DEPARTMENT OF COMMUNITY HEALTH

REPORT # 21:

GEORGIA FAMILIES PROGRAM HOSPITAL UPDATE CLAIMS

INDEPENDENT ACCOUNTANT'S REPORT ON APPLYING AGREED-UPON PROCEDURES

AUGUST 3, 2012

Myers and Stauffer LC
Certified Public Accountants

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Myers and Stauffer LC
Certified Public Accountants

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 for the purpose of testing the pricing of inpatient and outpatient hospital claims adjudicated by the Georgia Families Program contracted Care Management Organizations. The Department will determine the applicability and use of the results from applying these agreed-upon procedures. DCH's management is responsible for the Department's policies and procedures, as well as vendor management functions.

We have performed the agreed-upon procedures described in Exhibit 1: Agreed-Upon Procedures dated February 17, 2010, which were agreed to by the Department. 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. Consequently, we make no representation regarding the sufficiency of the procedures described in Exhibit 1: Agree-Upon Procedures either for the purpose for which this report has been requested or for any other purpose.

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.

- ***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).

- ***Centers for Medicare and Medicaid Services 1500 (CMS-1500 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 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 Processing System*** – A computer system or set of systems that determine the reimbursement amount for services billed by the healthcare provider.

- ***Confidence Interval*** – An estimated range of values that is likely to include an unknown population parameter, the estimated range being computed from sample data with inferences made to the population.

- ***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.

- ***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.

- ***Encounter*** – A distinct set of health care services provided to a Medicaid or PeachCare for Kids™ Member enrolled with a Contractor on the dates that the services were delivered.

- ***Encounter Data*** – Health Care Encounter Data include: (i) All data captured during the course of a single Health Care encounter that specify the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the Member receiving services during the encounter; (ii) The identification of the Member receiving and the Provider(s) delivering the Health Care services during the single encounter; and, (iii) A unique, i.e. unduplicated, identifier for the single encounter.

- ***Extrapolation*** – The application of the mean dollar amount in error from the sample of claims to a population of claims.

- ***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. In some cases, the service must be authorized in advance.

- ***Fee-For-Service (FFS) Claim*** – A payment made by a payor to a healthcare 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 healthcare 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.

- ***In-Network Provider*** – A provider that has entered into a Provider Contract with the CMO or its dental subcontractor to provide services.

- ***Inpatient Facility*** – Hospital or clinic for treatment that requires at least one overnight stay.

- ***Underpayment*** – 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.

- ***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's subcontractor) coverage, payment policies, and contractual obligations resulting in either an overpayment or underpayment to the entity receiving the claim payment.

- ***Outpatient Services*** – Medical procedures, surgeries, or tests that are performed in a qualified medical center without the need for an overnight stay.

- ***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.

- ***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 healthcare payor that describes the coverage and payment policies for healthcare providers that provide healthcare services to patients covered by the payor.

- ***Overpayment*** – 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.

- ***Uniform Billing (UB or UB-92 or UB04) 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 UB04 version in 2007. CMS refers to the UB-92/UB04 claim form as the CMS 1450 claim form.

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 CMOs, and selected Georgia Families policies and procedures. Initial phases of the engagement focused on hospital, physician, and dental provider subjects. Previously issued reports, are available online at:

http://dch.ga.gov/00/channel_title/0,2094,31446711_102898636,00.html.

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 objective of this engagement is to apply agreed-upon procedures to test the accuracy of payments for a sample of hospital provider claims adjudicated by the CMOs that administer the Georgia Families program. These claim payments were analyzed to determine if the payment was made according to the CMO's coverage policies, payment policies, and contract between the CMO and the provider. If the outcome of a claim is not in accordance with these provisions, a determination was made of the amount of the mispayment for the claim in consultation with the CMO, the Department, and/or the provider.

The scope of this report is limited to the agreed-upon procedures described in Exhibit 1 dated February 17, 2010. The Claims Selection Methodology and Analytical Procedures used for this engagement are also described there.

In consultation with the Department, we analyzed the data and documentation received from the CMOs and we did not independently validate or verify the information. Each CMO attested and warranted that the information they provided was "accurate, complete and truthful, and [was] consistent with the ethics statements and policies of DCH."

FINDINGS

Myers and Stauffer applied the agreed-upon procedures to test the pricing accuracy of payments for a sample of hospital inpatient and outpatient hospital claims adjudicated by the CMOs. These claims were analyzed to determine if the payment or denial was made according to the terms of the contract between the CMO and the hospital provider. Claims with potential mispayments were discussed with the CMO.

For confirmed mispayments, we determined the estimated amount of the underpayment or overpayment for the claim. As part of the mispayment confirmation process, we required the CMOs to prepare a response that illustrated how the claim was adjudicated, as well as submit supporting documentation such as provider contract language, rate adjustment letters, etc.

The claims universe that was tested included two sample periods. The first sample period included paid or denied claims with dates of service between December 1, 2007 and November 30, 2008. The second sample period included paid or denied claims with dates of service between December 1, 2008 and June 30, 2010.

The following tables illustrate the findings by CMO. For each CMO, findings are displayed for 1) Children's Healthcare of Atlanta and 2) all other hospitals.

Summary of Claims Payment Accuracy

AMERIGROUP

AMERIGROUP	Children's Healthcare of Atlanta (CHOA)				All Other Hospitals			
Claims Sample Periods	Sample I		Sample II		Sample I		Sample II	
Claims Type	Inpatient Claims	Outpatient Claims	Inpatient Claims	Outpatient Claims	Inpatient Claims	Outpatient Claims	Inpatient Claims	Outpatient Claims
Sample Size	1,401	214	1,401	214	1,357	150	1,357	150
Claims Paid/Denied Correctly	1,029	172	1,090	151	810	99	1,096	101
Percent of Claims Paid/Denied Correctly	73.4%	80.4%	77.8%	70.6%	59.7%	66.0%	80.8%	67.3%

Peach State Health Plan

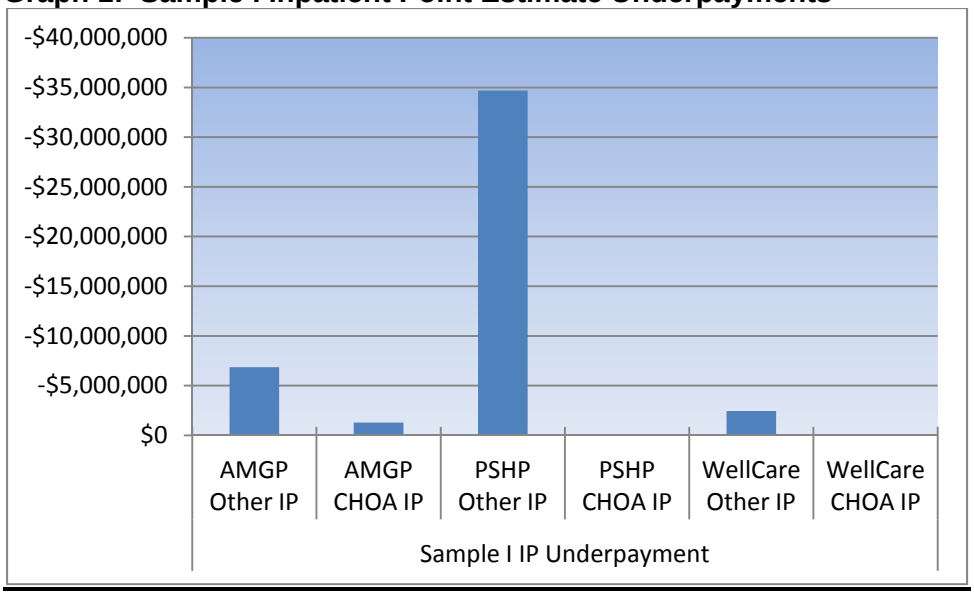
Peach State Health Plan	Children's Healthcare of Atlanta (CHOA)				All Other Hospitals			
Claims Sample Periods	Sample I		Sample II		Sample I		Sample II	
Claims Type	Inpatient Claims	Outpatient Claims	Inpatient Claims	Outpatient Claims	Inpatient Claims	Outpatient Claims	Inpatient Claims	Outpatient Claims
Sample Size	150	150	150	150	150	150	150	150
Claims Paid/Denied Correctly	145	117	134	119	71	109	102	103
Percent of Claims Paid/Denied Correctly	96.7%	78.0%	89.3%	79.3%	47.3%	72.7%	68.0%	68.7%

WellCare

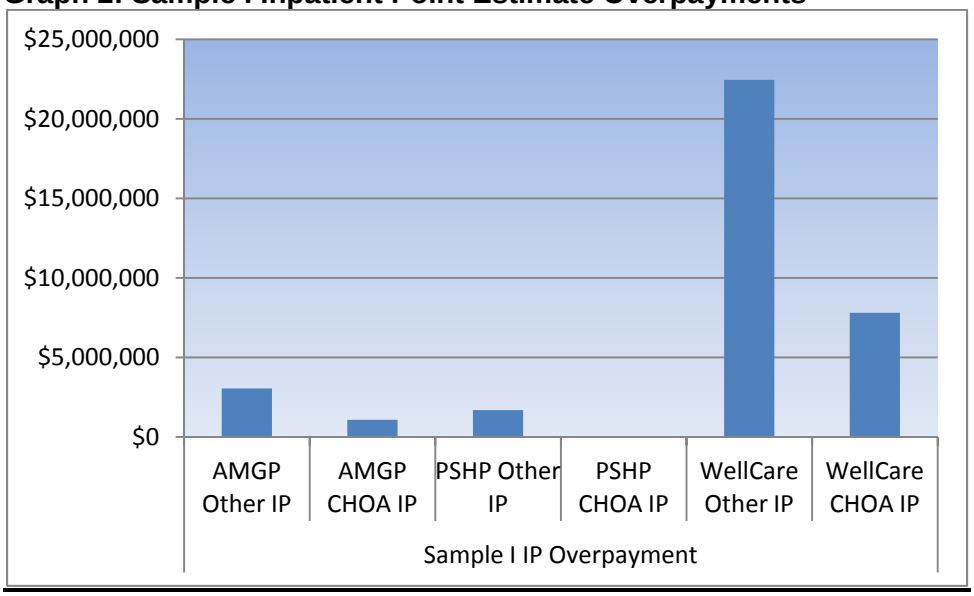
WellCare	Children's Healthcare of Atlanta (CHOA)				All Other Hospitals			
Claims Sample Periods	Sample I		Sample II		Sample I		Sample II	
Claims Type	Inpatient Claims	Outpatient Claims	Inpatient Claims	Outpatient Claims	Inpatient Claims	Outpatient Claims	Inpatient Claims	Outpatient Claims
Sample Size	376	150	376	150	150	150	150	150
Claims Paid/Denied Correctly	295	115	279	133	124	108	123	118
Percent of Claims Paid/Denied Correctly	78.5%	76.7%	74.2%	88.7%	82.7%	72.0%	82.0%	78.7%

The following graphs compare the point estimate underpayments or overpayments for each stratum, by sample and by CMO.

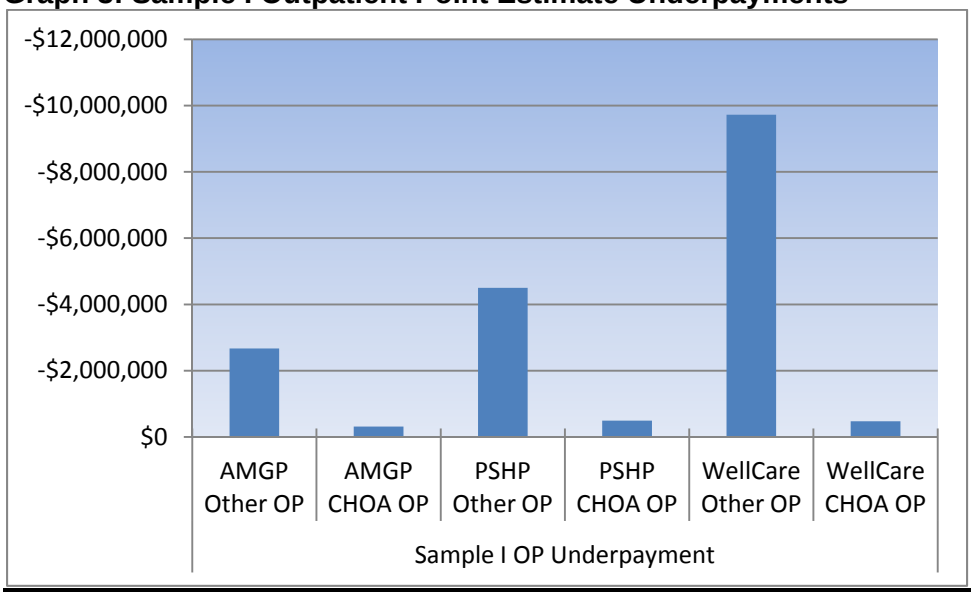
Graph 1: Sample I Inpatient Point Estimate Underpayments



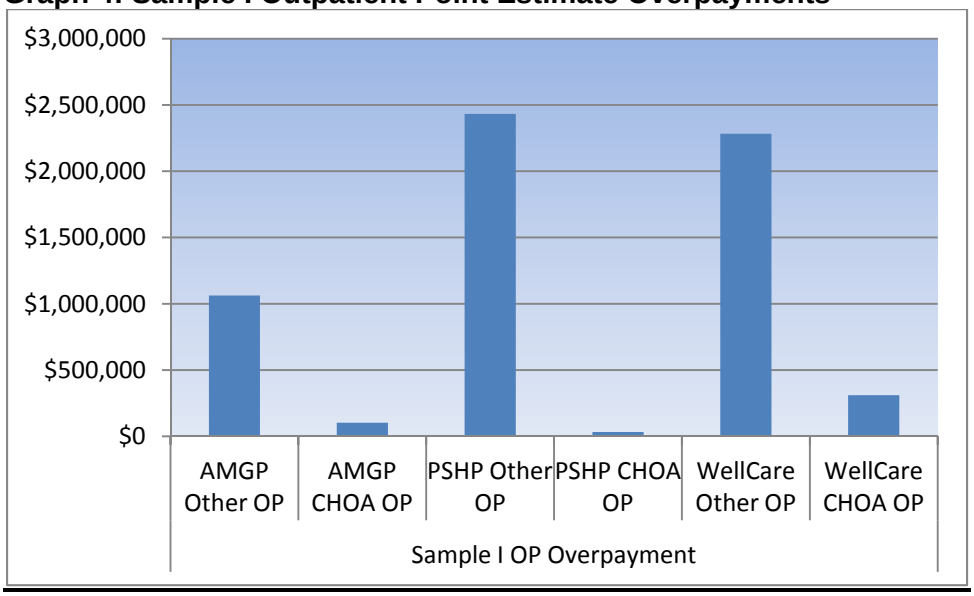
Graph 2: Sample I Inpatient Point Estimate Overpayments



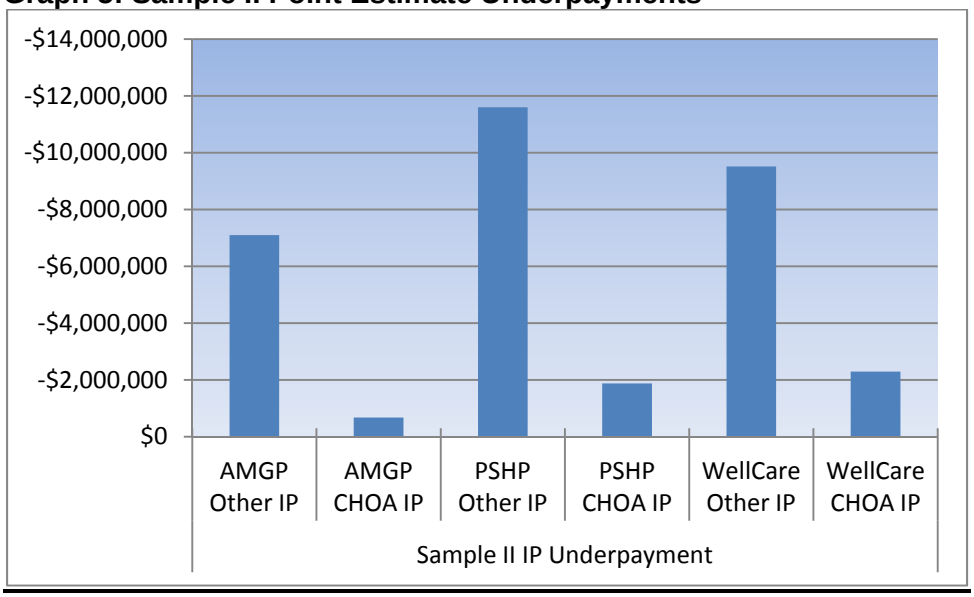
Graph 3: Sample I Outpatient Point Estimate Underpayments



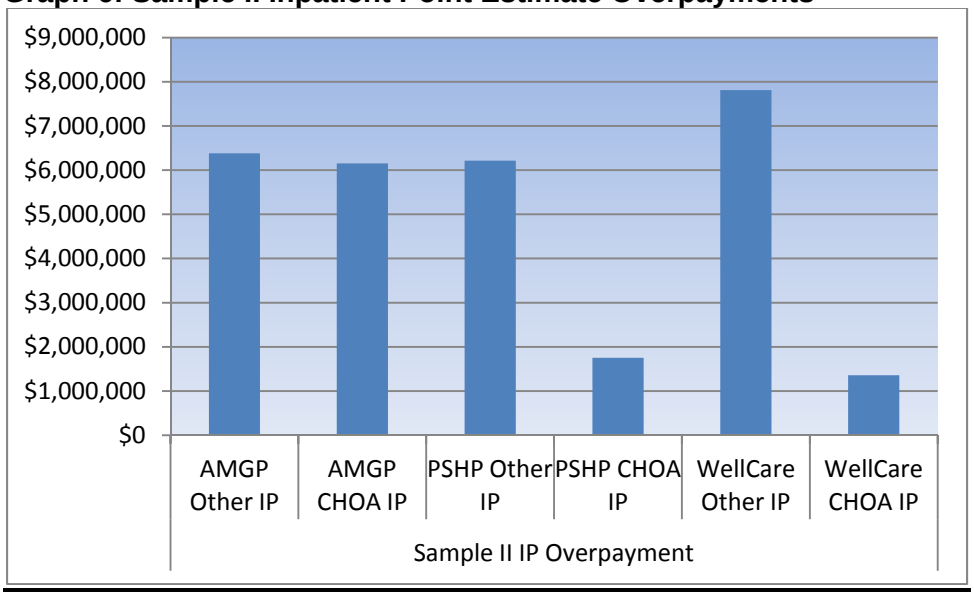
Graph 4: Sample I Outpatient Point Estimate Overpayments



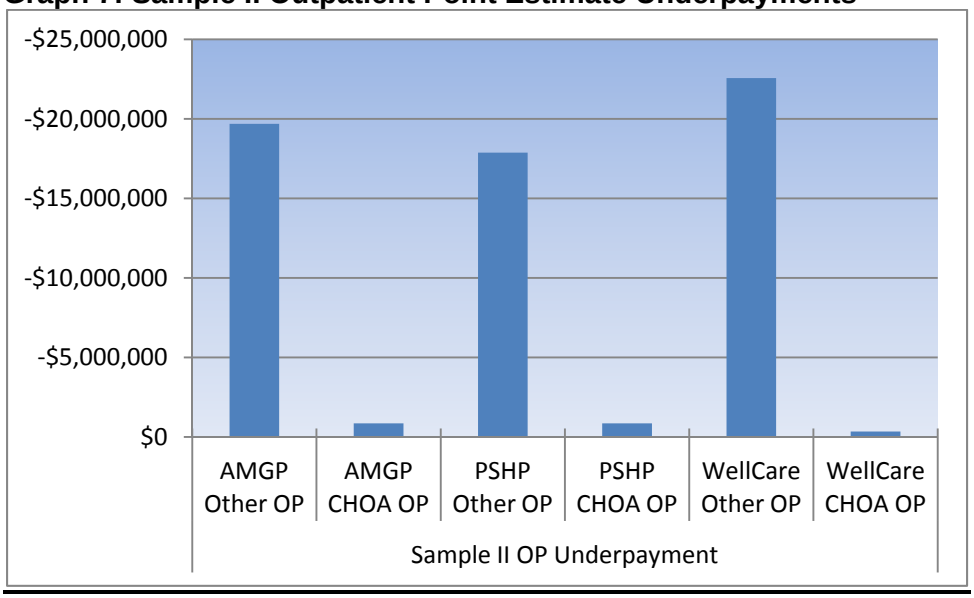
Graph 5: Sample II Point Estimate Underpayments



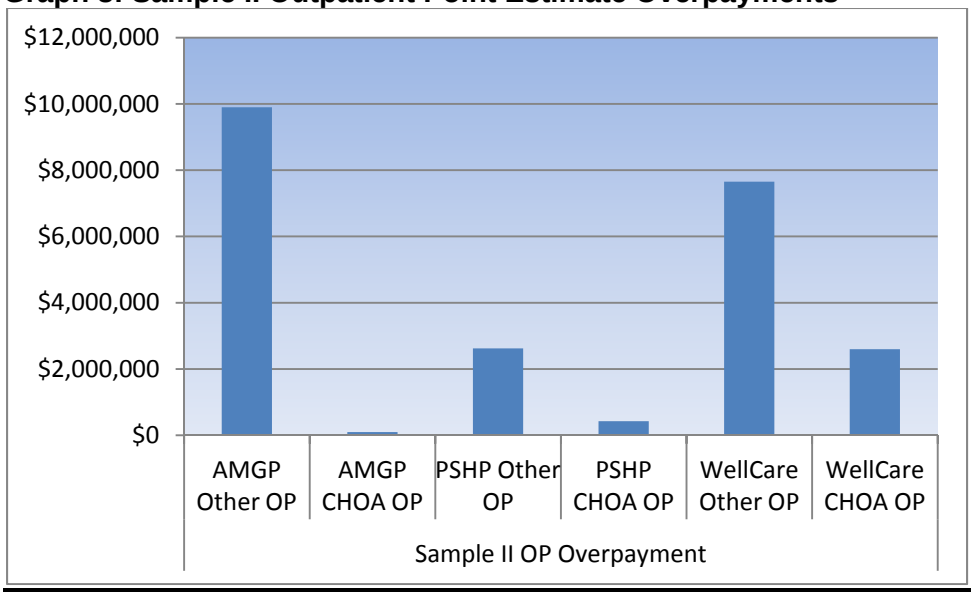
Graph 6: Sample II Inpatient Point Estimate Overpayments



Graph 7: Sample II Outpatient Point Estimate Underpayments



Graph 8: Sample II Outpatient Point Estimate Overpayments



Detail Statistics of Claim Mispayments

AMERIGROUP

AMERIGROUP	Children's Healthcare of Atlanta (CHOA)			
Claims Sample Periods	**Sample I**		**Sample II**	
Claims Type	Inpatient Claims	Outpatient Claims	Inpatient Claims	Outpatient Claims
Sample Underpayments	$1,124,191	$2,288	$369,763	$2,809
Sample Overpayments	$943,344	$755	$3,357,139	$313
Claims in Sample	1,401	214	1,401	213
Claims with Mispayments	372	42	311	62
Percent Claims with Mispayments	26.6%	19.6%	22.2%	29.1%

AMERIGROUP	Children's Healthcare of Atlanta (CHOA)			
Confidence Interval Total Population Mispayments	**Sample I**	**Sample I**	**Sample II**	**Sample II**
	Inpatient Hospital Claims	Outpatient Hospital Claims	Inpatient Hospital Claims	Outpatient Hospital Claims
Mean Underpayments	$802.42	$10.69	$263.93	$13.19
Mean Overpayment	$673.34	$3.53	$2,396.24	$1.47
Claims in Population	1,594	29,228	2,568	64,571
95% Point Estimate - Underpayments	($1,279,058)	($312,547)	($677,767)	($851,567)
Margin of Error - Underpayments	±$123,980	±$346,984	±$276,806	±$672,419
95% Point Estimate - Overpayments	$1,073,298	$103,056	$6,153,556	$94,819
Margin of Error - Overpayments	±$156,579	±$86,783	±$2,189,975	±$118,436

Note: Confidence interval boundaries may be adjusted to logical limits.

AMERIGROUP	All Other Hospitals			
Claims Sample Periods	**Sample I**		**Sample II**	
Claims Type	Inpatient Claims	Outpatient Claims	Inpatient Claims	Outpatient Claims
Sample Underpayments	$148,688	$1,668	$182,583	$6,114
Sample Overpayments	$334,070	$663	$164,181	$3053
Claims in Sample	1,357	150	1,357	149
Claims with Mispayments	547	51	261	48
Percent Claims with Mispayments	40.3%	34.0%	19.2%	32.2%

AMERIGROUP	All Other Hospitals			
Confidence Interval Total Population Mispayments	**Sample I** Inpatient Hospital Claims	**Sample I** Outpatient Hospital Claims	**Sample II** Inpatient Hospital Claims	**Sample II** Outpatient Hospital Claims
Mean Underpayment	$246.18	$11.12	$134.55	$41.03
Mean Overpayment	$109.57	$4.42	$120.99	$20.49
Claims in Population	27,849	240,141	52,758	483,085
95% Point Estimate - Underpayments	($6,855,952)	($2,670,976)	($7,098,523)	($19,821,594)
Margin of Error - Underpayments	±$4,130,886	±$2,217,700	±$2,732,852	±$12,690,954
95% Point Estimate - Overpayments	$3,051,443	$1,062,208	$6,383,103	$9,897,212
Margin of Error - Overpayments	±$2,898,090	±$830,594	±$3,972,266	±$7,057,408

Note: Confidence interval boundaries may be adjusted to logical limits.

Peach State Health Plan

PSHP	Children's Healthcare of Atlanta (CHOA)			
Claims Sample Periods	Sample I		Sample II	
Claims Type	Inpatient Claims	Outpatient Claims	Inpatient Claims	Outpatient Claims
Sample Underpayments	$2	$1,849	$73,334	$1,687
Sample Overpayments	$1,955	$123	$68,434	$832
Claims in Sample	150	150	150	150
Claims with Mispayments	5	33	16	31
Percent Claims with Mispayments	3.3%	22.0%	10.7%	20.7%

PSHP	Children's Healthcare of Atlanta (CHOA)			
Confidence Interval Total Population Mispayments	Sample I	Sample I	Sample II	Sample II
	Inpatient Hospital Claims	Outpatient Hospital Claims	Inpatient Hospital Claims	Outpatient Hospital Claims
Mean Underpayment	$0.01	$12.33	$488.89	$11.25
Mean Overpayment	$13.03	$0.82	$456.23	$5.55
Claims in Population	2,011	39,765	3,840	76,144
95% Point Estimate - Underpayments	($26)	($490,114)	($1,877,338)	($856,260)
Margin of Error - Underpayments	±$50	±$384,073	±$2,227,346	±$1,003,367
95% Point Estimate - Overpayments	$26,213	$32,515	$1,751,908	$422,508
Margin of Error - Overpayments	±$34,789	±$30,573	±$2,024,937	±$377,349

Note: Confidence interval boundaries may be adjusted to logical limits.

PSHP	All Other Hospitals			
Claims Sample Periods	**Sample I**		**Sample II**	
Claims Type	Inpatient Claims	Outpatient Claims	Inpatient Claims	Outpatient Claims
Sample Underpayments	$109,273	$2,173	$23,530	$4,304
Sample Overpayments	$5,306	$1,174	$12,602	$631
Claims in Sample	149	150	150	150
Claims with Mispayments	78	41	48	47
Percent Claims with Mispayments	52.3%	27.3%	32.0%	31.3%

PSHP	All Other Hospitals			
Confidence Interval Total Population Mispayments	**Sample I** Inpatient Hospital Claims	**Sample I** Outpatient Hospital Claims	**Sample II** Inpatient Hospital Claims	**Sample II** Outpatient Hospital Claims
Mean Underpayment	$733.37	$14.48	$156.87	$28.69
Mean Overpayment	$35.61	$7.83	$84.01	$4.21
Claims in Population	47,308	310,758	73,958	622,878
95% Point Estimate - Underpayments	($34,694,427)	($4,500,815)	($11,601,600)	($17,872,405)
Margin of Error - Underpayments	±$23,877,117	±$2,743,918	±$7,155,202.00	±$18,277,575
95% Point Estimate - Overpayments	$1,684,686	$2,432,237	$6,213,416	$2,621,660
Margin of Error - Overpayments	±$1,446,284	±$2,254,832	±$5,213,443	±$1,695,035

Note: Confidence interval boundaries may be adjusted to logical limits.

WellCare

WellCare	Children's Healthcare of Atlanta (CHOA)			
Claims Sample Periods	**Sample I**		**Sample II**	
Claims Type	Inpatient Claims	Outpatient Claims	Inpatient Claims	Outpatient Claims
Sample Underpayments	$24,233	$2,743	$183,421	$825
Sample Overpayments	$1,486,893	$1,807	$108,586	$6,259
Claims in Sample	376	150	376	150
Claims with Mispayments	81	35	97	17
Percent Claims with Mispayments	21.5%	23.3%	25.8%	11.3%

WellCare	Children's Healthcare of Atlanta (CHOA)			
Confidence Interval Total Population Mispayments	**Sample I**	**Sample I**	**Sample II**	**Sample II**
	Inpatient Hospital Claims	Outpatient Hospital Claims	Inpatient Hospital Claims	Outpatient Hospital Claims
Mean Underpayment	$64.45	$18.29	$487.82	$5.50
Mean Overpayment	$3,954.50	$12.04	$288.79	$41.72
Claims in Population	1,974	25,724	4,702	62,239
95% Point Estimate - Underpayments	($127,223)	($470,398)	($2,293,737)	($342,398)
Margin of Error - Underpayments	+$114,047	+$846,585	+$1,015,458	+$517,839
95% Point Estimate - Overpayments	$7,806,189	$309,804	$1,357,901	$2,596,833
Margin of Error - Overpayments	+$3,235,488	+$152,583	+$955,124	+$2,486,968

Note: Confidence interval boundaries may be adjusted to logical limits.

WellCare	All Other Hospitals			
Claims Sample Periods	**Sample I**		**Sample II**	
Claims Type	Inpatient Claims	Outpatient Claims	Inpatient Claims	Outpatient Claims
Sample Underpayments	$4,362	$2,644	$11,247	$3,013
Sample Overpayments	$39,970	$621	$9,174	$1,022
Claims in Sample	149	150	149	150
Claims with Mispayments	25	42	26	32
Percent Claims with Mispayments	16.8%	28.0%	17.4%	21.3%

WellCare	All Other Hospitals			
Confidence Interval Total Population Mispayments	**Sample I**	**Sample I**	**Sample II**	**Sample II**
	Inpatient Hospital Claims	Outpatient Hospital Claims	Inpatient Hospital Claims	Outpatient Hospital Claims
Mean Underpayment	$29.28	$17.62	$75.48	$20.09
Mean Overpayment	$268.65	$4.14	$61.57	$6.81
Claims in Population	83,722	551,749	126,886	1,123,350
95% Point Estimate - Underpayments	($2,451,122)	($9,724,024)	($9,577,596)	($22,566,005)
Margin of Error - Underpayments	±$4,742,478	±$6,882,603	±$5,680,145	±$12,841,857
95% Point Estimate - Overpayments	$22,458,724	$2,282,880	$7,812,490	$7,654,582
Margin of Error - Overpayments	±$12,304,255	±$1,888,387	±$7,852,760	±$13,896,035

Note: Confidence interval boundaries may be adjusted to logical limits.

OBSERVATIONS AND RECOMMENDATIONS

We make the following observations and recommendations regarding hospital claim pricing.

Recommendations Applicable to the CMOs

1) There was limited information available regarding the CMOs' bundling, coding, and pricing policies. Detailed bundling policies and service limits should be identified within the contract or referenced, when applicable.

2) Contracts and amendments between CMOs and providers should clearly identify the parameters used to determine when the contract terms are effective, specifically whether the effective date is based on service date of the claim or whether it is based on the adjudication or paid date of the claim. In the situation where service date is the appropriate parameter, the contract should specify whether the date is the first or last date of service.

3) Contracts should identify situations in which the Medicaid fee-for-service fee schedules or payment policies are the default basis for payment.

4) In some cases, the contracts are not amended to change a rate for inpatient or outpatient services. The CMOs should have a tracking mechanism to record changes in rates which is communicated to the provider and could be used to substantiate changes in the pricing tables in the claims system. The high error rates could be due to the CMOs not providing documentation regarding rate changes and the provider's consent to such rate changes.

5) DCH may wish to require the CMOs to correct all of the claims in error, and/or claims in universe with similar problems. For the accuracy percentages that are low, the CMO may need to submit a Corrective Action Plan (CAP) to address why the accuracy is low. It may also be necessary to correct systems issues, or conduct provider education.

Recommendation Applicable to Hospital Providers

Hospital providers should review contracts with the CMOs and ensure that all provisions are clear and unambiguous within the contract itself, and any verbal assurances by a representative of a health plan are detailed in writing within the contract.

Analytical Limitations

- The claims 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.

- 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.

We were not engaged to, and did not conduct an examination, the objective of which would be the expression of an opinion on the inpatient and outpatient hospital claims adjudicated by the Georgia Families Program contracted Care Management Organizations. 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
Indianapolis, Indiana
February 24, 2012

EXHIBIT 1: AGREED UPON PROCEDURES

SFY 2010: GEORGIA FAMILIES

HOSPITAL CLAIMS TESTING UPDATE FOR THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH

EXHIBIT 1: AGREED-UPON PROCEDURES

FEBRUARY 17, 2010

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 hospital provider claims testing performed for the Department of Community Health (the "Department"), including a computation of a sample mispayment rate. After applying these agreed-upon procedures to a sample of claims, the Department may request that we also compute an estimate of the aggregate dollar value mispayments for each Care Management Organization (CMO) for claims with dates of service between December 1, 2007 and November 30, 2008 and between December 1, 2008 and June 30, 2010 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. The sufficiency of these procedures is solely the responsibility 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.

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.

- ***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 DCH 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.

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

- ***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.

- ***Uniform Bill 2004 or UB04 or UB-04 or CMS-1450 Form*** – Claim form developed by the National Uniform Billing Committee for hospitals and other institutional providers to submit patient data for reimbursement of health care services. The UB04 was mandated effective on May 23, 2007. All previous versions of the Uniform Bill are not allowed to be submitted for reimbursement.

PROJECT TEAM

The following key personnel will be used for this engagement:

Jared Duzan – co project director
Keenan Buoy, CPA – co project director
Beverly Kelly, CPA, CFF, CFE – co project manager
Ryan Farrell – co project manager
Kevin Londeen, CPA – 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 and Indianapolis 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 hospital provider claims adjudicated by the CMOs that administer the GF program. These claim payments will be analyzed to determine if the payment was made according to the CMO's coverage policies, payment policies, and contract between the CMO and the provider. If the outcome of a claim is not in accordance with these provisions, a determination will be made of the amount of the mispayment for the claim in consultation with the CMO, the Department, and/or the provider.

CLAIMS UNIVERSE FOR TESTING

The claims universe will include CMO paid and denied claims of both Medicaid and PeachCare for Kids™ members for hospital provider claims. The claims will have dates of service between December 1, 2007 and November 30, 2008 for the first sample and between December 1, 2008 and June 30, 2010 for the second sample. For each time period, a sample of inpatient hospital and outpatient hospital provider claims will be selected from the claims submitted by the CMOs.

CLAIM SELECTION METHODOLOGY AND ANALYTICAL PROCEDURES

There will be two sample periods. The first sample period will include paid or denied claims with dates of service between December 1, 2007 and November 30, 2008. The second sample period will include paid or denied claims with dates of service between December 1, 2008 and June 30, 2010. All claims will be tested at the claim header level. Each claim in the sample will be tested based on the contract between the CMO and the 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 the claim payment status of 'denied' appears to be inappropriate, compute the expected payment for the claim based on the contract between the hospital provider and the CMO.
4) If claim payment status is 'paid', compute the expected payment for the claim based on the contract between the hospital provider and the CMO.
5) Compute the potential dollar value of the mispayment, as applicable, for the claim.
6) Potential mispayments will be sent to the CMO for comment. Unless indicated otherwise, we will rely on the follow-up information received from the CMO in determining whether the potential mispayment is, in fact, a confirmed mispayment and the dollar value of the mispayment. 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.
7) Compute the sample mispayment rate.
8) As requested by the Department, compute an estimate of the aggregate dollar value of mispayments for each Care Management Organization (CMO) for claims with dates of service between December 1, 2007 and November 30, 2008 and between December 1, 2008 and June 30, 2010.

Sample Size

For hospital service claims with dates of service between December 1, 2007 and November 30, 2008, Sample I the total claim count from all CMOs is 1,361,823. The total claim count from all CMOs for inpatient hospital services is 164,458. The total claim count from all CMOs for outpatient hospital services is 1,197,365. The agreed upon total sample size is 4,548 claims from all CMOs. For hospital service claims with dates of service between December 1, 2008 and June 30, 2010, Sample II the total claim count from all CMOs is 2,696,979. The total claim

count from all CMOs for inpatient hospital service is 264, 712. The total claim count from all CMOs for outpatient hospital services is 2,432, 267. The agreed upon total sample size is 4,548 claims from all CMOs.

It should be noted that the variability of the observed mispayments are a function of each CMOs claims processing and adjudication, and other unique factors specific to the CMOs and hospital 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.

Sample I Sizes for CMO Hospital Claims

Care Management Organizations	Universe Claim Count					Sample Size				
	Total	CHOA Inpat	CHOA Outpat	Other Inpat	Other Outpat	Total	CHOA Inpat	CHOA Outpat	Other Inpat	Other Outpat
AMERIGROUP Community Care	298,812	1,594	29,228	27,849	240,141	3,122	1,401	214	1,357	150
Peach State Health Plan	399,842	2,011	39,765	47,308	310,758	600	150	150	150	150
WellCare of Georgia	663,169	1,974	25,724	83,722	551,749	826	376	150	150	150
TOTAL	**1,361,823**	**5,579**	**94,717**	**158,879**	**1,102,648**	**4,548**	**1,927**	**514**	**1,657**	**450**

Sample II Sizes for CMO Hospital Claims

Care Management Organizations	Universe Claim Count					Sample Size				
	Total	CHOA Inpat	CHOA Outpat	Other Inpat	Other Outpat	Total	CHOA Inpat	CHOA Outpat	Other Inpat	Other Outpat
AMERIGROUP Community Care	602,982	2,568	64,571	52,758	483,085	3,122	1,401	214	1,357	150
Peach State Health Plan	776,820	3,840	76,144	73,958	622,878	600	150	150	150	150
WellCare of Georgia	1,317,177	4,702	62,239	126,886	1,123,350	826	376	150	150	150
TOTAL	**2,696,979**	**11,110**	**202,954**	**253,602**	**2,229,313**	**4,548**	**1,927**	**514**	**1,657**	**450**

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. Based on an analysis of previously analyzed claims and the projected variability of post implementation period hospital claims, Dr. Bivin provided several sampling options for the Department's consideration. These options were presented to the Department in a memorandum dated November 17, 2009. After considering the options, the Department informed us that they selected Option #3, which was based on the variability of previously tested claims with trimmed outliers to seven standard deviations.

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 each 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 the claim accuracy rate from applying the agreed-upon procedures to each sample and if requested, the estimate of the total mispayments applicable to the universe of claims. We will work closely with the Department to determine the appropriate course of action based on the findings from each sample.

DELIVERABLES

We will report the claim accuracy rate from applying the agreed-upon procedures to each sample. This rate will be based on the number of claims without mispayments, the total number of claims selected for each CMO, and will be reported as follows:

	CMO			
	CHOA Inpatient	CHOA Outpatient	Non-CHOA Inpatient	Non-CHOA Outpatient
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 the 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 example tables below:

	CMO			
Statistics	CHOA Inpatient	CHOA Outpatient	Non-CHOA Inpatient	Non-CHOA Outpatient
Sample Underpayments				
Sample Overpayments				
Claims in Sample				
Claims with Mispayments				
Percent Claims with Mispayments				

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

MSLC Workpapers

Spreadsheet tools, formulas, databases, and computerized algorithms will be utilized as a means to test and analyze 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.

DEPARTMENT OF COMMUNITY HEALTH

SFY 2012: GEORGIA FAMILIES

REPORT # 21

EXHIBIT 2: CMO RESPONSE LETTERS

Myers and Stauffer LC

Certified Public Accountants

Amerigroup RealSolutions in healthcare

July 16, 2012

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

RE: Hospital Update Claim Repricing Analysis

Dear Savombi:

Please find this letter as our acknowledgement of the hospital audit findings published by Myers and Stauffer. After reviewing the findings, we feel the accuracy of our hospital claims payments is higher than the stated payment accuracy published in the report. We understand the analytical limitations encountered by the Myers and Stauffer were a cause for sourcing payments errors and we would support the decision to conduct additional testing on these cases. We feel that if these cases were to be retested, our payment accuracy would improve in each of the extract samples.

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

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Peach State Health Plan™

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July 16, 2012

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

RE: Hospital Update – Claim Repricing Follow-up

Dear Ms. Fields:

In follow up to the request submitted by Myers and Stauffer to Peach State Health Plan (Peach State) on July 3, 2012, please accept this letter as confirmation that, to the best of my knowledge and information, the responses provided by Peach State Health Plan in the enclosed spreadsheets are true and accurate.

As the Plan's responses indicated, the associated claims were processed in accordance with the payment methodologies set forth in the applicable provider agreement. Therefore, we respectfully request additional information regarding the "Final Errors" assessed by your firm. Specifically, we are seeking to understand why the errors were assessed. We would also like to have the claims retested. Any assistance you can provide would be greatly appreciated.

It should also be noted that this letter does not constitute a response to Myers & Stauffer's Draft Report # 21, which we received earlier today.

Should you have questions or require additional information, please do not hesitate to contact me directly at 678-556-2439.

Sincerely,

Clyde A. White, Jr.
Vice President, Compliance

Enclosures:
PSHP sample 1 errors for review 062612.xls
PSHP S2 errors to review 062712.xls

July 20, 2012

Kathy Haley, MPL, CFE
Myers & Stauffer LC
9265 Counselors Row, Suite 200
Indianapolis, IN 46240

RE: Draft Report #21: Georgia Families Program Hospital Update Claims

Dear Ms. Haley,

This letter is written in acknowledgement of our receipt of Draft Report #21: Georgia Families Program: Hospital Update Claims, dated February 24, 2012. WellCare values your feedback and are committed to remedial action on matters recognized as areas for improvement. In the spirit of offering feedback, there are two sections of this report that we would like to draw your attention to as the first appears to be a calculation error and the second reflects an inconsistency in the sampling methodology employed.

Calculation Error –
Under the WellCare claims sample table on page 9, we have identified four numerical errors, while comparing the data in this table, against the data captured within the WellCare table on page 19. These errors are listed below:

a. All Other Hospitals – Sample I – Inpatient Claims – Sample size is 149 and not 150
b. All Other Hospitals – Sample II – Inpatient Claims – Sample size is 149 and not 150
c. All Other Hospitals – Sample I – Inpatient Claims - % of claims paid/denied correctly should be 83.2% and not 82.7%
d. All Other Hospitals – Sample II – Inpatient Claims - % of claims paid/denied correctly should be 82.5% and not 82.0%

Sampling Methodology –
Under Exhibit 1 (Agreed-Upon Procedures), page 10, table two, Myers & Stauffer identifies the sample sizes selected for each of the three CMOs. The sample size for one CMO appears to be disproportionate to the sample sizes of the remaining two CMOs. (shown graphically below)

CMO	Total Universe	Sample Size	Sample is X% of Universe
Amerigroup	602,982	3,122	.5%
PeachState	776,820	600	.1%
WellCare	1,317,177	826	.1%

Myers & Stauffer acknowledged that "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." Therefore, WellCare questions whether the sample sizes used to create this report should have been more evenly distributed among all three CMOs, which may have resulted in lower "mispayment" amounts for those two CMOs exposed to a lower sample size.

WellCare has no further comments on this draft report at this time. We appreciate your analysis of our performance and the opportunity to respond accordingly. We remain committed to working with DCH as partners in administering the Georgia Families program.

Sincerely,

Annette Zerbe, CHC
Sr. Director, Regulatory Affairs
WellCare of Georgia, Inc.

cc: David McNichols, Georgia State President
Kathy Ryland, Georgia Chief Operating Officer
Joshua Luft, Sr. Manager, Reporting & Analytics
Jerry Dubberly, Chief, Medicaid Division
Claudette Bazile, Deputy Director of Operations, Medicaid Division

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