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Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan Provider Advisory Committee Meeting

2240 E. Gonzales, Suite 200, Oxnard, CA 93036
Tuesday, February 12, 2013
3:30 p.m.

AGENDA

CALL TO ORDER / ROLL CALL

PUBLIC COMMENT

1. **APPROVE MINUTES**
   Regular Meeting of August 22, 2012

2. **INTRODUCTIONS**

3. **INFORMATIONAL ITEMS**
   a. **Corrective Action Plan Update**
   b. **Ventura Transportation System**
   c. **ACA PCP Rate Increase**
   d. **Healthy Families Plan Transition**

COMMENTS FROM COMMITTEE MEMBERS

ADJOURNMENT

Meeting Agenda available at http://www.goldcoasthealthplan.org

ADMINISTRATIVE REPORTS RELATING TO THIS AGENDA AND MATERIALS RELATED TO AN AGENDA ITEM SUBMITTED TO THE COMMISSION AFTER DISTRIBUTION OF THE AGENDA PACKET ARE AVAILABLE FOR PUBLIC REVIEW DURING NORMAL BUSINESS HOURS AT THE OFFICE OF THE CLERK OF THE BOARD, 2220 E. GONZALES ROAD, SUITE 200, OXNARD, CA.

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT, IF YOU NEED SPECIAL ASSISTANCE TO PARTICIPATE IN THIS MEETING, PLEASE CONTACT TRACI AT 805/981-5340. REASONABLE ADVANCE NOTIFICATION OF THE NEED FOR ACCOMMODATION PRIOR TO THE MEETING (48 HOURS ADVANCE NOTICE IS PREFERABLE) WILL ENABLE US TO MAKE REASONABLE ARRANGEMENTS TO ENSURE ACCESSIBILITY TO THIS MEETING

Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) Provider Advisory Committee Meeting Minutes

August 22, 2012

(Not official until approved)

CALL TO ORDER

Provider Relations Manager Wright called the meeting to order at 4:09 p.m. in Suite 280 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

1. ROLL CALL

COMMITTEE MEMBERS PRESENT
Brett Zaer, Superior Mobility
C. Albert Reeves, MD, Ventura County Health Care Plan
Antonio Alatorre, Clinicas del Camino Real, Inc.
Alger Brion, Maywood Acres SNF
John Roughan, Simi Valley Hospital & Health Care Services
Joyce Weckl, RN, Certified Nurse Midwife
Mark Minnis, Livingston Memorial VNA Home Health & Hospice
Kimberly Bridges, RN, BSN, Centers for Family Health, Community Memorial Health System

EXCUSED / ABSENT COMMITTEE MEMBERS
Clive Salmon, DPM, Podiatrist

STAFF IN ATTENDANCE
Cassie Undlin, Interim CEO
Dr. Nancy Wharfield, Associate Medical Director
Jenny Palm, Interim COO
Rebecca Wright, Provider Relations Manager
Sherri Bennett, Provider Contracts Manager
Traci R. McGinley, Clerk of the Board

2. PUBLIC COMMENT / CORRESPONDENCE

None.

4. INTRODUCTIONS

Staff and Committee Members were introduced.

3. APPROVE MINUTES – February 9, 2012

Committee Member Alatorre moved to approve the Meeting Minutes of February 9, 2012. Committee Member Minnis seconded the motion. The motion carried. **Approved 8-0.**

5. INFORMATION ITEMS

Retrospective Member Enrollment
Community Based Adult Services ("CBAS")
Child Health and Disability Prevention Program ("CHDP")
Clarification of Podiatry Benefits
Modification of Prior Authorizations Required
Transportation
Healthy Families Transition
Payment of CPT Codes Ending in "99"
Use of County vs. Out of County Providers

Manager Wright advised the Committee Members that a Provider Newsletter went out. Discussion was held that no Committee Members had yet seen the Newsletter.

Manager Wright reviewed her presentation. She stated that GCHP has clarified CHDP and those things GCHP considers included in the capitation and those payable as a fee for service basis.

Will Garand proclaimed that Community Memorial Health System is on record as disputing this as a change in the terms and conditions of their contract.

Interim COO Palm stated that there was confusing language in the contract, when GCHP looked at the CPT codes for Well Care. The CPT and CHDP codes do not link identically but they do enough to look at primary care for children and generally when a PCP is capitated they're capitated for Well Care, not necessary for Sick Care. GCHP linked the codes with the CPT codes that are listed in the back of the contract as capitated services.

Interim CEO Undlin stated that staff also identified the ones that were not capitated and those will be billed fee for service. Interim COO Palm added, as well as the immunization administration fee.

Member Alatorre asked if others knew about this and if they were disputing it. Interim CEO Undlin responded yes, there are three major PCP contracts.

There was also discussion regarding moving pediatric PCP providers to fee for service agreements as they do not get fairly reimburse a pediatrician in a stand alone clinic.

Interim CEO Undlin stated that with regard to the CPT Codes Ending in "99" and claims payment, one issue is that "99" is not specific enough. The claims get denied or get pended for further review and then it impacts the ability to process the claims.

Interim COO Palm stated that GCHP does not know what the Provider is billing for if they use the "99" so it takes a lot of manual work for the claims processor to figure out what is being billed and none of those codes price in Medi-Cal fee schedules so it delays payment when there is a more specific code so that GCHP knows exactly what was done and it will price in the system.

CEO Undlin closed stating that the only solution seems to be to deny "99" claims.

6. AUGMENTATION OF OUTPATIENT HOSPITAL REIMBURSEMENT

Manager Wright reported that Committee Member Roughan asked that this item be added to the Agenda. Committee Member Roughan stated that his facility had been paid this by Medi-Cal and GCHP are on the same ground rules so they expect to continue to be paid.

Interim CEO Undlin responded that GCHP is taking that position; the difficulty is determining what services are included. Manager Bennett added that GCHP needs to go back to 2001 to get the base rate and do further research as to what is and is not covered.

OPEN DISCUSSION

Interim CEO Undlin stated that GCHP is to have EFT at the three test sites on August 31, 2012 and she believes at the same time they are testing the 835 transaction. Only providers that submit claims electronically will be able to get EFT and the 835. GCHP is working on trying to do something for the smaller size providers on the 835, EDI is a big catch.

Committee Member Brion reported that there is a problem with how his facility gets paid. They will be a problem when they have their Medi-Cal audit. Manager Wright responded that there are issues with co-insurance, share of cost and cross-overs. Interim CEO Undlin stated that she is discussing this with ACS and suggested at this time the only work around would be to submit claims manually.

Committee Member Brion asked who determines share of cost. Interim CEO Undlin responded that the State does. Committee Member Brion stated that the family members do not pay their share.

Committee Member Alatorre stated that VSP's system is different for providers that do not contract with them directly and it is difficult to access for eligibility and authorization for patients and processing of those patients. Interim CEO Undlin stated that VSP was to contact Clinicas.

Discussion was held Urgent Care Hours and Utilization.

Interim CEO Undlin asked the Committee Members what GCHP could do; there was minor discussion but nothing that fell under GCHP prevue.

ADJOURNMENT

Meeting adjourned at 5:50 p.m.

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Provider Advisory Committee Meeting

February 12, 2013

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Presentation

- ACA Primary Care Payment Increase
- Health Families Program Transition

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Primary Care Payment Increase

ACA Section 1202 Implementation

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Overview

- Section 1202 of the Affordable Care Act increases payments to the Medicare equivalent for specified services for qualified providers.
- Final rule was published in Federal Register November 6, 2012
- For CY2013 and CY2014, States must pay Medicare rates for specified primary care services.
- Guidance continues to be provided regarding:
  - An updated 2013 Medicare Physician Fee Schedule
  - Statewide rates
  - Managed care rate methodology
- The increased payments are retroactive to January 1, 2013 for both FFS Medi-Cal and Managed Care.

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Eligible Providers

- **According to the final rule, physicians must meet the following rules:**
  - Board certification in family medicine, internal medicine and/or pediatric medicine. (OB/GYN and Emergency physicians are not categorically eligible), or
  - Board certified in subspecialty related toone of the listed specialties, or
  - At least 60 percent of billed services to Medi-Cal must fall within the E&M or vaccine administrative codes covered by the regulation
  - Nurse Practitioners and other physician extenders are eligible if the work under the direct supervision of a qualified physician.
  - Providers must be enrolled in Medi-Cal

Services provided by Federally Qualified Health Centers ,Rural Health Clinics , and health department/clinics are not qualified but will continue to receive their PPS Rate.

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Eligible Providers

- The recognized boards are:
  - American Board of Medical Specialties – www.abms.org
  - American Osteopathic Association- www.osteopathic.org
  - American Board of Physician Specialties – www.abps.org
    - **A listing of qualified subspecialties is available at each web site.*

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Eligible Providers

- Physician's must "self-attest" their eligibility
- Once the self attestation mechanism is developed by DHCS, there will be an established timeframe for providers to attest.
- Those who self-attest during that timeframe will receive payments retro-active to January 1, 2013.
- Physicians cannot receive additional payments until they self-attest.

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Services and Fee Schedule

- E&M Codes 99201 – 99499 and their successor codes.
- Vaccine administrative codes 90460, 90461, and 90471-90474 and their successor codes.
- Codes that are not covered by Medi-Cal are not eligible for the increase.
- The increase does not apply to services provided to beneficiaries dually eligible for Medicare and Medi-Cal.
- CMS will provide equivalent rates to codes that are not covered by Medicare.

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Claims Payment / Methodology

It is up to DHCS to develop a payment methodology to MCOs for CMS approval – they have until March 31, 2013 to do so.

Three Models have been proposed:

Model 1: ***Full risk prospective capitation***

- The State would calculate a capitation rate based on the enhanced rates and pay MCPs prospectively with no reconciliation

Model 2: ***Prospective capitation with risk-sharing that incorporates retrospective reconciliation***

- The State would pay the MCP prospectively, but would reconcile retrospectively.

Model 3: ***Non-risk reconciled payments for enhanced rates***

- MCPs summarize actual encounter data to calculate the total payment owed to eligible providers and submit to State for payment.

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Claims Payment / Methodology

- Increased rates must be passed on to the rendering provider – this includes salaried physicians.
  - Payment directly to rendering provider?
  - Payment to group and the group reports back to the MCP that 100% of the money was distributed to rendering provider?
- Reconciliation must take place at least quarterly.
- Plans are not required to pay enhanced payments until they receive funding from DHCS (estimate June/July 2013)
- Retroactive payments are not subject to timely filing requirements.

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Claims Payment / Methodology

- It is important for providers *(especially capitated providers)* to submit claims with all encounter information – without this information, GCHP will not be able to adequately identify claims that are eligible for retro-active payment.

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Healthy Families Program Transition to Medi-Cal

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Background

- California Assembly Bill (AB)1494, Chapter 28, Statutes of 2012
  - Provides for the transition of HFP subscribers to Medi-Cal commencing no sooner than January 1, 2013
  - Ceases all new enrollments into HFP
  - Coverage and enrollment of these children under Medi-Cal
  - HFP previously administered by Managed Risk Medical Insurance Board (MRMIB),serves over 863,000 children with health, dental and vision coverage.

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Timeline One Year/Four-Phase Period

- **Phase 1a** Started January 1, 2013
- **Phase 1b** Starting March 1, 2013
- **Phase 1c** Starting April 1, 2012
- **Phase 2** Starting no sooner than April 1, 2013
- **Phase 3** Starting no sooner than August 1, 2013 – Ventura County
- **Phase 4** Starting no sooner than September 1, 2013

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HFP Transition to Medi-Cal

HFP Enrollment in Ventura County

Health Plan	Number of Members	% of Total
Anthem Blue Cross - EPO	43	0.2 %
Anthem Blue Cross - HMO	5,876	29.0%
Kaiser Permanente	3,185	15.7%
Ventura County Health Plan	11,162	55.1%
Total	20,266	100%

Source: MRMIB – 12/2012

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Healthy Family Program Transition

- Health Families Program becomes Medi-Cal
  - Ventura County – Phase 3 – August 1, 2013
  - About 20,000 lives
  - Newly enrolled members, as of January 1, 2013 will be enrolled directly into Medi-Cal
- Eligibility will be determined through the Ventura County Human Services Agency (previously through MRMIB)

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Healthy Family Program Transition

- Family income levels of > 150% will continue to pay premiums.
  - Example: Family of four - $34,500/year
  - $13/child per month / maximum $39/family per month.
- Premiums will continue to be collected through a third party vendor – Maximus.

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Benefit Changes

- Benefits will mirror Medi-Cal
- Continue to have access to services through CHDP and Vaccines for Children (VFC)
- Dental Services covered through Denti-Cal
- Behavioral Health Services covered through Ventura County Mental Health
- No Co-payments

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Goals for Smooth Transition

- Continuity of Care
- Minimize Disruptions
- Network Adequacy

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Continuity of Care

- Maintain current PCP connection if possible
- Continue ongoing established treatment plan without disruption
- If PCP transition is needed, ensure that transition is smooth
- Provide medical record transfer to facilitate ongoing care
- Ensure coordination of care with carved out services

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Network Adequacy

- Meetings with providers to keep them up to date on changes and to ensure network adequacy.
- Network Development/Coordination of Care
- Meetings with Kaiser, Anthem and VCHP
  - Kaiser Plan to Plan
  - Anthem Network
    - 20 – 30% already in GCHP Network
    - SeaView IPA and Valley Care IPA

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Notification to Members

- **MRMIB**
  - MRMIB Mailed General Information 90-day Notices to HFP Members Statewide in Late October 2012.
- **DHCS**
  - Mailed 60-day Notice in early November and 30-day Notice in early December to HFP Members Transitioning in Phase 1.
- **GCHP**
  - In addition to 90,60, and 30-day notices, GCHP will use media, newsletters and community resources to reach out to Members.

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Outreach to Members

- GCHP staff will conduct an aggressive and effective communication and outreach effort to Members.
- GCHP is committed to ensuring that children have minimal or no disruptions in coverage.
- Weekly meetings and dialogue with the state DHCS to receive updated information about the transition process and next steps.

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Assistance & Service

- HSA Enrollment Assistance 1 805 385-9363
- GCHP Member Services 1 888 301-1228
- TDD/TTY Line 1 888 310-7347
- State HFP Member Line 1 886 848-9166

- Website: www.goldcoasthealthplan.org

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Contact

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Gold Coast Health Plan's Mission

To Improve the Health of Our Members
Through the Provision of the Best Possible
Quality Care and Services

Contact GCHP
888-301-1228
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