

MEDICAID PROVIDER ISSUES

Credentialing

Very long, complicated enrollment forms requiring an instruction manual in order to complete enrollment forms correctly.

The "Guide for Completing a Medicaid Provider Enrollment Application" is 59 pages long.

Medicaid requires each individual practitioner to complete an enrollment application

Medicaid also requires that the group needs to complete a "group" enrollment application which is identical to the individual enrollment application

Each individual provider in the group must complete a "Group Membership Authorization" and they must be included with the group enrollment application

Each individual provider must submit an individual W-9 form using their social security number to accompany their individual enrollment application, even though the billing uses the group tax I.D number

A group W-9 form with the group's tax I.D. number must accompany the group enrollment application

For each location that the physician practices out of, i.e., each office location and each hospital location, a "New Location Code Request" form must be sent for each location that the physician provides services. For The Woman's Group, this means that each individual physician must complete six of these forms to accompany their individual application as well as six forms for the group application.

Once completed, credentialing can take between 60-120 days provided that there are no errors on the applications.

I spent 2 hours with two very nice individuals at our local Medicaid office in an effort to help me clarify exactly what forms were required for each application. While these ladies were extremely nice, they had difficulty explaining what forms were required and referred frequently to the manual. Even they had trouble interpreting the manual and the forms requirements.

Most commercial carriers use the CAQH or "Council for Affordable Healthcare" Universal Provider Datasource to obtain up-to-date credentialing information for physicians.

This UPD or Universal Provider Datasource service is the industry standard in collecting provider data used in credentialing and claims processing. By streamlining data collection electronically they reduce duplicative paperwork. Their UPD form meets the data collection requirements of URAC and the National Committee for Quality Assurance (NCQA).

This tool allows us to credential our new physicians with most major health plans within a month or two of them joining our group. It also allows providers to manage and revise their information in real time, i.e., update licensures, address changes, etc.

Billing

Obstetrical care and delivery must be billed on a per visit, per service basis with Medicaid while commercial insurance companies recognize the global maternity codes for billing and payment purposes.

Patients have been able to obtain Medicaid even while they are currently employed and are covered under a commercial insurance plan.

We understand that Medicaid is considered the payer of last resort, so we must bill their commercial carrier first using the procedure codes recognized by the AMA. This makes billing Medicaid as a secondary carrier difficult as it requires prorating the primary insurance payment and breaking the balance down into per visit claims using Medicaid's "procedure codes," i.e. H1000 and H1001 codes for visits and then billing the delivery only

Medicaid patient's eligibility is determined on a month by month basis and the patient can be changed from "straight" Medicaid to one of the Medicaid HMO plans during the course of their pregnancy. Also, not all Medicaid patients receive the same level of benefits as some have shared cost plans which require that the patient pay a certain dollar amount before Medicaid begins paying.

Each Medicaid recipient receives the same gold Medicaid eligibility card that only contains a Medicaid control number. This number is not their Medicaid I.D. number and we must call or go through the automated eligibility line to obtain the patient's Medicaid number.

The Medicaid card issued to all recipients does not identify their coverage eligibility. We must call each month and obtain the patient's eligibility and whether the patient is on an HMO plan or a shared cost plan

We have found that in following up on unpaid claims that while the automated eligibility line showed that the recipient was eligible at the time of service, the claims are being denied for no coverage. When we call to question the denial, we are told the patient was not covered for that month and we have no recourse to appeal the denial. In short, there seems to be a discrepancy between what information we get via the automated system and the information the Medicaid customer service reps give with regard to patient eligibility.

Medicaid Issues for prenatal care access

Dear Madelyn.

I am more encouraged tonight than I have been in months. Thank you for allowing me to listen in (and interject) with your interview.

When Healthy Start was initiated by Chiles in the 1990's, the goal was to increase access to prenatal care statewide--first trimester and to improve outcome by connecting pregnant women to services. Initial data showed earlier first visits, reduction in preterm birth, better outcomes.... Early 2000's we started to see a reversal in this trend. Discussions with physicians, health departments, DCF, hospitals and service organizations led us to the conclusion that this was timed with the entry of medicaid HMOs into our county. Multiple well meaning attempts to fix cost, access to care and improve outcomes became layered upon one another (the privatization being a part of this) and the result was fewer physicians taking the medicaid flavors, later entry into care, sicker patients coming to the hospital and more adverse outcomes--with more costs to the state (NICU stays and need for post natal intervention)

We hired "One Voice for Volusia" in our county to do a study on this issue and present the problems to a coalition of physicians, hospitals, health departments, DCF, AHCA and others which occurred in spring of 2008. We have been working on solutions ever since. Senator Evelyn Lynn, Rep Alan Hayes among others have been highly supportive of our efforts, but it has been a struggle. I will follow this email with several white papers and a copy of the study if I can find it in my archives.

In a nutshell, we initially thought we would request a carve out/waiver to hold off medicaid reform in our county and instead request that medicaid dollars go to our delivery hospitals as medical homes. Pregnant women would apply for medicaid through qualified designated providers (QDPs from DCF) at the hospitals and enter the system there. Whether they were destined to have medipass, HMO, be undocumented--all would be lumped into a single population and physicians would provide care in their offices and be paid by the hospital as service providers and therefore have sovereign immunity under the hospital taxing authority. The SI would only apply to those delivering at Halifax and I foolishly wanted wording in our legislative action to expand SI to the other delivering hospitals in our county that were not state taxing authorities. This made us toxic to the legislature that year and we could not get out of committee.

Next step was to try and do this model under the health department, which would hire the physicians in order to provide the sovereign immunity. We are working on this now and hope to reach out to Senate Leader Haridopolos, whose county has a similar and highly successful model through their health department leader Dr. Heshmate.

I have so many anecdotes about why reform cannot be expanded. Patient after patient is autoassigned out of their medipass into healthsease or something similar and finds out mid way through their practice that their visits are no longer covered in my office. Initially my practice (five physicians and three midwives delivering up to 700 babies yearly) tried to work out contracts with the HMOs and they would simply not work with us in a logical and reasonable fashion. So patients could not stay with our practice (unless we agreed to see them without reimbursement, which we often did) We cannot find any consultations for orthopedic, neurologic, dental, psychiatric issues and end up managing these high risks issues on our own. Medicaid will only pay for 8 visits in a low risk pregnancy and twelve in a high risk pregnancy. They pay for only one ultrasound. With diabetics, hypertensives, twins, substance users, we use up twelve visit before thirty weeks and do all subsequent visits and antepartum testing pro bono. We have all the exposure (high risk populations and no support system) and virtually no reimbursement. At the end we are paid \$800 for delivery regardless of the intensity or difficulty. We quickly lose the

patients afterwards as their coverage is terminated—often before interconceptual counseling can be done to prevent close spacing.

An anecdote--I was on call for all comers this Saturday when I was called by the triage nurse that a 20 year old with no prenatal care near term had been brought in by her sister because they were frightened she was getting close and didn't know what to do. This girl was developmentally about 12--the baby was the result of an assault and the dates were unknown. Her family had private insurance but was told that they needed to remove her from this insurance in order to get medicaid. They attempted to do this and she was enrolled in Healthease after weeks of resubmitting information and a litany of calls and visits to DCF, etc. Once they obtained this "coverage", they could not find a practice that would accept Healthease and a woman in her third trimester with no prenatal care, so they came to the hospital. I took her pro bono and the sonogram today indicates she is about 40 weeks. She is likely diabetic with significant glucosuria and will be induced tomorrow.

An anecdote-- 22 yo swf G2P1 who learned she was pregnant and went to DCF to apply for medicaid. No persons are available at the DCF office in Daytona Beach who will meet with potential applicants. Written applications must be placed in a box. This was lost at least twice, and once she got her medicaid MU status (meaning it is in place until her finances are evaluated and may be discontinued if she is found ineligible) it was past twelve weeks. The health departments and the resident practice won't accept MU status or medicaid HMO because reimbursement doesn't support care. She was unable to get into any office on MU until she was autoassigned to Health ease. Her provider listed was in Lake County. She came in for bleeding at 22 weeks to our triage and found to have a previa. We followed her up in our office for the next visit and worked with her to switch her back to Medipass, which was successful. She saw us for a few visits and then was told she had been autoassigned to an HMO again. Rather than returning to us, she avoided care and came in with a severe bleed at 31 weeks. Baby ended up in NICU for several weeks--and will likely have severe deficits.

I have many other anecdotes, but cannot remember specifics (I am trying to listen to you speak!)

I would be privileged to talk to you, the FMA, the legislature at any time to review the issues of lack of access, consulting physicians, coverage for sonograms, labs and ancillary services that are considered standard of care--and the resulting poor outcomes resulting. At the most cold level of analysis, these results mean more tax dependents instead of tax payers. On the more ethical and moral ground it is the sad loss of potential for our citizens.

The legislators should demand metrics and outcome data from those HMO's who came in and dappled in the experiment--took their 30%, limited access to care and were entirely unaccountable for the resulting chaos.

I apologize that this is disjointed. I write often but not well under pressure! I lost access to the internet on your computer, so will go home and mail you the white papers. My colleagues are Dixie Morgese--ED of Healthy Start of Volusia//Flagler Counties and Bonnie Sorenson., Head of our Volusia County Health Department. We would welcome your support and dialogue to further the agenda for prenatal care models or access outside the current reform that has built in outcomes assessment and will be successful enough to template to other counties.

I love what you say about SGR, sovereign immunity, ACO's and PHYSICIAN CONTROL

Thank you for coming to our county. I respect you greatly!

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