GEORGIA DEPARTMENT OF COMMUNITY HEALTH

STATE FISCAL YEAR 2012
GEORGIA FAMILIES PROGRAM

REPORT 23: BEHAVIORAL HEALTH CLAIMS TESTING

INDEPENDENT ACCOUNTANT'S REPORT ON APPLYING AGREED-UPON PROCEDURES

FINAL
SEPTEMBER 24, 2012

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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GLOSSARY

The following terms may be used throughout this document:

- ***Adjudicate*** – A determination of the outcome of a health care claim. Claims may be paid, denied, or in some cases have an alternative adjudication outcome.

- ***Behavioral Health*** – Both acute and chronic psychiatric and substance abuse disorders as referenced in the most recent International Statistical Classification of Diseases and Related Health Problems (ICD-9).

- ***Behavioral Health Provider*** – *A* person who is licensed by the state, whose professional activities address a client's behavioral health issues. Examples include: physicians, psychiatrists, psychologists, certified clinical social workers, registered psychiatric nurse practitioners, marriage and family counselors, professional clinical counselors, certified substance abuse counselors, and certified mental health counselors.

- ***Boost Sample*** – An additional sample that is drawn and tested in order to reduce the margin of error on an estimate that results from testing of a sample.

- ***Capitation Claim*** – A Medicaid and/or PeachCare for Kids® per member fixed payment amount made by the Department to a Care Management Organization in return for the administration and provision of Health care services rendered to the enrolled Medicaid and/or PeachCare for Kids® member.

- ***Care Management Organization (CMO)*** – A private organization that has entered into a risk-based contractual arrangement with DCH to obtain and finance care for enrolled Medicaid recipients or PeachCare for Kids® members. CMOs receive a per capita or capitation claim payment from DCH for each enrolled member. The three CMOs contracted by the Department to provide services for DCH members are Amerigroup Community Care (Amerigroup or AMGP), Peach State Health Plan (Peach State or PSHP), and WellCare of Georgia (WellCare).

- ***Cenpatico Behavioral Health (Cenpatico)*** – One of the subcontractors under Peach State Health Plan. Cenpatico is a contractor under a capitation agreement to administer the provision of behavioral and mental health services to Peach State Health Plan Georgia Families members.

- ***Centers for Medicare and Medicaid Services 1500 (CMS1500 or "1500") Claim Form*** – Document most often required by payors to be utilized by physicians and other non-institutional providers for submission of a claim request for reimbursement to the health care payor.

- ***Claim*** – An electronic or paper record submitted by a health care provider to a payor detailing the Health care services provided to a patient for which the provider is requesting payment. A claim may contain multiple Health care services.

- ***Claim Detail (Claim Line)*** – A portion of a claim that documents a specific health care service.

- ***Claims Processing System*** – A computer system or set of systems that determine the reimbursement amount for services billed by the Health care provider.

- ***Confidence Interval*** – A range of values that act as good estimates of the unknown population parameter. The confidence interval is computed from sample data and enables inferences to be made about the population.

- ***Denied Claim*** – A claim submitted by a health care provider for reimbursement that is deemed by the payor to be ineligible for payment under the terms of the contract between the health care provider and payor.

- ***Dr. David Bivin*** – Associate Professor, Department of Economics, Indiana University – Purdue University Indianapolis, who specializes in econometrics. Dr. Bivin used statistical techniques to consider the statistical strategies and methods, and to perform quality assurance on the statistical findings.

- ***Dr. Ye Zhang*** – Assistant Professor, Department of Economics, Indiana University – Purdue University Indianapolis, who assisted in the performance of quality assurance measures on the statistical findings.

- ***Encounter Claim (Encounter)*** – A record of a health care service that was delivered to an eligible member and submitted for payment by a CMO or subcontractor that is subsequently submitted by the CMO or subcontractor to the Medicaid fiscal agent contractor to load and maintain in the Georgia Medicaid and PeachCare for Kids® MMIS. The Medicaid fiscal agent contractor does not generate a payment for the encounter claim, but rather it is maintained for program management, rate setting, and a variety of program oversight functions.

- ***Extrapolation*** – Refers to applying the mean dollar amount, determined from the sample of claims to have been paid in error, to a population of claims.

- ***Fee-For-Service (FFS)*** – A health care delivery system in which a health care provider receives a specific reimbursement amount from the payor for each health care service provided to a patient. In some cases, the service must be authorized in advance.

- ***Fee-For-Service (FFS) Claim*** – A payment made by a payor to a health care provider after a service has been provided to a patient covered by the payor. A FFS claim consists of one or more line items that detail specific health care service(s) provided.

- ***Georgia Families*** – The risk-based managed care delivery program for Medicaid and PeachCare for Kids® in which the Department contracts with Care Management Organizations to manage the care of eligible recipients.

- ***Inpatient Claim –*** A claim billed on the UB04 form for acute care, mental health, or rehabilitation care services which are provided in an inpatient hospital setting. Inpatient claims billed for inpatient care provided in a state mental health facility are not included in this analysis.

- ***Liability*** – A claim payment amount that was not made in accordance with CMO (or the CMO's subcontractor) coverage, payment policies, and contractual obligations resulting in an underpayment to the entity receiving the claim payment.

- ***Magellan Health Services, Inc (Magellan)*** – One of the four subcontractors under WellCare of Georgia. Magellan is a contractor under a capitation agreement to administer the provision of behavioral and mental health services to WellCare Georgia Families members.

- ***Margin of Error*** – The half width of the confidence interval and a measure of how close the estimate is to the true value.

- ***Medicaid Management Information System (MMIS)*** – Claims processing system used by the Department's fiscal agent claims processing vendor to process Georgia Medicaid and PeachCare for Kids® FFS claims and capitation claims.

- ***Mispayment*** – A claim payment amount that was not made in accordance with CMO (or the CMO subcontractor's) coverage, payment policies, and contractual obligations resulting in either an overpayment (receivable) or underpayment (liability) to the entity receiving the claim payment.

- ***Paid Claim*** – A claim submitted by a health care provider for reimbursement that is deemed by the payor to be eligible for payment under the terms of the contract between the health care provider and payor.

- ***PeachCare for Kids® Program (PeachCare)*** – The Georgia DCH's State Children's Health Insurance Program (SCHIP) funded by Title XXI of the Social Security Act, as amended.

- ***Point Estimate of the Population Total*** – The average error of the sample scaled by the number of observations (claims or lines) in the population.

- ***Provider Manual*** – A document created by a health care payor that describes the coverage and payment policies for health care providers that provide health care services to patients covered by the payor.

- ***Receivable*** – The portion of an actual claim payment amount in excess of the payment amount that would be in accordance with CMO (or the CMO subcontractor's) coverage, payment policies, and contractual obligations resulting in an overpayment to the entity receiving the claim payment.

- ***Subcontractor*** – Any third party who has a written contract with a CMO to perform a specified part of the CMO's obligations under their DCH contract.

- ***Suspended Claim*** – A claim submitted by a health care provider for reimbursement that is queued by the payor for examination, or where additional information is necessary to adjudicate the claim.

- ***Uniform Billing (UB-04) Claim Form*** – Document most often required by payors to be utilized by hospitals and other institutional providers for submission of a claim request for reimbursement to the health care payor. The UB-92 version of the claim form was replaced by the UB-04 version in 2007. CMS refers to the UB-92/UB-04 claim form as the CMS-1450 claim form.

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INDEPENDENT ACCOUNTANT'S REPORT ON APPLYING AGREED-UPON PROCEDURES

Georgia Department of Community Health:

The Department of Community Health (DCH or Department) engaged Myers and Stauffer LC to apply agreed-upon procedures enumerated in Exhibit 1 dated June 28, 2012 for the purpose of testing the accuracy of payments for a sample of behavioral health claims adjudicated under the Georgia Families program by contracted Care Management Organizations (CMO) or their behavioral health subcontractor(s). Claim payments were analyzed to determine if the payment was made in accordance with the CMO (or the CMO subcontractor's) coverage, payment policies, and contract provisions between the CMO/ behavioral health subcontractor and the behavioral health provider. The Department will determine the applicability and use of the results from applying these agreed-upon procedures. DCH management is responsible for the Department's policies and procedures, as well as vendor management functions.

This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Georgia Department of Community Health. Consequently, we make no representation regarding the sufficiency of the procedures described in Exhibit 1 dated June 28, 2012, either for the purpose for which this report has been requested or for any other purpose. The procedures used for this engagement are also described in Exhibit 1 under Claims Section and Analytical Procedures.

BACKGROUND

Myers and Stauffer LC was engaged to assist the Department in its efforts to assess the policies and procedures of the Georgia Families program, including studying and reporting on certain issues presented by providers, selected claims paid or denied by the CMOs, and selected Georgia Families policies and procedures. Initial phases of the engagement focused on hospital and physician provider subjects. Previously issued reports, are available online at http://dch.georgia.gov. These reports assessed payment and denial trends of hospital, physician, and dental claims, the payment accuracy of selected claims, and certain CMO policies and procedures.

"The scope of this report is limited to the agreed-upon procedures described in Exhibit 1 dated June 28, 2012. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in the report. The Claims Section and Analytical Procedures used for this engagement are also described there."

METHODOLOGY

The objective of this engagement was to apply agreed-upon procedures to test the accuracy of payments for a sample of behavioral health claims adjudicated by the CMOs or their behavioral health subcontractor(s) that administer the Georgia Families program. These claim payments were analyzed to determine if the payment was made according to the CMO's (or the CMO subcontractor's) coverage, payment policies and the contract between the CMO/ behavioral health subcontractor and the behavioral health provider. If the claim was paid incorrectly, we estimated the amount of the underpayment or overpayment (collectively referred to as "mispayments") for the claim in consultation with the CMO, the CMO's subcontractor, and/or the Department.

The claims data universe, described in Exhibit 3 dated June 10, 2011, from which the sample was drawn included CMO/subcontractor submitted data and encounter paid and denied claims submitted by the CMOs to the fiscal agent of both Medicaid and PeachCare for Kids® members for professional, inpatient, and outpatient behavioral health claims. The claims requested from the CMOs included all behavioral health claims with dates of service from July 1, 2010 through June 30, 2011.

The sampling methodology and statistical procedures used for this analysis were developed in consultation with Dr. David Bivin, a statistical consultant to Myers and Stauffer. Dr. Bivin has previously assisted in developing the sampling methodologies and statistical estimations for the Georgia Families hospital, physician, and dental claims.

The margin of error on the estimate of mispayments depends upon the variability of the data and when, as in this analysis, there is no prior knowledge of the variance, there is a potential of drawing too few observations to achieve the desired reliability. Therefore, the recommended approach was to determine a minimum sample size that would be used as a beta sample. The Department would determine the need for a boost sample after the analysis of the beta sample has been completed.

The selection and analysis of 60 professional (CMS 1500) claims and 40 inpatient and outpatient (UB-04) claims per CMO provided confidence intervals at the 95 percent level for the mean dollar amount of mispayment per claim and the total dollars in mispayments per CMO. Because prior testing results of behavioral health mispayments were not available, it was not possible to achieve a desired level of precision on the estimated margins of error. The final margins of error are based on the distribution and variability of the observed mispayments, which are a function of each CMO/subcontractor, their individual claims processing and adjudication and other unique factors. Table 1 below illustrates the universe counts and beta sample size by CMO.

Table 1: Sample Size for Behavioral Health Claims by CMO

Care Management Organization/Subcontractor	Universe Claim Count UB-04	Universe Claim Count CMS 1500	Sample Size
Amerigroup	18,077	752,927	100
Peach State Health Plan/ Cenpatico	16,866	724,221	100
WellCare/ Magellan	23,887	1,313,169	100
TOTAL	58,830	2,790,317	300

A supplemental data request was prepared and sent to each CMO/subcontractor on October 27, 2010 that requested all paid and denied claims for the time period July 1, 2010 through October 31, 2010. The due date for each CMO to provide the requested data and information was November 30, 2010. A second supplemental data request was prepared and sent to each CMO/subcontractor on June 28, 2011 that

requested all paid and denied claims including behavioral health services for the time period November 1, 2010 through June 30, 2011. The due date for each CMO to provide the requested data and information was August 1, 2011. Both requests required submissions of all contracts, rate files, and reference data necessary to analyze claim payments and denials. Significant communication with the CMOs and their subcontractor(s) occurred to address questions, obtain additional information or clarifications, or resolve various issues involving the claims data submitted. Although substantial portions of the data were received, a contract request was prepared and sent to each CMO/subcontractor on February 22, 2012. Myers and Stauffer received approval from the Department to establish March 7, 2012 as the cut-off date for the CMOs to submit additional data, corrections and clarifications and to proceed at that time with the planned analysis despite certain unresolved issues with the data.

The sample period included paid and denied claims at the 'header' (claim) level. Each behavioral health procedure on a selected claim in the sample was independently re-priced based on the contract between the CMO or its subcontractor(s) and the behavioral health provider. The following steps were used to test claims:

1) We determined the payment status of the claim;
2) If claim payment status was 'denied', we analyzed the reason and attempted to determine, with the information available, whether the denial was appropriate;
3) If claim payment status of 'denied' appeared to be inappropriate, we computed the expected payment for the claim based on the contract between the behavioral health provider and the CMO or subcontractor;
4) If claim payment status was 'paid', we computed the expected payment for the claim based on the contract between the behavioral health provider and the CMO or subcontractor;
5) We computed the dollar value mispayment, as applicable, for the claim, and;
6) Sent identified mispayments to the CMO or behavioral health subcontractor for comment and/or confirmation. Unless indicated otherwise, we relied on the follow-up information received from the CMO or its subcontractor(s) in determining whether the potential mispayment was, in fact, a confirmed mispayment and the dollar value of the mispayment.[1]

[1]We reserved the right to not accept the information from the CMO or its subcontractor(s) in the event that circumstances required special consideration or handling. CMOs have been required to attest to the accuracy and reliability of the information they have provided for this initiative. In the event of a dispute between Myers and Stauffer and the CMO regarding the correct adjudication or payment amount on a claim, the Department's decision regarding the adjudication determination will constitute the final decision.

Upon completing the analysis for each sampled claim, the results were sent to Dr. Bivin and Dr. Zhang to complete the analyses of the mean per claim mispayment amounts, total mispayment amounts, and confidence intervals for each CMO, as well as perform quality assurance procedures to confirm the statistical calculations. Please refer to Exhibit 2 for more additional information regarding the statistician's review.

The claims universe included paid and denied behavioral health claims of both Medicaid and PeachCare for Kids® members. The claims included dates of service from July 1, 2010 through June 30, 2011. Sampled behavioral health claims were analyzed to determine if the payment was made according to the CMO's (or the CMO subcontractor's) coverage, payment policies, and the contract between the CMO/ behavioral health subcontractor and the behavioral health provider (or the fee schedule applicable to the provider).

The CMOs were given an opportunity to provide comments or submit additional information. We noted in several instances that the comments and/or additional information submitted by the CMOs raised additional questions, or was insufficient to support their position. Once all outstanding questions to the CMOs were addressed, we finalized the list of claims with mispayments. In many cases, the CMOs could not provide supporting documentation and/or we came to a different conclusion on the claim.

For confirmed mispayments, we determined the estimated amount of the underpayment (liability to the CMO) or overpayment (receivable to the CMO) for the claim on the header level. All potential errors were provided to the CMOs. The CMOs were asked to provide a detailed response indicating how the claim was adjudicated, including providing all applicable documentation. We discussed the sampled claims noted with potential mispayments with the Department, the CMOs and the subcontractors, as necessary.

For reference, Table 2 illustrates the payment totals for each CMO/subcontractor received and utilized in our analyses. These claims include behavioral health claims from physicians, hospitals, professional counselors, and other behavioral health specialists with incurred dates of service from July 1, 2010 through June 30, 2011 billed on the UB-04 or CMS 1500 claim forms (claim type).

SUMMARY OF CLAIMS PAYMENT ACCURACY

Table 2: Behavioral Health Claim Payments by CMO

Claim Type	AMGP	PSHP / Cenpatico	WellCare / Magellan	Total
Behavioral Health Providers UB-04	$33,340.34	$133,610.67	$16,305.46	$183,256.47
Behavioral Health Providers CMS1500	$8,685.66	$11,488.45	$8,277.58	$28,451.69
Total	$42,026.00	$145,099.12	$24,583.04	$211,708.16

The following tables display the findings of this analysis as well as provide the percentage of total mispayments per issue by CMO.

Table 3: Summary of Behavioral Health Claims Paid/Denied Correctly

Statistics	AMGP	PSHP / Cenpatico	WellCare / Magellan
Sample Size	100	100	100
Claim Paid/Denied Correctly	89	84	83
Percent of Claim Paid/Denied Correctly	89%	84%	83%

Amerigroup

Table 4: Primary Issues Affecting Claims Payment Accuracy for AMGP

Issue	Number of Claim Errors	Percent of Total Mispayments
Incorrect rate applied from fee schedule (Professional claim)	4	36.4%
Inadequate response or supporting documentation to demonstrate maximum amount/unit applied.	1	9.1%
Hospital Rate Add-on Tax was not appropriately applied	1	9.1%
Incorrect rate applied from fee schedule/invalid modifier	1	9.1%
Incorrect rate applied from provider contract	2	18.2%
Incorrect rate applied from fee schedule (Outpatient claim)	2	18.2%
Total	**11**	**100% =100.1%**

Peach State Health Plan/Cenpatico

Table 5: Primary Issues Affecting Claims Payment Accuracy for PSHP/Cenpatico

Issue	Number of Claim Errors	Percent of Total Mispayments
Incorrect rate applied from fee schedule/provider type	4	25.0%
Incorrect rate applied from fee schedule	1	6.3%
Hospital Rate Add-on Tax inappropriately applied twice (Inpatient claim)	5	31.3%
Hospital Rate Add-on Tax inappropriately applied twice (Outpatient claim)	4	25.0%
Covered days incorrectly calculated	1	6.3%
Copayment was not appropriately applied	1	6.3%
Total	**16**	**100% =100.2%**

WellCare/Magellan

Table 6: Primary Issues Affecting Claims Payment Accuracy for WellCare/Magellan

Issue	Number of Claim Errors	Percent of Total Mispayments
Incorrect rate applied from fee schedule/invalid modifier(Professional claim)	1	5.8%
Incorrect rate applied from fee schedule	1	5.8%
Incorrect rate applied from fee schedule/provider type (Professional claim)	1	5.8%
Inadequate response or supporting documentation to demonstrate maximum amount/unit being applied	1	5.8%
Incorrect rate applied from provider contract (Inpatient claim)	7	41%

Issue	Number of Claim Errors	Percent of Total Mispayments
Incorrect rate applied from fee schedule (Outpatient claim)	3	18%
Copayment inappropriately applied	2	12%
Incorrect Pricing Methodology applied	1	5.8%
Total	**17**	**100%**

The following figures demonstrate the point estimate underpayments and overpayments for hospital (UB04) and professional (CMS 1500) claims for each CMO.

Figure 1: Behavioral Health Hospital Point Estimate Underpayments by CMO

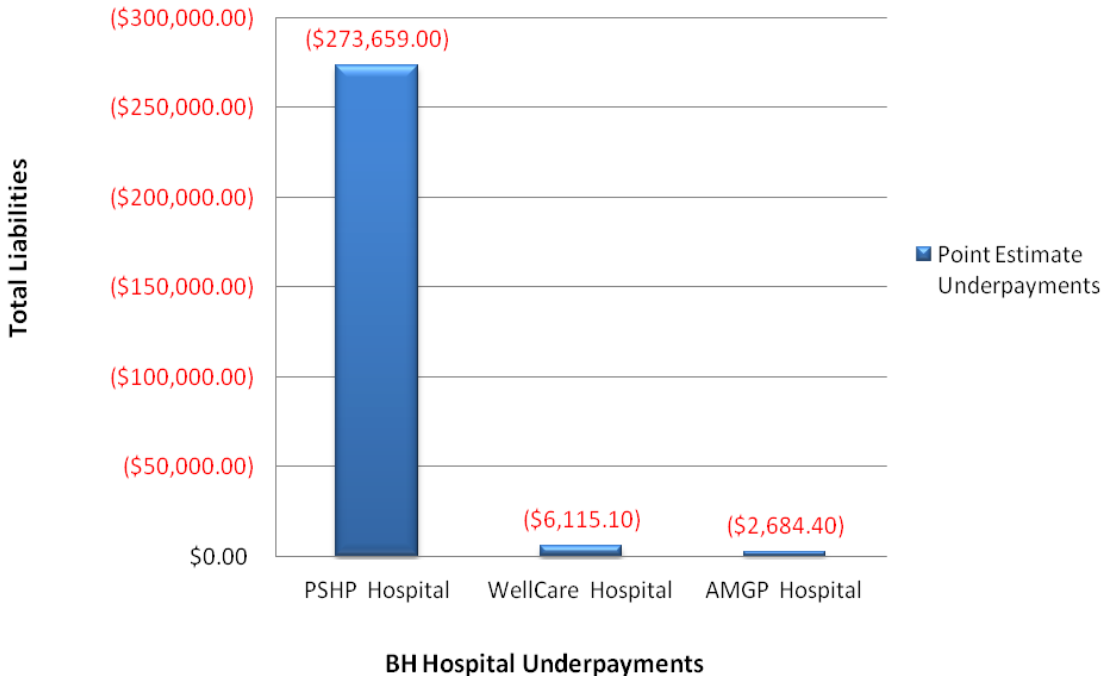

Figure 1 illustrates the amount of hospital underpayments extrapolated over the universe during the sample period. For Amerigroup and WellCare/Magellan, hospital mispayments were minimal. These mispayments were due to incorrect pricing methodology and provider fee schedule and contract per diem term pricing issues. PSHP mispayments resulted in $273,659.00 with 6.3 percent of the errors relating to inappropriate pricing methodology applied to one claim. Please refer to Tables 4, 5, and 6 for descriptions of claim mispayment errors.

Figure 2: Behavioral Health Hospital Point Estimate Overpayments by CMO

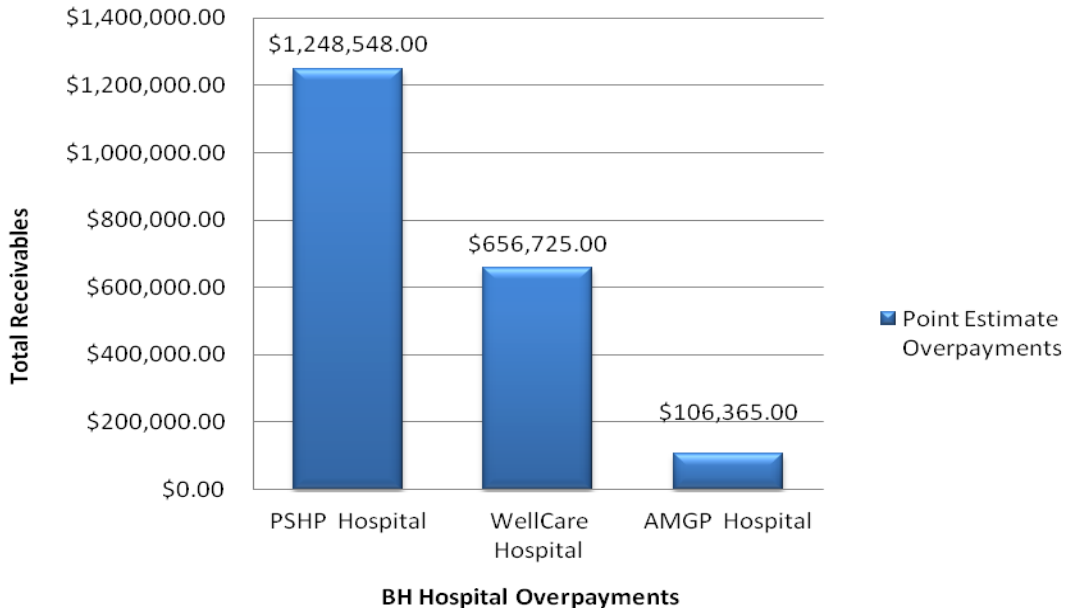

Figure 2 illustrates the total amount of hospital overpayments extrapolated over the universe during the sample period. For Amerigroup, mispayments resulted in $106,365.00 due to provider fee schedule and contract per diem term pricing issues. WellCare mispayments resulted in $656,725.00 due to discrepancies in contract per diem terms and the rate reflected in CMO's system. For PSHP/Cenpatico, mispayments resulted in $1,248,548.00, with 31.3 percent of the errors relating to the hospital rate add-on tax inappropriately applied twice to claims. Please refer to Tables 4, 5, and 6 for descriptions of claim mispayment errors.

Figure 3: Behavioral Health Professional Point Estimate Underpayments by CMO

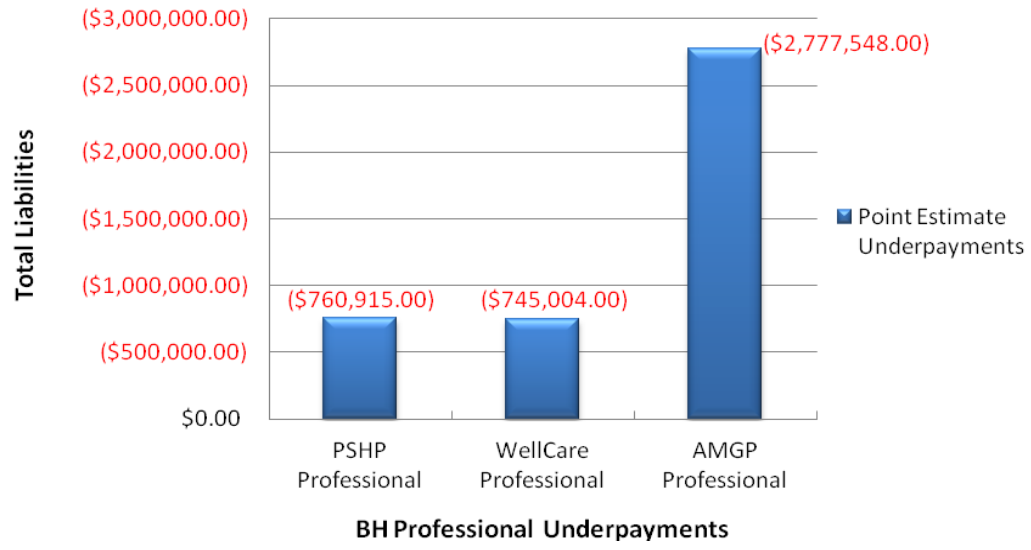

Figure 3 illustrates the amount of professional claim underpayments extrapolated over the universe during the sample period. For Amerigroup, mispayments resulted in $2,777,548.00 with 36.4 percent of the errors relating to provider fee schedule and contract per diem term pricing issues. Please refer to Tables 4, 5, and 6 for descriptions of claim mispayment errors.

Figure 4: Behavioral Health Professional Point Estimate Overpayments by CMO

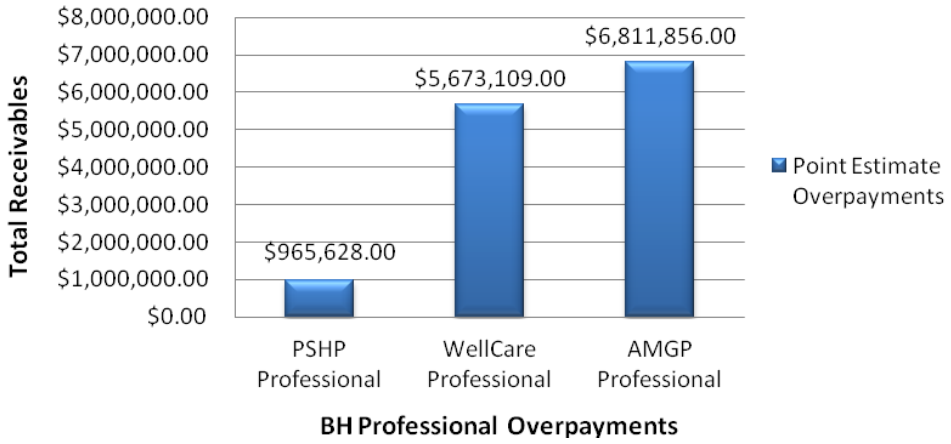

Figure 4 illustrates the amount of professional claim overpayments extrapolated over the universe during the sample period. Overpayments reflected for all CMO's were due to varying discrepancies in fee schedule rate, contract per diem terms and the rate reflected in CMO's system. For Amerigroup, overpayments resulted in $6,811,856.00 WellCare appeared to have the largest percentage of mispayments due to this issue, accounting for 41 percent of the claims. Please refer to Tables 4, 5, and 6 for descriptions of claim mispayment errors.

Detail Statistics of Claim Mispayments

The tables below provide the summary of mispayments and the statistical calculations related to the beta sample. Table 7 includes the total liabilities (underpayments) and receivables (overpayments) resulting from the analysis of the sample, as well as the mispayment rate for each CMO and behavioral health subcontractor.

Table 7: Beta Sample Findings

Statistics	CMO/Claim Type					
	AMGP Hospital	AMGP Professional	PSHP Hospital	PSHP Professional	WellCare Hospital	WellCare Professional
Total Sample Liabilities	-$5.94	-$221.34	-$649.02	-$63.04	-$10.24	-$34.04
Total Sample Receivables	$235.36	$542.83	$2961.10	$80.00	$1,099.72	$259.21
Claims in Sample	40	60	40	60	40	60
Claims with Mispayments	5	6	11	5	13	4
Percent Claims with Mispayments	12.5%	10.0%	27.5%	8.3%	32.5%	6.7%
Claim Header Lines in Population	18,077	752,927	16,866	724,221	23,887	1,313,169

Table 8 below includes the population estimates computed based on the findings from the beta sample. The "point estimate" is the average liability or receivable from the beta sample extended to the population. However, the true value of the mispayments falls between the lower and upper boundaries of the confidence interval.

Table 8: Population Estimates Based on Beta Sample Findings

Statistics						
Confidence Interval Total Population Mispayments	**AMGP Hospital**	**AMGP Professional**	**PSHP Hospital**	**PSHP Professional**	**WellCare Hospital**	**WellCare Professional**
Liabilities Mean	$0.30	$5.47	$32.78	$1.47	$0.39	$1.11
Receivable Mean	$6.82	$15.15	$46.03	$2.10	$26.53	$8.21
Claims in Population	18,077	752,927	16,866	724,221	23,887	1,313,169
95% Lower Bound - Liabilities	-$8,109.18	-$6,896,418.41	-$826,615.71	-$1,824,462.51	-$15,488.67	-$2,206,616.44
95% Upper Bound - Liabilities	$2,740.31	$1,341,322.41	$279,297.71	$302,632.51	$3,258.47	$716,608.44
95% Point Estimate - Liabilities	-$2,684.40	-$2,777,548.00	-$273,659.00	-$760,915.00	-$6,115.10	-$745,004.00
Margin of Error - Liabilities	$5,424.75	$4,118,870.41	$552,956.71	$1,063,547.51	$9,373.57	$1,461,612.44
95% Lower Bound - Receivables	-$16,888.30	-$4,596,761.46	$472,179.27	-$554,077.47	$23,004.07	-$5,105,739.73
95% Upper Bound - Receivables	$229,618.30	$18,220,473.46	$2,024,916.73	$2,485,333.47	$1,290,445.93	$16,451,957.73
95% Point Estimate - Receivables	$106,365.00	$6,811,856.00	$1,248,548.00	$965,628.00	$656,725.00	$5,673,109.00
Margin of Error - Receivables	$123,253.30	$11,408,617.46	$776,368.73	$1,519,705.47	$633,720.93	$10,778,848.73

Based on the findings for the beta sample, the Department determined that there was not a need to conduct a boost sample. Therefore, no additional testing will be completed on behavioral health claims at this time.

We make the following recommendations regarding behavioral health claim pricing by the Georgia Families CMOs and subcontractors.

Recommendations Applicable to the CMOs and/or Subcontractors

1) Contracts between the subcontractors and the behavioral health providers should clearly identify all of the parameters used to determine the pricing of the claims. We noted that although "lesser of" language was included in some contracts, the criteria for exceptions to that logic were not included in the contract, even though exceptions appear to be applicable through our analysis.

2) The CMOs/subcontractors should ensure that the applicable coverage and benefit limitations are being properly applied.

3) The CMOs/subcontractors should ensure that systematic updates to provider rates are completed when fee schedule changes occur and claim reimbursement based on provider type, modifier, and specialty are being applied correctly.

4) The CMOs/subcontractors should ensure that systematic updates to provider per diems are completed when the specific provider contract is amended and reflect new pricing and/or rate changes.

5) Steps should be taken to review system pricing methodology to determine whether hospital rate tax supplement is being applied to the applicable provider.

6) The CMOs/subcontractors should ensure that the application of copayment requirement is in accordance with the policy manual. System application of copayment to claims should reflect guidelines set forth in policy.

7) DCH may wish to require the CMOs to correct all of the claims in error, and/or claims in universe with similar problems. It may also be necessary to correct systems issues or conduct provider education.

Recommendations Applicable to the Department

1) For confirmed mispayments, the Department may wish to require the CMO to carefully review the claims identified with mispayments and implement corrective actions, system enhancements or modifications, rate file changes, or other measures that will address the reasons for the mispayments. It may also be necessary to provide policy clarifications or conduct provider education.

Analytical Limitations

1) Although we requested all paid and denied claims, including behavioral health services, with dates of service from July 1, 2010 through June 30, 2011, it is possible the CMO/subcontractor may have submitted only those claims that were adjudicated during a specific time period. The claims payment accuracy rates presented in our findings could vary if the CMO/subcontractor had submitted all the claims that were specifically requested.

2) The claims with issues were sent to the CMOs to answer questions and/or confirm errors. In some cases, the CMOs' responses were not sufficient to determine if the claim was paid or denied correctly. These claims were marked as mispayments and are included in the margin of error for each CMO. Additional testing may be performed on these claims at the request of the Department.

3) There were claims that we identified as potential mispayments that the CMOs did not agree were incorrect. We reviewed the CMOs' responses and tested their responses for accuracy. If the response provided by the CMO did not appear to resolve the issue, the claim was considered a mispayment. Additional testing may be performed on these claims at the request of the Department.

4) Due to limited information and documentation, we were not able to test the interest payment calculations from the CMOs.

5) In some cases, the CMOs/subcontractors may have adjusted, reprocessed, or corrected claims that we identified as potential mispayments. This information may not have been provided to us in all cases or may have occurred subsequent to our providing the list of claims to each CMO/subcontractor. Therefore, as of the date of this report, the mispayment dollar amounts included in our findings may not reflect the actual amount owed to behavioral health providers by the CMOs/ subcontractors or owed by these providers to the CMOs/subcontractors.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the accuracy of payments for behavioral health claims adjudicated by the CMOs or their behavioral health subcontractor(s) that administer the Georgia Families program. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Georgia Department of Community Health and is not intended to be and should not be used by anyone other than this specified party.

Myers and Stauffer LC
Atlanta, Georgia
September 24, 2012

CMO RESPONSE TRACKING

CMO	Date Report Sent to CMO	CMO Staff who Received Notification/Report	Date Response Due from CMO	Date Response Received from CMO	Myers and Stauffer Comments
AMGP	7/31/2012	**Sent via email** to Tunde Sotunde, Fran Gary, Rachelle Whitacre, Bonnie Messinger **Sent via FTP** to Rachelle Whitacre	8/15/2012	8/14/2012	None
PSHP	7/31/2012	**Sent via email** to Debra Peterson-Smith, Patrick Healy, Clyde White, Donna McIntosh **Sent via FTP** to Donna McIntosh	8/15/2012	8/15/2012	Documentation to address and support the rate issues (Deemer Amendment) was sent. Since this documentation was not sent during the analysis process, the report does not reflect any changes.
WellCare	7/31/2012	**Sent via email** to Kathy Ryland, Joshua Luft, Franklin Moultrie **Sent via FTP** to Joshua Luft and Franklin Moultrie	8/15/2012	8/20/2012	None

EXHIBIT E-1:
AGREED-UPON PROCEDURES

SFY 2012: GEORGIA FAMILIES

BEHAVIORAL HEALTH CLAIMS TESTING FOR THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH

EXHIBIT 1: AGREED-UPON PROCEDURES

FINAL
JUNE 28, 2012

Myers and Stauffer LC
Certified Public Accountants

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INTRODUCTION

This document provides a summary of the study methodology and agreed-upon procedures used for Georgia Families Program behavioral health claims analysis performed for the Department of Community Health (the "Department"), including a computation of a sample mispayment rate. After Myers and Stauffer LC (MSLC) has applied these agreed-upon procedures to a sample of claims, the Department may request that we also compute an estimate of the aggregate dollar value of mispayments for each Care Management Organization for claims adjudicated between July 1, 2010 and June 30, 2011 as addressed by these procedures. These procedures will be completed for the Department and no other specified parties. The Department will determine the applicability and use of the results from applying these agreed-upon procedures.

This agreed-upon procedures engagement will be conducted in accordance with the attestation standards established by the American Institute of Certified Public Accountants (AICPA). The sufficiency of these procedures is solely up to the discretion of the Department. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which the report has been requested or for any other purpose.

GLOSSARY

The following terms may be used throughout this document:

- ***Adjudicate*** – A determination of the outcome of a healthcare claim. Claims may pay, deny, or in some cases have an alternative adjudication outcome.

- ***Behavioral Health*** – Both acute and chronic psychiatric and substance abuse disorders as referenced in the most recent International Statistical Classification of Diseases and Related Health Problems (ICD-9).

- ***Behavioral Health Provider*** – *A* person who is licensed by the state, whose professional activities address a client's behavioral issues examples include: physicians, psychiatrists, psychologists, certified clinical social workers, registered psychiatric nurse practitioners, marriage and family counselors, professional clinical counselors, certified substance abuse counselors, and certified mental health counselors.

- ***Boost Sample –*** An additional sample that is drawn and tested in order to reduce the margin of error on an estimate that results from testing of a sample.

- ***Capitation Claim*** - A per Medicaid and/or PeachCare for Kids™ member fixed payment amount made by the Department to a care management organization in return for the administration and provision of health care services rendered to the enrolled Medicaid and/or PeachCare for Kids™ member.

- ***Care Management Organization (CMO)*** – A private organization that has entered into a risk-based contractual arrangement with DCH to obtain and finance care for enrolled Medicaid recipients or PeachCare for Kids™ members. CMOs receive a per capita or capitation claim payment from DCH for each enrolled member. The three CMOs contracted by the Department to provide services for eligible members are AMERIGROUP Community Care (AMERIGROUP or AMGP), Peach State Health Plan (Peach State or PSHP), and WellCare of Georgia (WellCare).

- ***Claim*** – An electronic or paper record submitted by a healthcare provider to a payer detailing the healthcare services provided to a patient for which the provider is requesting payment. A claim may contain multiple healthcare services.

- ***Claim Detail (Claim Line)*** – A portion of a claim that documents a specific healthcare service.

- ***Denied Claim*** – A claim submitted by a healthcare provider for reimbursement that is deemed by the payor to be ineligible for payment under the terms of the contract between the healthcare provider and payor.

- ***Georgia Families (GF)*** – The risk-based managed care delivery program for Medicaid and PeachCare for Kids™ in which the Department contracts with Care Management Organizations to manage the care of eligible recipients.

- ***Fee-For-Service (FFS)*** – A healthcare delivery system in which a healthcare provider receives a specific reimbursement amount from the payor for each healthcare service provided to a patient.

- ***Fee-for-service (FFS) claim*** - A payment made by a payor to a health care provider after a service has been provided to a patient covered by the payor. In some cases, the service must be authorized in advance. A FFS claim consists of one or more line items that detail specific health care service(s) provided.

- ***Inpatient Claim*** – A claim billed on the UB04 form for acute care, mental health, or rehabilitation care services which are provided in an inpatient hospital setting. Inpatient claims billed for inpatient care provided in a state mental health facility are not included in this analysis.

- ***Liability*** – A claim payment amount that was not made in accordance with CMO (or the CMO's subcontractor) coverage, payment policies, and contractual obligations resulting in an underpayment to the entity receiving the claim payment.

- ***Medicaid Management Information System (MMIS)*** – Claims processing system used by the Department's fiscal agent claims processing vendor to process Georgia Medicaid and PeachCare for Kids™ FFS claims and capitation claims.

- ***Mispayment –*** A claim payment amount that was not made in accordance with CMO (or the CMO's subcontractor) coverage, payment policies, and

contractual obligations resulting in either an overpayment (receivable) or underpayment (liability) to the entity receiving the claim payment.

- ***Paid Claim*** – A claim submitted by a healthcare provider for reimbursement that is deemed by the payor to be eligible for payment under the terms of the contract between the healthcare provider and payor.

- ***PeachCare for Kids™ program (PeachCare)*** – The Georgia DCH's State Children's Health Insurance Program (SCHIP) funded by Title XXI of the Social Security Act, as amended.

- ***Receivable*** – The portion of an actual claim payment amount in excess of the payment amount that would be in accordance with CMO (or the CMO's subcontractor) coverage, payment policies, and contractual obligations resulting in an overpayment to the entity receiving the claim payment.

- ***Subcontractor*** -- Any third party who has a written contract with a CMO to perform a specified part of the CMO's obligations under their DCH contract.

- ***Suspended Claim*** – A claim submitted by a healthcare provider for reimbursement that is queued by the payor for examination, or where additional information is necessary to adjudicate the claim.

PROJECT TEAM

The following key personnel will be used for this engagement:

Michael Johnson, CPA, CFE –project director
Beverly Kelly, CPA, CFE – co project manager
Savombi Fields, CFE – co project manager
Jared Duzan, CFE – quality assurance
Ron Beier, CPA – quality assurance
David Bivin, PhD – statistician
Ye Zhang, PhD - statistician

We anticipate that staffing for this engagement may include resources in our Atlanta, Indianapolis, Topeka, and Kansas City offices. Other firm-wide resources and consultants may be utilized as necessary to accomplish project objectives.

OBJECTIVE

The objective of this engagement is to apply agreed-upon procedures to test the accuracy of payments for a sample of inpatient and outpatient behavioral health claims adjudicated by the CMOs, or their subcontractor(s), that administer the GF program. Claim payments will be analyzed to determine if the payment was made according to the CMO's (or the CMO's subcontractor) coverage, payment policies, and contract between the CMO or its subcontractor(s) and the provider. If the outcome of a claim is not in accordance with these provisions, the CMO, the subcontractor(s), the Department, and/or the provider will be consulted to make a determination of the amount of the mispayment for the claim.

IDENTIFICATION OF CLAIMS UNIVERSE

This analysis includes inpatient and outpatient behavioral health services claims. For each of the CMOs, we identified the required elements that must be billed on the behavioral health claim to be included in the universe. If any of the required elements were not present on a claim, then a supplemental request for this data was submitted to each of the CMOs and then added to the claims data when received.

Claims for services of a behavioral health nature provided as a part of a preventative (annual adult or well child exam) assessment were not included in the claims data universe. These claims appear to have been consistently paid by the CMOs rather than a behavioral health subcontractor.

CLAIMS UNIVERSE FOR TESTING

The claims universe will include CMO/subcontractor paid and denied claims of both Medicaid and PeachCare members for behavioral health claims. The claims will have dates of service between July 1, 2010 and June 30, 2011. A sample of behavioral health claims will be selected from the claims submitted by the CMOs or their subcontractors.

CLAIM SELECTION AND ANALYTICAL PROCEDURES

The sample period will include paid or denied claims with dates of service between July 1, 2010 and June 30, 2011. Claims will be analyzed based on whether the claim is paid or denied at the 'header' (claim) level. Each behavioral health procedure on a selected claim in the sample will be independently re-priced based on the contract between the CMO or its subcontractor(s) and the behavioral health provider. The following steps will be used to test claims:

1) Determine the payment status of the claim;
2) If claim payment status is 'denied', analyze the reason and attempt to determine, with the information available, whether the denial is appropriate;
3) If claim payment status of 'denied' appears to be inappropriate, compute the expected payment for the claim based on the contract between the behavioral health provider and the CMO or subcontractor;
4) If claim payment status is 'paid', compute the expected payment for the claim based on the contract between the behavioral health provider and the CMO or subcontractor;
5) Compute the dollar value mispayment, as applicable, for the claim, and;
6) Send identified mispayments to the CMO, subcontractor and/or behavioral health provider for comment and or/confirmation. Unless indicated otherwise, we will rely on the follow-up information received from the CMO or its subcontractor(s) in determining whether the potential mispayment is, in fact, a confirmed mispayment and the dollar value of the mispayment.[1]

[1]We reserve the right to not accept this information from the CMO or its subcontractor(s) in the event that circumstances require special consideration or handling. CMOs have been required to attest to the accuracy and reliability of the information they have provided for this initiative. In the event of a dispute between Myers and Stauffer and the CMO regarding the correct adjudication or payment amount on a claim, the Department's decision regarding the adjudication determination will constitute the final decision.

Sample Size

The agreed-upon sample size is 100 claims for each CMO. We will review 40 UB04 claims and 60 CMS 1500 claims per CMO. The results of the claim universe counts are presented in Table 1. It should be noted that achieving any estimated margin of error might not be possible due to the variability of the observed mispayments, which are a

function of each CMO or CMO/subcontractor claims processing and adjudication, and other unique factors specific to the CMOs, its subcontractor(s) and behavioral health claims. The sample size was not prepared to achieve a desired margin of error and as such, may indicate findings that are significantly different from those that would be achieved by utilizing a larger sample size. Based on the initial results of the analysis, Myers and Stauffer in consultation with DCH may choose to increase the sample size for one or all of the CMOs in order to reduce the margin of error on the estimates.

Table 1: Sample Size for Behavioral Health Claims by CMO

Care Management Organizations	Universe Claim Count UB 04	Universe Claim Count 1500	Sample Size
AMERIGROUP	18,077	752,927	100
Peach State Health Plan	16,866	724,221	100
WellCare	23,887	1,313,169	100
TOTAL	58,830	2,790,317	300

After applying these agreed-upon procedures to the selected sample for each CMO, Myers and Stauffer and Dr. Bivin will provide information to the Department regarding the sample, including whether the sample size was sufficient to achieve a minimal margin of error. At that time, the Department may authorize Myers and Stauffer to perform a boost sample, if necessary, to reduce the margin of error on the estimate to acceptable levels, as determined by the Department. In the event the Department does not authorize a boost sample, we will report only the claim accuracy rate from applying the agreed-upon procedures to the sample. This rate will be based on the number of line items without mispayments and the total number of line items selected for each CMO. No other statistics will be provided other than the accuracy rate of the sample, unless requested by the Department. We will work closely with the Department to determine the appropriate course of action based on the findings from the sample.

DELIVERABLES

We will report the claim accuracy rate from applying the agreed-upon procedures to the sample. This rate will be based on the number of claims without mispayments and the total number of claims selected for each CMO. The results will be presented in Table 2.

Table 2: Total Number of Claims per CMO

Statistics	CMO					
	PSHP Hospital	PSHP Professional	WellCare Hospital	WellCare Professional	Amerigroup Hospital	Amerigroup Professional
Sample Size						
Claims Paid/ Denied Correctly						
Percent of Claims Paid/ Denied Correctly						

In the event that the sample size is sufficient to achieve a minimal margin of error on the estimate, we will also provide the estimated dollar value of mispayments by CMO. This estimate may also be provided based on a boost sample, or at the request of the Department, as discussed in the previous section. The average dollar amount of mispayments per claim, by CMO, will be used to compute an estimate of the mispayments applicable to the universe of claims for each CMO. A confidence interval, margin of error, point estimate, lower bound, and upper bound will be prepared for each CMO. This information will generally be presented as illustrated in the Tables 3 and 4 below:

Table 3: Mispayments by CMO – Claims Sample

Statistics	CMO					
	PSHP Hospital	PSHP Professional	WellCare Hospital	WellCare Professional	Amerigroup Hospital	Amerigroup Professional
Sample Liabilities						
Sample Receivables						
Sample Underpayments						
Sample Overpayments						
Claims in Sample						
Claims with Mispayments						
Percent Claims with Mispayments						

Table 4: Mispayments by CMO – Total Population

Statistics Confidence Interval Total Population Mispayments	AMGP	PSHP	WellCare
Mean Mispayment			
Claims in Population			
95% Lower Bound - Liabilities			
95% Upper Bound - Liabilities			
95% Point Estimate - Liabilities			
Margin of Error - Liabilities			
95% Lower Bound - Receivables			
95% Upper Bound - Receivables			
95% Point Estimate - Receivables			
Margin of Error - Receivables			

In addition to the statistics reported above, we will provide an overview of the reasons for the mispayments, other observations, as well as any applicable recommendations for corrective actions. Recommendations, if necessary, will be subdivided by those applicable to the CMOs, those applicable to providers, and those applicable to the Department.

OTHER INFORMATION

M&S Workpapers

To test the volume of claims within the available time, spreadsheet tools, formulas, databases, and computerized algorithms will be utilized as a means to re-price claims. These tools are proprietary and are for Myers and Stauffer LC internal use only. Workpapers are available to the Department upon request.

Data Sources

Each CMO will provide the data, provider contracts, and reference file information needed for this engagement and attest to the accuracy of this information. Based on the CMO's signed attestation and direction from the Department, Myers and Stauffer LC will accept this information as accurate and reliable. The CMO, or their subcontractor(s), may provide additional information on the selected claims as necessary.

Timeline

Testing of behavioral health claim payments will begin upon the Department's approval of these agreed upon procedures and continue through approximately June 30, 2012. Approximately eight to ten weeks will be used to complete this analysis. However, additional time may be necessary, depending on the number of potential mispayments identified and the response time of the CMOs.

EXHIBIT E-2:
STATISTICIAN'S REPORT

DEPARTMENT OF COMMUNITY HEALTH

SFY 2012: GEORGIA FAMILIES

BEHAVIORAL HEALTH CLAIMS TESTING

EXHIBIT 2: STATISTICIAN'S REPORT

MAY 23, 2012

Myers and Stauffer LC
Certified Public Accountants

Memorandum

Date: May 23, 2012

From: Ye Zhang, Indiana University-Purdue University Indianapolis

RE: Georgia Claims Confidence Intervals Check

The attached document contains confidence intervals results produced by me from the Georgia claims data for six IDNUMS.

The 95% confidence interval estimates for mean and total liabilities, mean and total receivables and their corresponding margins of error are produced by my program written with statistical language S. I carried out the calculations independently, and my results agree with Prof. David Bivin's results except for some very minor differences that are due to rounding errors, hence I confirm.

Georgia CI By Ye Zhang (05/23/2012)

Confidence Intervals	IDNUM 1	IDNUM 2	IDNUM 3	IDNUM 4	IDNUM 5	IDNUM 6
Claims in Population	1,313,169	23,887	724,221	16,866	752,927	18,077
95% Lower Bound-Mean Liabilities	-$1.68	-$0.65	-$2.52	-$49.01	-$9.16	-$0.45
95% Upper Bound-Mean Liabilities	$0.55	$0.14	$0.42	$16.56	$1.78	$0.15
Point Estimate-Mean Liabilities	-$0.57	-$0.26	-$1.05	-$16.23	-$3.69	-$0.15
Margin of Error-Mean Liabilities	$1.11	$0.39	$1.47	$32.78	$5.47	$0.30
95% Lower Bound-Total Liabilities	-$2,206,616.44	-$15,488.67	-$1,824,462.51	-$826,615.71	-$6,896,418.41	-$8,109.07
95% Upper Bound-Total Liabilities	$716,608.44	$3,258.47	$302,632.51	$279,297.71	$1,341,322.41	$2,740.27
Point Estimate-Total Liabilities	-$745,004.00	-$6,115.10	-$760,915.00	-$273,659.00	-$2,777,548.00	-$2,684.40
Margin of Error-Total Liabilities	$1,461,612.44	$9,373.57	$1,063,547.51	$552,956.71	$4,118,870.41	$5,424.67
95% Lower Bound-Mean Receivables	-$3.89	$0.96	-$0.77	$28.00	-$6.11	-$0.93
95% Upper Bound-Mean Receivables	$12.53	$54.02	$3.43	$120.06	$24.20	$12.70
Point Estimate-Mean Receivables	$4.32	$27.49	$1.33	$74.03	$9.05	$5.88
Margin of Error-Mean Receivables	$8.21	$26.53	$2.10	$46.03	$15.15	$6.82
95% Lower Bound-Total Receivables	-$5,105,739.73	$23,004.07	-$554,077.47	$472,179.27	-$4,596,761.46	-$16,888.30
95% Upper Bound-Total Receivables	$16,451,957.73	$1,290,445.93	$2,485,333.47	$2,024,916.73	$18,220,473.46	$229,618.30
Point Estimate-Total Receivables	$5,673,109.00	$656,725.00	$965,628.00	$1,248,548.00	$6,811,856.00	$106,365.00
Margin of Error-Total Receivables	$10,778,848.73	$633,720.93	$1,519,705.47	$776,368.73	$11,408,617.46	$123,253.30

TO: Kathy Haley, Myers and Stauffer, LLC

FROM: David Bivin, Ph.D.

RE: Estimating Total Liabilities and Receivables for Georgia Medicaid Providers

DATE: May 23rd, 2012

My name is David Bivin and I am a Professor of Economics at Indiana University Purdue University Indianapolis (IUPUI). I have more than 30 years of experience teaching statistics at all levels of the curriculum.

I have reviewed the estimates of Total Liabilities and Total Receivables among claims submitted by Amerigroup, Peach State Health Plan, and WellCare for Hospital and Professional claims. I conclude that the calculations conform to standard statistical methodology and that the figures presented are accurate.

EXHIBIT E-3:
CLAIMS DATA UNIVERSE METHODOLOGY

SFY 2011: GEORGIA FAMILIES

BEHAVIORAL HEALTH CLAIMS TESTING AND ANALYSES FOR THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH

EXHIBIT 3: CLAIMS DATA UNIVERSE METHODOLOGY

JUNE 10, 2011

Myers and Stauffer LC
Certified Public Accountants

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GLOSSARY

The following terms may be used throughout this document:

- ***Adjudicate*** – A determination of the outcome of a healthcare claim. Claims may pay, deny, or in some cases have an alternative adjudication outcome.

- ***Affiliated Computer Services, Inc. (ACS)*** – State fiscal agent claim processor from implementation of the Georgia Families program until October 31, 2010.

- ***Behavioral Health Services*** – A branch of medicine that deals with the emotional and psychological well-being. Behavioral Health includes services provided for substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

- ***Care Management Organization (CMO)*** – A private organization that has entered into a risk-based contractual arrangement with DCH to obtain and finance care for enrolled Medicaid recipients or PeachCare for Kids™ members. CMOs receive a per capita or capitation claim payment from DCH for each enrolled member. The three CMOs contracted by the Department to provide services for DCH members are AMERIGROUP Community Care (AMERIGROUP or AMGP), Peach State Health Plan (Peach State or PSHP), and WellCare of Georgia (WellCare).

- ***Category of Service (CoS)*** – A unique category assigned to each claim by the Department based on the type of service delivered and/ or location of service.

- ***Cenpatico Behavioral Health (Cenpatico)*** – One of the subcontractors under Peach State Health Plan. Cenpatico is a contractor under a capitation agreement to administer the provision of behavioral and mental health services to Peach State Health Plan Georgia Families members.

- ***Claim*** – An electronic or paper record submitted by a healthcare provider to a payer detailing the healthcare services provided to a patient for which the provider is requesting payment. A claim may contain multiple healthcare services.

- ***Claims Universe*** - The population parameters for claims to be tested, including the type of claim, the categories of service, and paid dates.

- ***Denied Claim*** – A claim submitted by a healthcare provider for reimbursement that is deemed by the payor to be ineligible for payment under the terms of the contract between the healthcare provider and payor.

- ***Department of Community Health (DCH or Department)*** – the Department within the State of Georgia that oversees and administers the Medicaid and PeachCare for Kids™ programs.

- ***Encounter Claim (Encounter)*** – A record of a health care service that was delivered to an eligible member and submitted for payment by a CMO or subcontractor that is subsequently submitted by the CMO or subcontractor to the Medicaid fiscal agent contractor to load and maintain in the Georgia Medicaid and PeachCare for KidsTM MMIS. The Medicaid fiscal agent contractor does not generate a payment for the encounter claim, but rather it is maintained for program management, rate setting, and a variety of program oversight functions.

- ***Georgia Families (GF)*** – The risk-based managed care delivery program for Medicaid and PeachCare for Kids™ in which the Department contracts with Care Management Organizations to manage the care of eligible recipients.

- ***Fiscal Agent Contractor (FAC)*** – The entity contracted with the Department to process Medicaid and PeachCare for Kids™ claims and other non-claim specific payments.

- ***Hewlett-Packard Enterprise Services (HP)*** - (formerly Electronic Data Systems [EDS]) – State fiscal agent contractor as of November 1, 2010.

- ***Magellan Health Services, Inc (Magellan)*** – One of the four subcontractors under WellCare of Georgia. Magellan is a contractor under a capitation agreement to administer the provision of behavioral and mental health services to WellCare Georgia Families members.

- ***Paid Claim*** – A claim submitted by a healthcare provider for reimbursement that is deemed by the payor to be eligible for payment under the terms of the contract between the healthcare provider and payor.

- ***PeachCare for Kids™ program (PeachCare)*** – The Georgia DCH's State Children's Health Insurance Program (SCHIP) funded by Title XXI of the Social Security Act, as amended.

IDENTIFICATION OF CLAIMS UNIVERSE

This document provides a description of the claims data universe and the methodology used in identifying that universe of data which will be used for Georgia Families Program behavioral health facility and provider claims testing and analyses performed for the Department of Community Health (the "Department").

The universe includes Care Management Organization (CMO) claims with adjudication dates between June 1, 2006 and October 31, 2010. This includes CMO paid and denied claims of both Medicaid and PeachCare for Kids™ members for behavioral health provider claims, and includes both facility and physician claims.

Peach State Health Plan (PSHP) and WellCare of Georgia (WellCare) each utilize a subcontractor who is responsible for securing the behavioral health provider network and adjudicating and paying behavioral health claims. PSHP contracts with Cenpatico Behavioral Health (Cenpatico) for these services. Magellan Health Services, Inc. (Magellan) is the behavioral health subcontractor for WellCare. AMERIGROUP Community Care (AMERIGROUP or AMGP) adjudicates and pays behavioral health claims without utilizing a third party for this service.

For each of the CMOs, we identified certain required elements that must be included on each behavioral health claim in order to include it in the universe. If any of the required elements were not present on a claim, then a supplemental request for this data was submitted to each of the CMOs and then added to the claims data when received.

Because the CMOs do not administer their behavioral healthcare services area in an identical fashion, the methodology for identifying the appropriate data to include in the claims universe was unique for each plan. Below we summarize the distinct characteristics of each methodology.

- PSHP utilizes Cenpatico as their subcontractor. The PSHP encounter data has an identifier in the patient account field that signifies Cenpatico adjudicated the claim. Based on the identifier, the claims that Cenpatico adjudicated have been identified. The claims will have an adjudication date between June 1, 2006 and October 31, 2010.

- Because of known deficiencies in the WellCare/Magellan encounter data submitted to the fiscal intermediary, Magellan provided a file of their claims data as of December 2, 2010 directly to Myers and Stauffer. This file will be used for all behavioral health analyses to be performed as they relate to WellCare.

- AMERIGROUP's behavioral health claims data is intermingled with their medical claims data. To identify the behavioral health claims, we utilized AMERGROUP policies and the standard ICD-9 diagnosis, CPT codes, Revenue codes, and place of service (POS) codes which represent behavioral health. These codes include the following:

  - ICD-9 codes
    - Primary diagnosis code beginning with 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, or
    - Primary diagnosis code of 995.50, 995.51, 995.52, 995.53, 995.54, 995.55, 995.56, 995.57, 995.58, 995.59, V61.10, V61.11, V61.12, V61.20, V61.21, V61.22, V61.23, V61.24, V61.25, V61.26, V61.27, V61.28, V61.29, V61.8, V61.9, V62.0, V62.1, V62.21, V62.22, V62.23, V62.24, V62.25, V62.26, V62.27, V62.28, V62.29, V62.3, V62.4, V62.5, V62.6, V62.81, V62.82, V62.83, V62.84, V62.85, V62.86, V62.87, V62.88, V62.89, V65.2, V62.42, V71.01, V71.02, V71.09
    - Procedure codes beginning with 94.x
  - CPT codes
    - 90782, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875, 90876, 96100, 96101, 96102, 96103, 96105, 96110, 96111, 96116, 96118, 96119, 96120, 96150, 96151, 96154, 96155, 99510, H0004, H0005, H0007, H0014, H0015, H0018, H0019, H0020, H0030, H0031, H0032, H0035, H0038, H0039, H0043, H1011, H2010, H2011, H2012, H2013, H2014, H2015, H2021, H2032, S9480, T1006, T1027, T2033, T2034, T2048
  - Revenue codes
    - 115, 124, 134, 144, 154, 204, 513, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919
  - POS codes
    - 51, 52, 53, 57

  We also utilized the criteria included in the WellCare and PSHP subcontractor contracts to compare and add additional criteria, if applicable. Finally, we utilized ASC's behavioral health services criteria used to assign a category of service (CoS) to each claim to determine if there were any remaining claims that might be considered behavioral health that we had not yet included in the universe.

The claims identified in each of these steps were then aggregated into a comprehensive universe of Georgia Families behavioral health care services claims. This comprehensive universe will be used for all of the analyses related to behavioral health services.

Assumptions and Limitations

- We identified approximately 3,000 claim detail lines where a CMO, while utilizing a behavioral health subcontractor, paid what appeared to be a behavioral healthcare claim instead of the subcontractor adjudicating and paying the claim. We did not include any of these types of claims in the claims data universe. In many instances, these claims were physician claims in which the services provided appeared to be of a medical nature rather than a behavioral healthcare nature.

- This universe only includes claims submitted to the Department's prior fiscal agent, ACS or submitted directly to Myers and Stauffer by the CMO's behavioral health subcontractor.

- In the event a claim was continuing to lack critical elements required for these analyses after the inclusion of the supplemental data provided by the CMO, we excluded these partial claims from the universe and will not include them in any of our analyses. We excluded 111,190 claims, 94,795 from PSHP and 16,395 from AMGP, for this reason.

- Only the final adjudication of the claim with a paid amount greater than zero was included in the universe.

- Claims for services of a behavioral health nature provided as a part of a well-child assessment were not included in the claims data universe. These claims appear to have been consistently paid by the CMOs rather than a behavioral health subcontractor.

EXHIBIT E-4:
CMO RESPONSE LETTERS

SFY 2012: GEORGIA FAMILIES

BEHAVIORAL HEALTH CLAIMS TESTING

EXHIBIT 4: CMO RESPONSE LETTERS

Myers and Stauffer LC
Certified Public Accountants

Amerigroup RealSolutions in healthcare

August 14, 2012

Savombi Fields, CFE
Manager
Myers and Stauffer LC
133 Peachtree Street NE, Suite 3150
Atlanta, Georgia 30303

RE: Report #23: Behavioral Health Claims Testing

Dear Savombi:

Please find this letter as our acknowledgement of the Behavioral Health analysis published by Myers and Stauffer.

Thank you for allowing us the opportunity to review your findings. We take great strides to ensure the payment accuracy of our claims is consistent with the parameters of the State and provider contracts. We'll take the observations and recommendations put forth by this report and ensure we incorporate them into our internal processes.

Sincerely,

Aaron

Aaron Lambert
Associate Vice President, Operations
Amerigroup Community Care

303 Perimeter Center North
Suite 400
Atlanta, Georgia 30346
678.587.4840

www.amerigroupcorp.com

PEACH STATE HEALTH PLAN RESPONSE TO MYERS AND STAUFFER REPORT NO. 23

M&S Report pgs. 12-13	
Area of Concern	**CMO Response**
• Myers and Stauffer calculated that 84% of Peach State's/Cenpatico's Behavioral Health Claims paid/denied correctly. Primary issues affecting claims payment accuracy for Peach State/Cenpatico claims were: o Incorrect rate applied from fee schedule/provider type o Incorrect rate applied from fee schedule o Hospital Rate Add-on Tax inappropriately applied twice (Inpatient claim) o Hospital Rate Add-on Tax inappropriately applied twice(Outpatient claim) o Covered days incorrectly calculated o Copayment was not appropriately applied	The Plan has reviewed the 16 claims in question and **agrees** that the following claims 5102851200720[redacted] 5102851200920[redacted] 5102781200500[redacted] 5102851200700[redacted] 5102781200500[redacted] 5102851200700[redacted] 5102370200400[redacted] 5102840200520[redacted] 5102840200820[redacted] 5102850400520[redacted] 701115910[redacted] are subject to the issues identified as affecting claims payment accuracy (**Hospital Rate Add-on Tax applied twice in error.** This was an isolated issue as a result of a special claims project in which the hospital tax was manually applied twice. It is important to note that our processing system is configured to pay the hospital tax at the appropriate rate. M&S Report 23 states that the hospital tax overpayment represents 31% of the errors and has been calculated using the extrapolation methodology. Because this is an isolated issue as a result of manually processing a special claims project, applying this rate across all hospital claims artificially inflates the error rate. As such, Peach State requests that the numbers are recalculated using actual data as opposed to the extrapolation method.; **copayment was not appropriately applied; Incorrect rate applied from fee schedule**) The Plan **partially agrees** with the assessment for claim 701122209[redacted]. Authorization was for 4 days which allowed for payment of [redacted] However, the hospital tax was applied incorrectly which resulted in [redacted] overpayment (10.63% above the allowed amount. The Plan **disagrees** with the findings for the following claims:

	5102601200401[redacted]– the rate change is effective 1/1/10 (not 10/1/10 as indicated in the M/S response in column N. Claim paid correctly - [redacted]). 5102600201200[redacted]– this claim paid correctly per page 6 of the All CSB H2011 rate deemer document which indicates that procedure code [redacted] 701118000[redacted]– Per the provider contact, page 36, the provider is not contracted for this procedure code and is therefore paid the default rate of [redacted]. This is correct based on the deemed rate for this code (and others). Please refer to the attached deemer amendment. 701111903[redacted]- Per the provider contact, page 36, the provider is not contracted for this procedure code and is therefore paid the default rate of [redacted] This is correct based on the deemed rate for this code (and others). Please refer to the attached deemer amendment.

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Suite 200
Smyrna, GA 30082
P: 770-437-3001
F: 866-532-0837

March 12, 2010

[First Name] [Middle Init]. [Last Name] [Title]
[Street Address 1]
[Street Address 2]
[City], [State] [Zip]

Re: Agreement Amendment

Dear Cenpatico Provider,

Upon review of historical utilization data, and in order to better align reimbursement amounts with applicable billable provider types; **Cenpatico has modified the reimbursement amounts and modifiers for the H0004 and H2014 billing codes**. Pursuant to the "Amendment" provision of your Agreement with Cenpatico, we are providing the required written notification to amend your Agreement to replace your fee schedule (annexed as Exhibit 2 of your Agreement). These modifications shall be in effect on May 15, 2010, unless you reject this Amendment in writing within thirty (30) days of the date of this Amendment. Please attach this Amendment and updated Exhibit 2 to your Agreement for future reference.

Should you have any questions, do not hesitate to contact your local Network Development Manager;

Atlanta Region	***Central & Southwest Region***
Carla Menchion	Clinton Shedd
Phone: (770) 437-3001	Phone: (478) 951-7199
Email: cmenchion@centene.com	Email: cshedd@centene.com

Thank you for your continued participation in our Georgia provider network.

Sincerely,

Kathryn Curtis
Director, Network Management
Cenpatico

Enclosure