

Georgia Families®

Frequently Asked Questions & Answers

Provider-Related Questions and Assistance

- **Q: Who is DCH?**
A: The Department of Community Health (DCH) is the **single State Agency** designated to administer and supervise the administration of the Medicaid program. (42 C.F.R. § 431.10) DCH oversees program administration and funding for all Georgia Medicaid and PeachCare for Kids® services.
- **Q: What is Georgia Families®?**
A: Georgia Families® is a partnership between DCH and private health plans (*also called “care management organizations” or “CMOs”*) to provide benefits and health care services to Medicaid and PeachCare for Kids® members, Planning for Healthy Babies® (P4HB) enrollees, and Georgia Families 360°. PeachCare for Kids® is the State Children’s Health Insurance Program, and the P4HB program is Georgia’s Section 1115 Family Planning Waiver program. The Georgia Families 360° program facilitates the coordination of care for children, youth and young adults in Foster Care or receiving Adoption Assistance and select youth involved with the Department of Juvenile Justice.
- **Q: What is different about the Georgia Families® program that providers should know regarding members?**
A: Beginning July 1, 2017, the Georgia Families® program will provide Members a choice of four Care Management Organizations (CMOs): Amerigroup, CareSource, Peach State Health Plan, and WellCare. Georgia Families® Members were given the opportunity to select a CMO during the Open Enrollment process which took place during the month of March 2017. Some Members who did not make affirmative selections were auto-assigned to a CMO. In order to ensure a smooth transition and to ensure that all Members have access to care, each CMO has implemented Transition of Care processes.
- **Q: What is the ninety (90) day Choice Change Period?**
A: During the period of July 1, 2017 through September 30, 2017, all Members will have a one-time opportunity to change their assigned CMO without cause. This change will become effective on the first day of the month after the change is requested. The change will take place for the first of the next month even if the choice change is captured on the last day of the current month.
- **Q: What assurances are implemented to address a member’s transition of care?**
A: In order to ensure a smooth transition and to ensure that all members have access to care, DCH has worked with the CMOs to address the following:
 - ❖ Existing/Open Prior Authorizations
 - ❖ New Requests for Prior Authorization (i.e., requests submitted on July 1, 2017 and after)
 - ❖ Pharmacy Related Prior Authorizations
 - ❖ Claims Reimbursement for Office Visits and Sick Visits for Out-of-Network Providers/Non-Par Providers
- **Q: What is different about Existing/Open Prior Authorizations?**
A: If a Provider is rendering services to a Member who has a newly assigned CMO effective July 1, 2017, the newly assigned CMO will honor any current/open Prior Authorizations for forty-five (45) days, beginning on July 1, 2017 through August 14, 2017. This applies to in-network and out-of-network (non-par) Providers. Thus, if a Provider is rendering services to a Member who has a newly assigned CMO and that Provider is not

contracted with the newly assigned CMO, the newly assigned CMO will honor any current/open Prior Authorizations for forty-five (45) days, beginning on July 1, 2017 through August 14, 2017. If the Member requires services beyond August 14, 2017, Providers must contact the Member's new CMO to obtain authorization to continue those services. Providers will be required to follow the new CMO's prior authorization process for any services the Member needs after August 14, 2017.

- **Q: What is different about New Requests for Prior Authorizations?**

A: Providers will be required to submit new requests for Prior Authorization based upon the applicable CMO's guidelines. This applies to in-network and out-of- network (non-par) Providers. Prior Authorization decisions for non-urgent services will be made within three (3) business days. Expedited service authorization decisions will be made within twenty-four (24) hours. As a reminder, prior authorization is not required for emergency services, post-stabilization services, or urgent care services.

- **Q: What is different about Pharmacy Related Prior Authorizations?**

A: All current prescriptions (including medication step therapy) ordered/issued prior to July 1, 2017 will be transitioned and honored by the new CMO for the first 45 days, beginning on July 1, 2017 and ending on August 14, 2017. If after 45 days the member needs to continue on the non-PDL prescription, an authorization with proper documentation will be required from the prescribing physician. This is part of the Transition of Care process.

- **Q: Will the 45 day time period for authorizations and prescriptions also apply to changes to CMOs made during the Choice Change Period?**

A: For members transitioning July 1, 2017, the newly assigned CMO will honor any current/open Prior Authorizations for forty-five (45) days, beginning on July 1, 2017 through August 14, 2017. If the Member requires services beyond August 14, 2017, Providers must contact the Member's new CMO to obtain authorization to continue those services. Providers will be required to follow the new CMO's prior authorization process for any services the Member needs after August 14, 2017. After August 14, 2017, each CMO must comply with the contractual requirements. This is part of the Transition of Care process.

- **Q: What is different about Claims Reimbursement for Out-of-Network Providers/Non-Par Providers?**

A: If a Provider is rendering services to a member who has a newly-assigned CMO effective July 1, 2017, and is an out-of-network Provider, the Provider may submit claims for reimbursement for office-based and sick visits rendered to Georgia Families® members and Planning for Healthy Babies® recipients without an authorization. Claims may be submitted to Amerigroup, CareSource, Peach State Health Plan, and WellCare by out-of-network Providers for services provided from July 1, 2017 through August 14, 2017. In all instances timely filing requirements must be met.

- **Q: How can a Provider (In-Network or Out-Of-Network/Non-Par) submit claims to the CMOs?**

A: Both formats are acceptable. Claims may be submitted electronically or via paper through the mail.

- **Q: Will the payments to the providers be made via EFT, paper check, or in both formats?**

A: If a provider is signed up to accept an electronic payment from a clearinghouse, CMOs can honor an EFT payment. Otherwise, the CMOs will send payment via check.

- **Q: Does the provider have to be contracted with the CMO in order to receive payment via EFT?**

A: No. Providers do NOT have to be contracted with the CMO in order to receive payment via EFT.

- **Q: Will identification numbers for non-participating providers be generated by the plans once a claim is received or will the provider need to request one? If yes, how long will it take to obtain an identification number?**
A: The CMOs use the Georgia Medicaid ID# and the NPI# to process claims, therefore providers will not need a unique ID number for claims processing.
- **Q: How much will Non-Participating Providers be reimbursed during the 45 day period?**
A: Please contact the appropriate CMO with any questions regarding reimbursement rates.
- **Q: What is the website address or outline the process for non-participating providers to submit claims?**
A. Non-par providers can submit claims in the following ways:
 - Via paper claims through the mail. Refer to the CMO Provider Manual for mailing addresses.
 - Electronically through trading partner clearinghouses
 - Electronically through the appropriate provider website at the following links:
 - Amerigroup: <https://providers.amerigroup.com/pages/ga-2012.aspx>
 - CareSource: <https://www.caresource.com/providers/georgia/medicaid/authorization-claims-and-appeals/claims/>
 - Peach State: <http://www.pshpgeorgia.com/for-providers/electronic-transactions/edi/>
 - WellCare: <https://www.wellcare.com/Wellcare/Georgia/Providers/Medicaid/Claims>
- **Q: Will identification numbers for non-participating providers be generated by the plans once a claim is received or will the provider need to request one? If yes, how long will it take to obtain an identification number?**
A: The CMOs use the Georgia Medicaid ID# and the NPI# to process claims, therefore providers will not need a unique ID number for claims processing.
- **Q: When can providers begin submitting Prior Authorizations (PAs) for the new CMO, CareSource?**
A: Effective Friday, June 23, 2017 providers will be able to submit CareSource PAs via the Centralized PA Portal. All PAs associated with the Centralized PA Portal will be processed for CareSource members beginning on July 1, 2017.
- **Q: What forms are currently associated with the Centralized PA Portal?**
A: The following forms are currently associated with the Centralized PA Portal:
 - ❖ Newborn Delivery Notification
 - ❖ Pregnancy Notification
 - ❖ Inpatient Hospital Admissions and Outpatient Procedures
 - ❖ Hospital Outpatient Therapy
 - ❖ Durable Medical Equipment
 - ❖ Children's Intervention Services
 - ❖ Outpatient Behavioral Health
- **Q: If a member is under a provider's care but has transitioned to a CMO for which the provider is out-of-network, what should the provider do?**
A: If a provider is treating a member and is NOT enrolled in the member's new CMO, the provider should treat the member and contact that CMO for assistance. We strongly encourage providers to participate with all four CMOs. CMOs that work with Georgia Families® are:

- **Q: What are some of the new Georgia Families® CMO contract requirements?**

A: Listed below are some of the new contract requirements:

1. Discharge Planning Pilot Program
2. Dental Home for Members under 21
3. Emergency Room Diversion Pilot
4. Prior Authorizations Response Time
5. Ombudsman Resources
6. Monitoring and Oversight Committee
7. Member Advisory Committee
8. Provider Advisory Committee

- **Q: What is new about the Discharge Planning Pilot Program?**

A: CMOs will enter into agreements with select hospitals to coordinate onsite discharge planning.

- **Q: What is new about the Dental Home Program?**

A: All members under the age of 21 will now have a Primary Dental Provider (PDP) who will serve as the member's dental home.

- **Q: What is new about the Emergency Room Diversion Pilot?**

A: CMOs will enter into agreements with hospitals to reduce use of emergency rooms for non-emergent conditions.

- **Q: What is new about Prior Authorizations Response Time?**

A: Prior authorization decisions for non-emergent services must be made within three (3) business days of the request.

- **Q: What is an Ombudsman Coordinator?**

A: The CMO Ombudsman staff facilitate provider and member inquiries for expedited resolutions.

The Ombudsman Coordinator is defined as an employee of the CMO who is responsible for coordinating services with local community organizations and working with local advocacy organizations to assure that Members have access to Covered Services and non-Covered Services.

- **Q: What is an Ombudsman Liaison?**

A: The CMO Ombudsman staff facilitate provider and member inquiries for expedited resolutions.

The Ombudsman Liaison is defined as an employee of the CMO who is responsible for collaborating with DCH's designated staff in the identification and resolution of issues. Such collaboration includes working with DCH staff on issues of access to Health Care services, and identifying the communication and education needs of Members, Providers and caregivers. The Ombudsman Liaison must assist Members and Providers in coordinating services with local community organizations.

- **Q: How can the Ombudsman staff be reached?**

A: Providers can contact the CMO Ombudsman staff at the contact details listed below:

- ❖ Amerigroup Community Care
Phone: 1-855-558-1436
Email: helpomb@amerigroup.com
- ❖ CareSource
Phone: 678-214-7580
Email: GAombudsman@caresource.com

- ❖ Peach State
Phone: 1-866-874-0633
Email: PSHPOmbudsmanServices@CENTENE.COM
- ❖ WellCare
Phone: 1-866-231-1821 (*Georgia Families® and PeachCare for Kids®*)
Phone: 1-877-379-0020 (*Planning for Healthy Babies® (P4HB)*)
Web/Email: <https://www.wellcare.com/en/Georgia/Contact-Us>

- **Q: What is the role of the CMO Member Advisory Committee?**
A: Based on member input, the CMO Member Advisory Committee develops recommendations for the CMOs' quality management activities and policy and operational changes. The committee consists of current and former Medicaid members that will help develop recommendations for CMO quality management activities as well as other areas of performance.
- **Q: What is the role of the Provider Advisory Committee?**
A: Based on provider input, the Provider Advisory Committee develops recommendations for the CMOs' quality management activities and policy and operational changes. The committee consists of contracted providers that will help serve members and develop recommendations of CMO quality management activities as well as other areas of performance.
- **Q: What is the role of the Monitoring and Oversight Committee?**
A: The Monitoring and Oversight Committee is a forum to assess the CMOs performance, best practices, and opportunities for improvement.
- **Q: What is the current credentialing process?**
A: Most Medicaid providers are **credentialed** through the centralized Credentialing Verification Organization (CVO) process prior to entering into a contract with a CMO. Providers may, also, be credentialed through Delegated Credentialing Agreements. After being credentialed, **contracting** is a separate process that occurs with each individual CMO.
- **Q: How can providers reach the CMO Provider Call Centers?**
A: Providers can reach the CMO Provider Call Centers at the numbers below:
 - ❖ Amerigroup Community Care
Phone: 1-800-454-3730 (General Provider Inquiries)
Phone: 1-844-367-6112 (GA Pharmacies-Express Scripts, Inc.)
Email: nova@amerigroup.com
 - ❖ CareSource
Phone: 1-855-202-1058
Email: GAProviderRelations@CareSource.com
Web: www.caresource.com/providers/georgia/medicaid/
 - ❖ Peach State
Phone: 1-866-874-0633
Web: www.pshpgeorgia.com/contact-us/
 - ❖ WellCare
Phone: 1-866-231-1821
TDD/TTY: 1-877-247-6272
Web: www.georgia.wellcare.com

- **Q: Who should a provider contact regarding CMO-related questions or concerns?**

A: Providers should always contact their CMO for questions or concerns. If a provider cannot reach the CMO, the provider can contact DCH at:

- ❖ The Department of Community Health (DCH)
Phone: 1-404-656-4507
Email: constituentservices@dch.ga.gov
Web: www.dch.georgia.gov