior Authorization or Pre-Certification has been issued and a Medically Necessary service which falls within the same family grouping of CPT/HCPCS codes is provided, the

Contractor will consider such service to have been authorized and will not deny the Claim for lack of Prior Authorization or Pre-Certification. The Contractor shall provide a current list of its family of codes groupings to a Provider upon request. In addition, the Contractor shall work in good faith with other Contractors to reach consensus on the family of code groupings in order to develop a common list of families of codes that will be used by all Contractors.

4.11.1.3.9 Each Prior Authorization or Pre-Certification granted by the Contractor shall include authorization of all Medically Necessary “add on” services not anticipated before the initial outpatient visit as long as the Provider notifies the Contractor of such “add on” services within thirty (30) Calendar Days after the outpatient visit in which the services were performed and prior to submitting any Claim for payment.

4.11.1.3.10 The Contractor shall reimburse Providers for all Medically Necessary “add on” services regardless of whether Prior Authorization or Pre-Certification was required for the originally scheduled outpatient procedures or services during which the “add on” services were performed as long as the Provider notifies the Contractor within thirty (30) Calendar Days after the outpatient visit in which the services were performed and prior to submitting any Claim for payment.

## **18. Delay in Discharge to Lower Levels of Care**

Another common problem related to authorizations occurs when a patient that has been receiving inpatient care is ready for discharge to a different level of care but the facility is either unable to identify a provider offering such level of care in the CMO network or to obtain prompt authorization from the CMO for the lower level of care. This necessitates the continuation of inpatient care, yet even when the delay in discharge is due to action or inaction by the CMOs, the CMOs may deny authorization for the continued inpatient care required until a transfer can be arranged. Therefore, GHA recommends addition of the following provision to the Contract:

4.11.1.3.7 The Contractor shall not deny payment for care rendered by a Provider when a Member can be safely discharged to an alternate level of care but such discharge is delayed because such care is not available through Contractor’s network or because of Contractor’s delay in providing authorization of such alternate level of care.

\*Note: the terms “Supplier,” “Contractor,” “Care Management Organization” and “CMO” may be used interchangeably.