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**FINAL REPORT OF THE SENATE STUDY COMMITTEE ON MEDICAID CARE  
MANAGEMENT ORGANIZATIONS CREDENTIALING**

**COMMITTEE MEMBERS**

**Senator Dean Burke, Chair**  
**District 11**

**Senator Charlie Bethel**  
**District 54**

**Senator Gail Davenport**  
**District 44**

**Senator Tim Golden**  
**District 08**

**Senator Chuck Hufstetler**  
**District 52**

**Senator Lester Jackson**  
**District 02**

**Senator Fran Millar**  
**District 40**

**Prepared by the Senate Research Office**  
**December 1, 2014**

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## INTRODUCTION

The Senate Medicaid Care Management Organizations (CMO) Credentialing Study Committee (the "Committee") was created by Senate Resolution 1175 during the 2014 Legislative Session. The Committee was charged with undertaking a study of the conditions, needs, issues, and problems related to the credentialing process in Georgia.

Senator Dean Burke of the 11<sup>th</sup> chaired the Committee, which held three public hearings on the following dates and corresponding locations:<sup>1</sup>

- August 27, 2014, at the Capitol in Atlanta, Georgia;
- September 15, 2014, at Hamilton Health Systems in Dalton, Georgia; and
- October 6, 2014, at Moultrie Technical College in Moultrie, Georgia.

Senator Charlie Bethel of the 54<sup>th</sup>, Senator Gail Davenport of the 44<sup>th</sup>, Senator Tim Golden of the 8<sup>th</sup>, Senator Chuck Hufstetler of the 52<sup>nd</sup>, Senator Lester Jackson of the 2<sup>nd</sup>, and Senator Fran Millar of the 40<sup>th</sup> served as members of the Committee.

## BACKGROUND

Senate Resolution 1175 recognized that credentialing is a necessary and critical first step in securing qualified practitioners to render and manage care under Medicaid CMOs and expressed concern that the lack of a standardized credentialing application in Georgia results in burdensome delays, limits access, an unnecessary administrative burden, and unnecessary repetition for participating providers.

Like other states, Georgia is increasingly adopting managed care as a response to growing Medicaid expenditures. Senate Resolution 1175 acknowledged this trend and expressed the Senate's understanding that it is crucial to evaluate the credentialing process and explore options for streamlining procedures and eliminating unnecessary repetition, while continuing to ensure only qualified providers serve the health needs of our Medicaid patients.

"Credentialing" is the collection, review, and verification of information for the purpose of determining the current qualifications of a provider. Hospitals and health plans, including CMOs, engage in credentialing providers. The credentialing process must be completed before a provider can participate in a CMO's provider network.

The Department of Community Health (DCH) does not engage in credentialing providers, but it does regulate providers that provide services to Medicaid beneficiaries through Medicaid provider enrollment. In order to participate in a CMO's provider network, a provider must enroll in Georgia Medicaid and PeachCare for Kids through the Georgia Medicaid Management Information System (GAMMIS) Web Portal within DCH. Therefore, Medicaid providers must complete the Georgia Medicaid provider enrollment before they can be credentialed by a CMO. Specifically, DCH requires providers to: (1) enroll in the Fee-For-Service (FFS) Medicaid

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<sup>1</sup> See Appendix A of this Report for a list of witnesses who testified at these hearings and a brief summary of their testimony.

program; (2) obtain a unique Medicaid provider identification (ID) number; and (3) separately enroll and obtain unique Medicaid provider ID numbers in each practice location.

While Medicaid provider enrollment is a separate process from CMO credentialing, there is a nexus between these two processes. This link can be found in the contractual relationship between DCH and the CMOs. DCH partners with private CMOs to deliver health care services to members of Medicaid and PeachCare for Kids through the Georgia Families program. Currently, DCH contracts with three CMOs: Amerigroup Community Care ("Amerigroup"), Peach State Health Plan ("Peach State"), and Wellcare of Georgia, Inc. ("Wellcare").

The CMOs are required under their contract with DCH to maintain policies and procedures for credentialing and re-credentialing providers using standards established by the National Committee for Quality Assurance ("NCQA"), the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), or the American Accreditation Healthcare Commission (also known as "URAC"). The contract also states that at a minimum, a CMO is to require that each provider meet credentialing requirements in accordance with State law and Federal regulations. As stated above, one of these requirements is that a provider must complete Medicaid provider enrollment through DCH. A provider must obtain a valid and active Medicaid provider ID number before a CMO can initiate the credentialing process.

Currently, CMOs are required to complete the credentialing process within 120 calendar days of receipt of a complete application from a provider. Providers seeking to be part of multiple CMO provider networks must be credentialed individually by each CMO. Currently, there is a wide variation in: the application process, the notification to providers of an incomplete application, and the internal process for application approval.

## FINDINGS

Based on the testimony presented, the Committee makes the following findings:

1. The credentialing process is repetitive, time consuming and different from the process used for other payers. The provider credentialing process should be streamlined to alleviate administrative and healthcare delivery burdens on providers.

Before the Committee held its first meeting, DCH was preparing a request for proposal (RFP) for a Credentialing Verification Organization (CVO) in order to improve the Medicaid enrollment process and standardize the CMO credentialing process. The department is now exploring the possibility that this improvement to its processes may not require an RFP and may be done under its current Hewlett-Packard Enterprise Services contract. The CVO is expected to refine and improve some of the issues with providers wanting to know the status of an application. Providers will no longer have to go to each CMO for credentialing; it will be a centralized process whereby the one organization will handle the process for all healthcare providers. Providers must still ensure their applications are complete before the credentialing process can occur. The CVO will have 30 days to turn an application around. The re-procurement with the CMOs will also include retroactive reimbursement.

2. There is a strong desire in the provider community to be more informed throughout the credentialing process.

Providers would like to receive timely electronic feedback on the status of an application. Specifically, they would like to be able to verify whether a submitted application has been received and whether the application is deemed "complete" or "incomplete." Providers often do not know that an application is missing necessary information until they are contacted by the CMO.

3. The 120 calendar day period within which a CMO must credential a provider following receipt of a complete application should be re-evaluated.

With the exception of some outliers, most providers are credentialed by a CMO in less than 120 days. Testimony that was given at the second and third meetings reflected a consensus in the provider community that the credentialing processing time should be shortened to 45 calendar days or less.

4. DCH requires that providers obtain separate, unique Medicaid ID numbers for each practice location to protect against Medicaid fraud and abuse.

Scenarios where this requirement must be met include when a provider opens a new practice location, relocates a practice, or starts seeing new or existing patients at an additional practice location, such as a satellite facility. Providers find this policy to be burdensome and overly restrictive. Provider testimony indicated that the majority of other states do not have this policy in their Medicaid managed care programs. The rationale behind Georgia's policy is to protect against Medicaid fraud and abuse.

5. The CMOs provide outreach education for providers, yet some aspects of the credentialing process are still not well understood by providers.

There is a distinction between a provider being credentialed and being contracted with a CMO. This distinction is often not understood by the provider, and without a contract in place with the CMO, the CMO cannot upload the provider into the claims payment system. A provider must reach a contracted status with the CMO before the CMO can upload payment rates.

6. There are delays between the date the provider is approved by the CMO and the date the provider is uploaded into the CMO claims payment system, and DCH's contract with the CMOs does not define a timeframe within which the uploading process should be completed.

The credentialing process is complete on the date the credentialing application is approved. Providers shared with the Committee that there are delays between this date and the date payment actually begins. Delays are attributed to the time it takes the CMO to upload a provider's information into its claims payment system once a credentialing application is approved.

Additional delays have occurred when a provider has been credentialed but is not under contract with the CMO. In addition to becoming credentialed by the CMO, a provider must also obtain a contracted status with that CMO in order to be uploaded into the claims payment system.

7. Once credentialed, providers would like for the CMOs to automatically issue retroactive payments for services rendered back to the date the completed application was received by the CMO. A CMO can retroactively pay the provider for services rendered back to this date.

Retroactive payments for services rendered before the approval date are limited by NCQA guidelines.

### RECOMMENDATIONS

Based on the foregoing findings, the Committee makes the following recommendations:

1. The Committee supports and recommends that DCH complete its CVO, which will credential all providers and streamline the application process. The use of the Georgia Uniform Healthcare Practitioner Credentialing Application or a similarly formatted process should be considered.
2. The credentialing process should be shortened from 120 days to a maximum of 45 days. This means the credentialing process would need to be completed within 45 calendar days of the provider's submission of a complete application.
3. An advisory board or similar body should be created, the purpose of which would be to inform persons involved in the credentialing process and facilitate communication between providers, DHC, and the CMOs. Once created, this body should hold meetings on a quarterly basis. Provider groups should receive notice of these meetings with the option of adding to the agenda any issues for discussion. This may be accomplished by adding this as an agenda item to an already scheduled ongoing meeting.
4. The Committee recommends that DCH explore options to address the challenges faced by providers with multiple practice locations who must acquire multiple, unique Medicaid ID numbers while continuing to protect against Medicaid fraud and abuse.
5. Providers should be educated and continue to receive updates during the credentialing process that becoming credentialed by a CMO is a separate process from submitting a contract to that CMO. Any software or online process that is engaged in this process should have links to make sure this step is clear and simple to begin the process.

Before a CMO can upload a provider into its claims payment system, the provider must have a contracted and credentialed status with that CMO. To reduce unnecessary delays, a provider should receive notice about submitting a contract to the CMO sites upon his or her completion of the CVO input process.

6. 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.
7. 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.
8. A follow-up Senate Resolution charged with ensuring adequate implementation of these recommendations and confirming improvement of the credentialing process should be considered during the next Legislative Session.

## Appendix A

### Summary of Witnesses and Testimony

#### Meeting 1, Wednesday, August 27, 2014

The first meeting was held at the State Capitol and consisted of an overview of the credentialing process by DCH and the CMOs, Amerigroup, Peach State, and Wellcare.

#### **Jerry Dubberly, Pharm. D., MBA, Chief Medical Assistance Plans Georgia Department of Community Health (DCH)**

Dr. Dubberly provided the Committee with a presentation on CMO provider enrollment responsibilities and an overview of the credentialing process, including any improvements that were in progress. He clarified to the Committee that all Medicaid providers must be enrolled in FFS Medicaid and that Medicaid requires by contract that CMOs attain and maintain accreditation from the NCQA. Dr. Dubberly also explained the importance of distinguishing between credentialing by CMOs and provider enrollment in FFS Medicaid.

#### **Aaron Lambert, Director Medicaid Field Operations Amerigroup Community Care of Georgia (Amerigroup)**

Mr. Lambert shared with the Committee that Amerigroup's service area includes six Medicaid Regions. He explained that providers are credentialed in accordance with State law and Federal regulations; this includes adherence to national standards. In order to be credentialed, a provider must have a valid and active Georgia Medicaid ID. Mr. Lambert told the Committee that Amerigroup's credentialing process is routinely audited by external parties for compliance with State and Federal guidelines. Amerigroup divides the credentialing process into three stages, which are completed in the following order: (1) credentialing application management; (2) Primary Source Verification (PSV); and (3) Medical director review. Amerigroup's process allows for delegated credentialing, allowing Amerigroup to assign credentialing responsibilities to another group or entity.

Mr. Lambert explained Amerigroup's "Medical Director Clean File Review" process to the Committee. This process enables Amerigroup to approve credentialing applications on a daily basis if the application is clean and free from any issues identified during the credentialing application process. If there are issues identified with the provider's application during the credentialing process that warrant a higher level of approval, Amerigroup presents these credentialing applications to the Credentialing Committee. The Credentialing Committee is comprised of external physicians and is typically chaired by the CMO's Medical Director. The Committee can make a motion to approve or deny a provider's application. This Committee meets monthly.

#### **Debra Peterson-Smith, Senior Vice President, Operations Peach State Health Plan (Peach State)**

Ms. Peterson-Smith shared with the Committee Peach State's credentialing process. Upon questioning about the possibility of having a medical director be given the authority to approve complete, clean, uncomplicated applications, it was made clear that Peach State would certainly review that possibility and see if it could be implemented.

**Marla Holcomb, Vice President of Network Management  
WellCare of Georgia, Inc. (Wellcare)**

Ms. Holcomb explained Wellcare's credentialing process to the Committee. Mirroring the comments by Peach State regarding Amerigroup's "Medical Director Clean File Review" process, Ms. Holcomb shared with the Committee Wellcare's intent to review and possibly adopt a similar policy.

**Meeting 2, Monday, September 15, 2014**

Hamilton Health Care System hosted the Committee in Dalton, Georgia.

**Temple Sellers, General Counsel  
Doug Patton, MD, Medical Director  
Georgia Hospital Association (GHA)**

Ms. Sellers provided the Committee with a presentation as well as written testimony. As a preliminary matter, she reminded the Committee of the difference between provider enrollment in FFS Medicaid and the credentialing process by the Medicaid CMOs. Ms. Sellers explained the administrative burdens for Medicaid providers related to the credentialing process and DCH's requirement that providers enroll and obtain unique Medicaid ID numbers for every separate location where they see Medicaid patients. CMOs use the provider's unique Medicaid ID number when paying providers. She said that this is problematic because a CMO will not load a provider's information into its claims payment systems or pay providers until it has a provider's valid and active Medicaid ID number that corresponds to the location where the patient was seen by the provider. GHA acknowledged that DCH is currently addressing ways to alleviate this administrative burden on providers.

Ms. Sellers also shared provider issues regarding retroactive payments, delays in uploading providers into a CMO's claims payment system, and the need for the standardization of applications among the CMOs. Additionally, GHA suggested that the credentialing application review process be reduced to 30 calendar days.

GHA commended DCH for issuing a request for proposal (RFP) for a Credentialing Verification Organization (CVO) in order to improve the Medicaid enrollment process and standardize the CMO credentialing process. Additionally, GHA recommended to the Committee that the CVO accept the Georgia Uniform Healthcare Practitioner Credentialing Application Form and the re-credentialing form. Providers also would like the opportunity to have input into the RFP, including the opportunity to identify improvements to the current enrollment process, particularly the web portal.

**Hugh Smith, MD, OB/GYN  
Georgia OB/GYN Society**

Dr. Smith echoed the testimony provided by GHA and told the Committee that he is very concerned about healthcare for women in the state, especially those in rural and underserved areas of Georgia; the credentialing process on a whole impedes providers' ability to provide quality care. He reported that six OB units have closed in Georgia in the past year and that it is very hard to recruit and retain OB/GYNs in a community. He agreed with the providers who already gave testimony that there should be a standardized form and the credentialing process be shortened to 30 calendar days. Specifically, Dr. Smith believes that retroactive payment

should be automatic, the requirement for location-specific Medicaid ID numbers is “archaic,” the communication between CMOs regarding the status of an application should be improved, and that there should be more transparency and accountability with the CMOs.

**Marla Mann, M.Ed. CCC-SLP; Owner, Building Bridges Therapy  
The Georgia Therapy Trialliance**

Ms. Mann, a speech-language pathologist, presented to the Committee on behalf of the Georgia Therapy Trialliance. She shared her experience with the credentialing process and reported that it often takes six to nine months to get credentialed. In one instance, she recalled being asked to submit a form three times even though there was no missing information on the form. She also reported that contact with some CMOs was frustrating and only occurred in the form of email. Ms. Mann told the Committee the lack of timely credentialing prevents children with special needs from receiving treatment. She suggested that the credentialing process be shortened to 30 calendar days and become completely electronic, including email notification of any status changes on an application.

**Deb Bailey, Director of Governmental Affairs  
Northeast Georgia Health System, Inc. (NGHS)**

Ms. Bailey echoed the testimony of GHA and presented on behalf of NGHS, a 560-bed community with over 250 providers. She shared with the Committee that 60 percent of the labor and deliveries at NGHS are on Medicaid; roughly 4,000 babies are delivered at NGHS each year. She provided to the Committee specific examples illustrating NGHS’s issues with multiple termination letters for “no documentation of ownership” when the provider is documented on record with a CMO. Ms. Bailey also shared that NGHS has experienced issues with CMOs recognizing the submission date of an application and that the communication between the CMOs and providers should be improved.

**Tim Kibler, Public Policy Director  
Georgia Alliance of Community Hospitals (GACH)**

Mr. Kibler, on behalf of GACH, submitted to the Committee a written summary of provider responses to an anonymous survey regarding their experiences with the credentialing application process.

**Response from DCH**

Dr. Jerry Dubberly provided brief comments in response to the testimony given to the Committee at the second meeting. He clarified that there is a single application for Medicaid, which is online and submitted electronically. Dr. Dubberly also explained that there is a legitimate rationale behind DCH’s policy requiring location-specific Medicaid ID numbers; it is very important to know where service is rendered in case an investigation becomes necessary. He also reported that DCH was “on track” with the CVO timeline.

### **Meeting 3, Monday, October 6, 2014**

Colquitt Regional Medical Center hosted the third meeting at Moultrie Technical College's Veterans Parkway Campus in Moultrie, Georgia.

#### **Marcus Downs, Director of Governmental Relations Medical Association of Georgia (MAG)**

Mr. Downs briefly presented MAG's positions within the past five years regarding the credentialing process. MAG supports requiring health insurance companies to use the Georgia Uniform Healthcare Practitioner Credentialing Application Form in applications and reapplications of participating providers. MAG also believes that health insurers should be required to expedite the credentialing process for all physicians, especially in the case where a physician is changing practice locations within Georgia and is already credentialed by the insurer. Further, MAG asserts that any physician who meets the overall credentialing criteria applied to all other providers and agreeing to the same method of payment be accepted into any health plan network to provide medical care.

#### **Pat Cota, Executive Director Georgia OBGyn Society**

Ms. Cota presented and submitted written testimony to the Committee on behalf of the Georgia OBGyn Society. The Georgia OBGyn Society provided the following suggestions to the Committee regarding the credentialing process: shorten the process to 30 days and centralized for all three CMOs and Medicaid; reconsider the need for specific Medicaid ID numbers for multiple locations; consider a process for retroactive payments; evaluate common issues and work with the provider community to increase first time application completions; and develop a reliable way for the provider community to be informed regarding the status of applications.

#### **Robin Rau, CEO Miller County Hospital**

Ms. Rau shared with the Committee that Miller County Hospital is one of the few remaining standalone hospitals in Miller County. She also shared with the Committee the details surrounding Miller County Hospital's acquisition of a rural health clinic and nursing home facility in February of 2013.

#### **Melana McClatchey, General Counsel Georgia Dental Association**

Ms. McClatchey shared with the Committee that there is often a problem where a CMO uses delegated credentialing; a dentist does not know a subcontractor is involved in the credentialing process and, in turn, the subcontractor does not know the dentist is attempting to get credentialed. She suggested that there could be a way to streamline this process and improve communication between providers, CMOs, and, in the case of delegated credentialing, subcontracted credentialing entities.

**Ashley Register, MD  
Cairo Medical Care**

Dr. Register briefly explained to the Committee the impact the credentialing process has on new doctor recruitment and practice. He shared that it can be very frustrating and discouraging to not be able to treat patients and bill for services while waiting for credentialing application approval, especially to new physicians wanting to begin practicing medicine.

**Lynne Byrd, MBA, BSMT (ASCP), Vice President, Revenue Cycle Operations  
Archbold Medical Center**

Ms. Byrd provided to the Committee examples of credentialing applications as well as a packet of screenshots of DCH's web portal. These materials were submitted to the Committee to help illustrate the process that providers go through for FFS Medicaid enrollment and CMO credentialing.

**Ben Marion, CEO  
Universal Health Services**

Mr. Marion, on behalf of Universal Health Services, told the Committee that the credentialing process is a barrier to treatment. He explained that once a hospital admits a behavioral health patient and begins treatment, the hospital is going to continue to treat that patient even though they will not be reimbursed.

**James Matney, President & CEO  
Colquitt Regional Medical Center**

Mr. Matney told the Committee that all the CMOs make an effort and an attempt to help providers through the credentialing process, however, the provider still has to get through the process. He also emphasized the need for a hospital to be able to see patients from day one in emergency departments. Finally, Mr. Matney recommended to the Committee that the policy requiring location-specific Medicaid ID numbers should be relaxed.

**Members' signature pages to follow**

**Signatures on file in the Senate Research Office**

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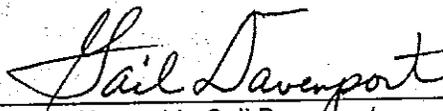
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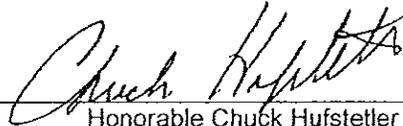
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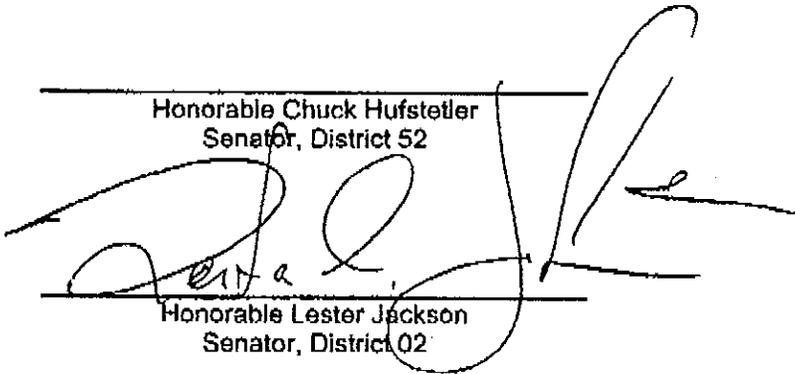
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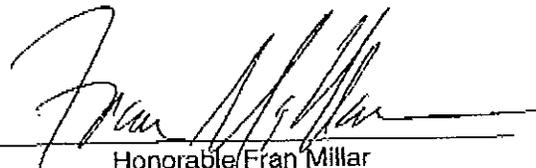
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