



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

GEORGIA FAMILIES PROGRAM

COMPARATIVE ANALYSIS

POLICIES AND PROCEDURES OF GEORGIA
CARE MANAGEMENT ORGANIZATIONS

FINAL DRAFT – JULY 17, 2008


Myers and Stauffer_{LC}
Certified Public Accountants

TABLE OF CONTENTS

TABLE OF CONTENTS.....	1
GLOSSARY.....	2
TABLE OF ACRONYMS.....	10
EXECUTIVE SUMMARY.....	11
BACKGROUND.....	25
PROJECT PURPOSE.....	28
SCOPE OF REPORT.....	29
POLICY AND PROCEDURE ANALYSIS.....	31
SECTION I	
COMPARISON OF GF MODEL CONTRACT TO OTHER STATE MEDICAID MANAGED CARE CONTRACTS.....	31
SECTION II	
COMPARISON OF GF MODEL CONTRACT REQUIREMENTS TO WRITTEN POLICIES AND PROCEDURES OF THE GEORGIA CMOs.....	42
SECTION III	
COMPARISON OF GF CMO WRITTEN POLICIES AND PROCEDURES TO MEDICAID CMOs IN OTHER STATES.....	70
SECTION IV	
ANALYSIS OF THE REGULATORY AND CONTRACTUAL REQUIREMENTS OF REIMBURSEMENT FOR EMERGENCY MEDICAL SERVICES - COMPLETED BY KRIEG DEVAULT LLP.....	90
FINDINGS AND RECOMMENDATIONS.....	93
EXHIBITS.....	114

- A. CMO LIST (OTHER STATES)
- B. SURVEY QUESTIONS FOR GEORGIA CMOs
- C. RESPONSES TO SURVEY QUESTIONS FROM GEORGIA CMOs
- D. SURVEY QUESTIONS FOR COMPARISON STATES AND MCOs
- E. TENNCARE ANALYSIS REPORT (FEB 2008)
- F. REPORT FROM KRIEG DEVAULT LLP
- G. DCH IMPLEMENTATION ACTIVITIES
- H. AMERIGROUP RESPONSE TO AUDIT FINDINGS
- I. PEACH STATE HEALTH PLAN RESPONSE TO AUDIT FINDINGS
- J. WELLCARE RESPONSE TO AUDIT FINDINGS

GLOSSARY

These terms and references are used throughout this report:

- **72-Hour Rule** – Diagnostic services (including clinical diagnostic laboratory tests) provided to a member by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital, within three days prior to and including the date of the member's admission. These services are deemed to be inpatient services (for reimbursement purposes) and are thus included in the inpatient payment.
- **Adjudicate** – A determination by the Care Management Organization of the outcome of a health care claim submitted by a health care provider. Claims may pay, deny, or in some cases have an alternative adjudication outcome.
- **Administrative Law Hearing** – The appeal process administered by the State in accordance with O.C.G.A. Title 50, Chapter 13 and as required by Federal law, 42 CFR 200 et al, available to Members and Providers after they exhaust the Contractor's Grievance System and Complaint Process.
- **Apollo Managed Care Criteria and Guidelines** – Apollo criteria and guidelines are evidence-based criteria that use national standards and are continuously updated as new clinical information becomes available.
- **Appeal** – A formal process whereby a health care provider requests that a payor review the outcome of a claim previously submitted to the payor for reimbursement. This term is typically reserved for claims that were originally denied for payment or paid at a lower amount by the payor, and the provider believes a payment should be made or paid at a higher amount.
- **Automatic Assignment ("Auto-Assignment")** – The enrollment of an eligible person, for whom enrollment is mandatory, in a CMO plan chosen by DCH or its Agent. Also the assignment of a new member to a primary care physician chosen by the CMO Plan, pursuant to the provisions of this contract.
- **Autopayable ("Autopay" or "Presumptive") List** – A list of diagnosis or procedure codes that, when submitted on a claim by a provider to a payor, are automatically paid at a specified level. For purposes of this report, the term is typically utilized when discussing reimbursement for emergency room services.
- **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 or PeachCare for Kids™ members. CMOs

receive a per capita or capitation claim payment from DCH for each enrolled member.

- **Case Management** – A collaborative process that accesses, plans, implements, coordinates, monitors, and evaluates an individual’s health needs to ensure the individual receives necessary services in an effective, helpful, efficient, timely, and cost-effective way. For purposes of this document, case management is also referred to as care coordination.
- **Centers for Medicare and Medicaid Services (CMS)** – The federal agency under the Department of Health and Human Services responsible for the oversight and administration of the federal Medicare program, state Medicaid programs, and State Children’s Health Insurance Programs.
- **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.
- **Claims Processing System** – A computer system or set of systems that determine the reimbursement amount for services billed by the health care provider.
- **Clean Claim** – A claim received by the CMO for adjudication in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment or alteration by the health care service provider in order to be processed and paid by the CMO. Per the DCH CMO model contract, the following exceptions apply: 1) A Claim for payment of expenses incurred during a period of time for which premiums are delinquent; 2) A Claim for which Fraud is suspected; and 3) A Claim for which a Third Party Resource should be responsible.
- **Current Procedural Terminology (CPT) Codes** – A listing of five character alphanumeric codes for use in reporting medical services and procedures performed by health care providers. CPT codes generally begin with a numeric character.
- **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.
- **Diagnostic Services (“Diagnostic Testing”)** – Any medical procedures or supplies recommended by a physician or other licensed medical practitioner, within the scope of his or her practice under State law, to enable him or her to identify the existence, nature or extent of illness, injury, or other health deviation in a member.

- **Disease Management** – A system of coordinated health care interventions and communications for patients with certain illnesses.
- **Electronic Data Interchange (EDI)** – The electronic transfer of data between different companies using networks.
- **Emergency Medical Treatment and Active Labor Act (EMTALA)** – As it pertains to this report, a portion of the Consolidated Omnibus Budget Reconciliation Act of 1986 (OBRA '86) statute that outlines the patient's rights and guidelines to prevent denial of emergency treatment.
- **External Review** – An independent panel's examination of a denied claim at a member's request. The request follows a health plan or health insurance company denial of payment for health care services to a member based on issues of medical diagnosis, care or treatment, medical necessity, preexisting conditions, or services that the health insurance carrier considers to be experimental or investigational.
- **Filing Time Limit** – The maximum amount of time a provider can utilize to submit a claim to a health plan.
- **Georgia Families (GF)** – The risk-based managed care delivery program for Medicaid and PeachCare for Kids™ where the Department contracts with Care Management Organizations to manage the care of eligible members.
- **Global Fee** – A payment for a health care service that includes both the professional and technical components of the service. It could also refer to a period of time for which all services relating to an original service are included in the reimbursement for the original service.
- **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.
- **Fee-For-Service (FFS) Claim** - A document, either paper or electronic, from a health care provider detailing health care services. Claims are submitted to a payor by 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 all specific health care service(s) provided.
- **Hayes Inc. Independent Health Technology Assessment** – A company that provides a suite of products to assist clinical decision makers when reviewing new health care technology.

- **Health Care Common Procedure Coding System Level II Codes (HCPCS Codes)** – A listing of five character alphanumeric codes for use in reporting medical services, supplies, devices, and drugs utilized by health care providers.
- **Hospitalist Physician** – Physicians contracted, directly or indirectly, with a health plan. The hospitalist is responsible for certain Primary Care Services, which a PCP is otherwise obligated to provide, for members who present to or are admitted as inpatients to a hospital.
- **ICD-9-CM (ICD-9) Codes** – The International Classification of Diseases, Clinical Modification, 9th Revision is used to code and classify morbidity data from the inpatient and outpatient records, physician offices, and hospitals onto claims to submit to a health plan. Codes are classified as either diagnosis-specific or procedure-specific.
- **InterQual®** – A McKesson company product that includes a suite of decision support products used to classify the acuity of a patient.
- **Inter-rater Reliability** –traditionally refers to how well two or more raters agree and is derived from the correlation of different raters' judgments.
- **Managed Care Organization (MCO)** – A health organization that finances and delivers health care using a specific provider network and specific services and products. MCOs are similar to Care Management Organizations and the two terms are utilized throughout the report. MCO is generally utilized when referencing these organizations in states other than Georgia.
- **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.
- **Medical Necessity** – Based upon generally accepted medical practices based on conditions at the time of treatment, these services are:
 - Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible member's medical condition.
 - Compatible with the standards of acceptable medical practice in the community.
 - Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms.
 - Not provided solely for the convenience of the member or the convenience of the Health Care Provider or hospital.
 - Not primarily custodial care unless custodial care is a covered service or benefit under the members evidence of coverage.

- **Medical Record** – A document or series of documents that detail a patient's medical history, including at least the medical diagnoses, services rendered by health care providers, informed consent and treatment plan.
- **Member** – A person eligible for health care benefits from a health plan.
- **Member Handbook** – A document created by a health care payor that describes the health care covered services and payment policies for its' members.
- **Milliman Care Guidelines®** - Annually-updated, evidence-based clinical guidelines that span the continuum of care, including chronic care management.
- **Model Contract** – A contract between a state agency and contractor(s) that does not indicate any specific contractor, specific financial terms, and/or any other addendums that may exist between the state agency and any individual contractor.
- **National Committee for Quality Assurance (NCQA)** – An organization that sets standards, and evaluates and accredits health plans and other managed care organizations.
- **Outpatient Services** – Medical procedures, surgeries, or tests that are done in a qualified medical center without the need for an overnight stay.
- **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.
- **Payor** – An entity that reimburses a health care provider a portion or the entire health care expenses of a patient for whom the entity is financially responsible.
- **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.
- **Pended (or Pend or Suspended) Claim** – A claim that has been submitted to the health plan for reimbursement but has not been adjudicated. The claim is typically in this status so that the health plan may review additional information regarding the services provided prior to adjudicating the claim.
- **Physician Incentive Plan (PIP)** – Any compensation arrangement between a contractor and a physician or physician group that may directly have the effect of reducing or limiting services furnished to members.

- **Post Stabilization Services** – Covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or to improve or resolve the member’s condition.
- **Presumptive List** – See “Autopayable List”.
- **Primary Care Physician (PCP)** – A physician who provides continuing care to a member.
- **Prior Authorization (Authorization, PA, or Pre-Certification)** – An approval given by a health care payor to a health care provider before a health care service is performed, that allows the provider to perform a specific health care service for a patient who is the financial responsibility of the payor with the understanding that the payor will reimburse the provider for the service.
- **Professional Services Claim (Professional Claim)** – A health care claim for reimbursement of services provided by a physician or other non-institutional provider.
- **Proposed Action** – The proposal of an action for the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure of the CMO to act within the time frames provided in 42 CFR 438.408(b).
- **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.
- **Provider Number (or Provider Billing Number)** – An alphanumeric code utilized by health care payors to identify providers for billing, payment, and reporting purposes.
- **Prudent Layperson** – A standard used to define what is or is not an emergency medical condition. The standard is determined by asking, “would a reasonable person, excluding the patient, believe that the patient’s health care condition requires emergency medical care?”
- **Quality Improvement** – An approach to the study and improvement of the processes of providing health care services to meet the needs of members.
- **Reconsideration** – A process whereby a health care provider requests that a payor review the outcome of a claim previously submitted to the payor for reimbursement. This term is typically reserved for claims that were originally reimbursed by the payor, however the provider disagrees with the amount paid.

- **Recoupment** – Repayment of an overpayment, either by a payment from the provider or an amount withheld from the payment on a claim.
- **Referral** – A request by a PCP for a member to be evaluated and/or treated by a different physician, usually a specialist.
- **Rehabilitation Services** – Any service in which an individual is taught the skills necessary to achieve specific goals that pertain to that individual's improved functioning in his/her vocational, social, and/or daily living environment.
- **Remittance Advice (RA)** – A document provided by a health care payor to a health care provider that lists health care claims billed by the provider to the payor and explains the payment (or denial) of those claims.
- **Resolution** – The outcome of an issue, disagreement, problem, or situation in which all parties agree that the issue, disagreement, problem, or situation no longer requires action.
- **Revenue Codes** – A listing of three digit numeric codes utilized by institutional health care providers to report a specific room (e.g. emergency room), service (e.g. therapy), or location of a service (e.g. clinic).
- **State Fair Hearing** – See “Administrative Law Hearing”.
- **Technical Component Claim** – A health care claim for reimbursement of the overhead portion of a health care service.
- **Triage** – The process of reviewing a patient’s condition to determine the medical priority and the need for emergency treatment.
- **Triage Rate** – The reimbursement rate paid to a provider when a patient enters the emergency room but is deemed to not be in need of emergency care.
- **Turn Around Time (TAT)** – Amount of time between the receipt of a claim and the adjudication of the claim by a payor. State mandates and/or prompt pay laws dictate minimum time frames related to this process.
- **Uniform Billing (UB or UB-92 or 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.

- **Utilization Management** – A service performed by the contractor which seeks to assure that covered services provided to members are in accordance with, and appropriate under, the standards and requirements established by the contractor, or a similar program developed, established or administered by DCH.
- **Utilization Review (UR)** - Evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective review.

TABLE OF ACRONYMS

CFR	Code of Federal Regulations
CMO	Care Management Organization
CMS	Centers for Medicare & Medicaid Services
CT or CAT Scan	Computed Tomography
DRG	Diagnosis Related Group
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ER	Emergency Room
FFS	Fee-for-Service
GF	Georgia Families
HIPAA	Health Insurance Portability and Accountability Act
MCO	Managed Care Organization
MRA	Magnetic Resonance Angiogram
MRI	Magnetic Resonance Imaging
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
PA	Prior Authorization
PET	Positron Emission Tomography
PCP	Primary Care Provider
QAPI	Quality Assessment Performance Improvement
SPECT	Single Photon Emission Computed Tomography
TDD	Telecommunication Device for the Deaf
UM	Utilization Management
UR	Utilization Review

State Agencies

Florida	Agency for Health Care Administration (AHCA)
Georgia	Department of Community Health (DCH)
Indiana	Family and Social Services Administration Office of Medicaid Policy and Planning (OMPP)
Michigan	Department of Community Health (DCH)
Missouri	Missouri Healthnet Division
Pennsylvania	Department of Public Welfare (DPW)
Virginia	Department of Medical Assistance Services (DMAS)

EXECUTIVE SUMMARY

In July 2005, the Georgia Department of Community Health (DCH or Department) contracted with AMERIGROUP Community Care (AMGP), Peach State Health Plan (PSHP) and WellCare of Georgia (WellCare), (hereinafter referenced as “CMOs”) to provide health care services under the Georgia Families care management program. This risk-based managed care program is designed to bring together private health plans, health care providers, and patients to work proactively to improve the health status of Georgia’s Medicaid and PeachCare for Kids™ members. Approximately 600,000 members in the Atlanta and Central regions of the state began receiving health care services through Georgia Families on June 1, 2006. Georgia Families was expanded statewide to the remaining four regions, and approximately 400,000 additional members, on September 1, 2006.

Following the implementation by DCH of the Georgia Families program, hospitals and other providers began reporting negative experiences with the Georgia Families care management program. In particular, providers reported concerns with claims adjudication by the CMOs. These concerns were reported to the CMOs, the Department of Community Health, members of the Georgia General Assembly, the Office of the Governor, and to the hospital and other provider industry associations.

In part due to these provider concerns, the Department of Community Health engaged Myers and Stauffer LC to study and report on specific aspects of the GF program, including selected GF policies and procedures. The initial phase of the engagement includes an analysis of hospital related issues, claims payment and denial issues, and a review of certain GF and CMO policies and procedures.

The scope of our analyses was developed by the Department of Community Health considering the issues and concerns raised by the hospital provider industry. The report includes the following four sections:

- I. Comparison of the GF Model Contract to Other State Medicaid Managed Care Contracts
- II. Comparison of the GF Model Contract Requirements to the Written Policies and Procedures of the Georgia CMOs
- III. Comparison of GF CMO Written Policies and Procedures to Policies and Procedures to Medicaid MCOs in Other States
- IV. Analysis of the Regulatory and Contractual Requirements of Reimbursement for Emergency Medical Services – Completed by Krieg Devault LLP

Myers and Stauffer analyzed the documentation provided by the three CMOs operating in Georgia and available online documentation to confirm if their policies and procedures appeared to meet the contractual requirements set forth in the GF model contract. Our assessment did not include confirmation of the CMO's operational practice of the procedures as written. Our findings are based on the documentation provided to us by the CMOs and the information available online. There may be other information regarding the CMOs' practices that was not available to us.

In addition to the analyses completed by Myers and Stauffer, applicable to this report only, we engaged the law firm of Krieg Devault LLP to assist us with the analysis of the federal prudent layperson standard and certain other contractual requirements. A summary of the analysis completed by Krieg Devault LLP is included in Section IV of this report while the full analysis is included in Exhibit F.

SECTION I

COMPARISON OF GF MODEL CONTRACT TO OTHER STATE MEDICAID MANAGED CARE CONTRACTS

The states included in our analysis are Florida, Indiana, Michigan, Missouri, Pennsylvania, and Virginia. Please refer to Exhibit A for the list of Medicaid managed care health plans contracted in each of the six states included in this analysis.

Nine specific contractual provisions from the GF model contract were identified for review and comparison with the six other state Medicaid managed care contracts. Best practices related to those provisions that were identified are listed below:

- **Provider Complaint System**
 - Georgia requires the contractor to provide a written notice of adverse action to the provider informing the provider of their right to request an administrative law hearing.
 - Pennsylvania requires the managed care contractor to establish a committee comprised of at 25% health care providers/peers to process formal provider appeals.
 - Pennsylvania also requires detailed and frequent reports from the contractor regarding appeals statistics.
 - Four of the 7 states, including Georgia, require an expedited appeal process.
- **Disease Management**
 - Georgia requires the development of four specific disease management programs by the contractor.
 - Three of the other seven state managed care contracts include specific requirements for the establishment of disease management programs.

- Indiana requires the managed care contractor to develop one specific disease management program, but includes a frequent reporting requirement regarding the efficacy and results of the program.
- Virginia is the most rigorous of the seven states we compared, requiring the development of a minimum of five disease management programs and including provisions for reporting prior to implementation, as well as very detailed annual reporting of program results.
- Quality Improvement – General
 - Georgia, as in other states, has standard quality improvement guidelines, including committee requirements and reporting standards.
 - Indiana specifically requires the managed care contractor to develop incentive programs.
 - The Michigan managed care contract requires the contractor’s quality assurance committee to specifically include the contractor’s key management staff.
 - The Pennsylvania contract requires the contractor to provide detailed evidence of interdepartmental collaboration and coordination:
 - The Missouri managed care contract includes certain quality assurance functions, including a mechanism for providing feedback to providers and members.
- Quality Improvement - Quality Assessment Performance Improvement (QAPI) Program
 - The DCH care management organization model contract states that the CMO will have an ongoing QAPI program in accordance with federal regulations outlined in 42.CFR.438.240.
 - Florida is the only state of those we compared that requires the contractor to have in place a prescriptive peer review process.
 - The Michigan managed care contract requires the contractor to perform and report on its own effectiveness review.
 - Missouri requires its managed care contractor to designate a Quality Assessment and Improvement and Utilization Management Coordinator(s) who must perform a number of quality assurance program functions.
 - The Virginia managed care contract requires that the contractor ensure that its grievance system is tied to its quality improvement program.
- Quality Improvement - Performance Improvement Projects
 - The DCH care management organization model contract requires the contractor to perform five clinical performance improvement projects.
 - Florida requires its managed care contractors to perform no less than six performance improvement projects.
 - The Virginia managed care contract requires the contractor to complete twelve specific HEDIS performance studies.
- Quality Improvement - Other Requirements
 - The DCH care management organization model contract is the only state contract we reviewed to require its contractor to adopt three clinical practice guidelines and to meet a compliance standard.

- Virginia is the only state that we reviewed to require its contractor to conduct a provider satisfaction survey every other year, according to specific requirements, in addition to the 12 HEDIS requirements.

SECTION II

COMPARISON OF GF MODEL CONTRACT REQUIREMENTS TO WRITTEN POLICIES AND PROCEDURES OF THE GEORGIA CMOs

This analysis provides a comparison of selected GF model contract provisions to the policy and procedures used by the GF CMOs. The full report contains a complete listing and analysis of the specific comparisons.

Please refer to Exhibit B for the list of questions posed to the three GF CMOs. Responses to these questions are included in Exhibit C.

In the table below, we identify the specific contract requirement and indicate one of two designations for each CMO (1) (√) Requirement Met; or (2) (U) Unable to Confirm [that the Requirement was Met].

DCH Contract Provisions	AMGP	PSHP	WellCare
4.3.3 Member Handbook Requirements			
4.3.3.2.12 The medical necessity definition used in determining whether services will be covered;	√	√	√
4.3.3.2.13 A description of all utilization management requirements for services.	√	√	√
4.3.3.2.14 The policy on referrals for specialty care and for other covered services not provided by the member's PCP.	√	√	√
4.3.3.2.15 How to obtain services when the member is out of the service region and for after-hours coverage	√	√	√
4.3.3.2.19 A description of utilization review policies and procedures used by the Contractor	√	U	√
4.3.3.2.24 Information on the extent to which, and how, after-hours and emergency coverage are provided (see report for specific requirements)	√	√	U
4.6.1 Emergency Services			
4.6.1.1 Emergency Services (ES) shall be available twenty-four (24) hours a day, seven (7) Days a week to treat an Emergency Medical Condition (EMC).	√	√	√
4.6.1.2 An EMC shall not be defined or limited based on a list of diagnoses or symptoms. Definition of an EMC also listed in 4.6.1.2.	√	√	√
4.6.1.3 ES shall be covered when provided by a qualified provider, regardless of network participation status, and prior authorization is not required. In addition, the contractor is required to pay for all medically necessary services until the member is stabilized and any screening examination performed to determine if an emergency medical condition exists is also a coverage requirement.	√	√	√
4.6.1.4 requires that a CMO base coverage decisions for ES on the severity of the symptoms at the time of presentation and shall cover ES when the presenting symptoms are of sufficient severity to constitute an EMC in the judgment of a prudent layperson.	U	√	U
4.6.1.6 The Contractor shall not retroactively deny a Claim for an emergency screening examination because the Condition, which appeared to be an EMC under the prudent layperson standard, turned out to be non-emergency in nature. If an emergency screening examination leads to a clinical determination by the examining physician that an actual EMC does not exist, then the determining factor for payment liability shall be whether the Member had acute symptoms of sufficient severity at the time of presentation. In this case, the Contractor shall pay for all screening and care services provided. Payment shall be at either the rate negotiated under the Provider Contract, or the rate paid by DCH under the Fee for Service Medicaid program.	√	√	√
4.6.1.7 The Contractor may establish guidelines and timelines for submittal of notification regarding provision of ES, but, the Contractor shall not refuse to cover an ES based on the emergency room Provider, hospital, or fiscal agent's failure to notify the Member's PCP, CMO plan representative, or DCH of the Member's screening and treatment within said timeframes.	√	U	U
4.6.1.8 When a representative of the Contractor instructs the Member to seek ES the Contractor shall be responsible for payment for the Medical Screening examination and for other Medically Necessary ES, without regard to whether the Condition meets the prudent layperson standard.	√	√	U
4.6.2 Post-Stabilization Services			
4.6.2.1 The Contractor shall be responsible for providing Post-Stabilization care services twenty-four (24) hours a day, seven (7) days a week, both inpatient and outpatient, related to an EMC, that are provided after a Member is stabilized in order to maintain the stabilized Condition, or, pursuant to 42 CFR 438.114(e), to improve or resolve the Member's Condition.	U	U	√

DCH Contract Provisions	AMGP	PSHP	WellCare
4.6.2.2 The Contractor shall be responsible for payment for Post-Stabilization Services that are Prior Authorized or Pre-Certified by an In-Network Provider or organization representative, regardless of whether they are provided within or outside the Contractor's network of Providers.	√	√	√
4.6.2.4 The Contractor is financially responsible for Post-Stabilization Services obtained from any Provider, regardless of whether they are within or outside the Contractor's Provider network, that are not prior authorized by a CMO plan Provider or organization representative but are administered to maintain, improve or resolve the Member's stabilized Condition if: (See report for specific requirements)	U	√	√
4.6.2.5 The Contractor's financial responsibility for Post-Stabilization Services it has not approved will end when: (see report for specific requirements).	U	√	√
4.6.2.6 In the event the Member receives Post-Stabilization Services from a Provider outside the Contractor's network, the Contractor is prohibited from charging the Member more than he or she would be charged if he or she had obtained the services through an In-Network Provider.	U	U	√
4.9.2.1 The Contractor shall issue a Provider Handbook to all network Providers which shall include:			
4.9.2.1.3 Emergency Service responsibilities;	√	√	√
4.9.2.1.7 Medical Necessity standards and practice guidelines;	√	√	√
4.9.2.1.11 Prior Authorization, Pre-Certification, and Referral procedures;	√	√	√
4.9.5 Toll-Free Telephone Hot Line			
4.9.5.5. Pursuant to OCGA 30-20A-7.1, the telephone hotline shall be staffed twenty-four (24) hours a day, seven (7) days a week to respond to Prior Authorization and Pre-certification requests.	√	√	U
4.11 Utilization Management and Care Coordination Responsibilities:			
4.11.1.1 (includes 4.11.1.1.1, 4.11.1.1.2, 4.11.1.1.3, 4.11.1.1.4) The Contractor shall provide assistance to Members and Providers to ensure the appropriate Utilization of resources, using the following program components: (see report for specific requirements)	√	√	√
4.11.1.1.1 Include protocols and criteria for evaluating Medical Necessity, authorizing services, and detecting and addressing over-Utilization and under-Utilization.	√	√	√
4.11.1.1.2 Address which services require PCP Referral or Prior-Authorization; how requests for initial and continuing services are processed, and which services will be subject to concurrent, retrospective or prospective review.	√	√	√
4.11.1.1.3 Describe mechanisms in place that ensure consistent application of review criteria for authorization decisions.	√	√	√
4.11.1.1.4 Require that all Medical Necessity determinations are made in accordance with DCH's Medical Necessity definition as stated in Section 4.5.4.	U	U	U
4.11.2.1 The Contractor shall not require Prior Authorization or Pre-Certification for Emergency Services, Post-Stabilization Services, or Urgent Care services.	√	√	√
4.11.2.2 The Contractor shall require Prior Authorization and/or Pre-Certification for all non-emergent and non-urgent inpatient admissions except for normal newborn deliveries.	√	√	√
4.11.2.5 Requirements for timeframes for standard, expedited, and retrospective requests, as well as, extension timeframes listed.	√	√	√
4.11.3.1 The Contractor may require that Members obtain a Referral from their PCP prior to accessing non-emergency specialized services.	√	√	√
4.11.3.2 (includes 4.11.3.2.1, 4.11.3.2.2, 4.11.3.2.3, 4.11.3.2.4) In the Utilization Management Policies and Procedures discussed in Section 4.11.1.1, the Contractor shall address:			
4.11.3.2.1 When a Referral from the Member's PCP is required;	√	√	√

DCH Contract Provisions	AMGP	PSHP	WellCare
4.11.3.2.2 How a Member obtains a Referral to an In-Network Provider or an Out-of-Network Provider when there is no Provider within the Contractor's network that has the appropriate training or expertise to meet the particular health needs of the Member;	√	√	√
4.11.3.2.3 How a Member with a Condition which requires on-going care from a specialist may request a standing Referral	√	√	√
4.11.3.2.4 How a Member with a life-threatening Condition or disease which requires specialized medical care over a prolonged period of time may request and obtain access to a specialty care center.	√	√	√
4.14.3 Proposed Action			
4.14.3.1 All Proposed Actions shall be made by a physician, or other peer review consultant, who has appropriate clinical expertise in treating the Member's Condition or disease.	√	√	√
4.14.3.3 (includes 4.14.3.3.1-7) Lists what information must be in a notice of Proposed Action.	√	√	√
4.14.3.4 (includes 4.14.3.4.1 , 4.14.3.4.4 , 4.14.3.4.5) The Contractor shall mail the Notice of Proposed Action within the following timeframes:			
4.14.3.4.1 For termination, suspension, or reduction of previously authorized Covered Services at least ten (10) Calendar Days before the date of Proposed Action or not later than the date of Proposed Action in the event of an exception. Exceptions listed in 4.14.3.4.1.	U	√	U
4.14.3.4.4 If the Contractor extends the timeframe for the decision and issuance of notice of Proposed Action according to Section 4.11.2.5, the Contractor shall give the Member written notice of the reasons for the decision to extend Grievance if he or she disagrees with that decision.	√	√	√
4.14.3.4.5 For authorization decisions not reached within the timeframes required in Section 4.11.2.5 for either standard or expedited Service Authorizations, Notice of Proposed Action shall be mailed on the date the timeframe expires, as this constitutes a denial and is thus a Proposed Action.	√	√	U
Provider Complaint			
4.9.7.5.1 - Allow Providers forty-five (45) Calendar Days to file a written complaint;	√	√	√
4.9.7.6 In the event the outcome of the review of the Provider Complaint is adverse to the Provider, the Contractor shall provide a written Notice of Adverse Action to the Provider.	√	U	√
Administrative Policies			
4.16.1.3 At a minimum, the Contractor shall run one (1) Provider payment cycle per week, on the same day each week, as determined by the Contractor.	√	√	√
Electronic Data Interchange (EDI)			
4.16.1.5 The Contractor shall encourage that its Providers, as an alternative to the filing of paper-based Claims, submit and receive Claims information through electronic data interchange (EDI). (See report for specific requirements)	√	√	√
Capacity of Plan			
4.8.14.1 The Contractor shall maintain written policies and procedures for the Credentialing and Re-Credentialing of network Providers. (See report for specific requirements)	√	√	√
4.3.10.1 The Contractor is required to provide oral translation services of information to any Member who speaks any non-English language regardless of whether a Member speaks a language that meets the threshold of a Prevalent Non-English Language.	√	√	√
4.13.2.1.11 Inclusion of information about Fraud and Abuse identification and reporting in Provider and Member materials.	√	√	√

DCH Contract Provisions	AMGP	PSHP	WellCare
Adjudication of Third Party Payments			
8.4.1 Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the Health Care expenses of the Member.	√	√	√
Timeliness Edits			
4.16.1.12 The Contractor may deny a Claim for failure to file timely. (See report for specific requirements)	√	√	√
Recoupment Information			
4.10.4.5 Upon receipt of notice from DCH that it is due funds from a Provider, the Contractor shall reduce payment to the Provider for all claims submitted by that Provider by one hundred percent (100%), or such other amount as DCH may elect, until such time as the amount owed to DCH is recovered. (See report for specific requirements)	U	√	√

In summary, we compared sixty-five DCH Model contract requirements with the policies and procedures of each of the CMOs. Eighty-three percent of the Model contract requirements reviewed were located in the available documentation for PSHP. We were also able to locate 82 percent of the Model contract requirements in the available documentation for WellCare and 65 percent in the available documentation for AMGP.

SECTION III

COMPARISON OF GF CMO WRITTEN POLICIES AND PROCEDURES TO MEDICAID CMOs IN OTHER STATES

This section provides a comparison of selected GA CMO policies and procedures to the policies and procedures of managed care organizations in other state Medicaid programs. Two of the key policy comparisons, prior authorization requirements and emergency services, are shown in tables below. The full report contains a complete listing and analysis of all of the specific comparisons. Please refer to Exhibit D for the list of questions posed to the Medicaid MCOs in other states.

In all cases, the comparison states implemented managed care utilizing a phased-in approach, for instance, expanding the coverage either by region or program area over a pre-determined period of time. The table below presents each state included in our comparison, their managed care implementation period, and the number of members transitioned from other programs to managed care during that period.

STATE	IMPLEMENTATION OF MANAGED CARE	APPROXIMATE MEMBERS TRANSITIONED
Florida	1982 ***	600,000
Georgia	June 2006 – September 2006	1,000,000
Indiana	1996 – 2005*	500,000
Michigan	October 1997 – April 1999**	880,000
Missouri	September 1995 – January 1997	250,000
Pennsylvania	February 1997***	900,000
Virginia	1996***	450,000

*Mandatory enrollment began in 2000

**Additional recipient groups have been in varying stages of implementation since this time.

***Based on current information, future managed care expansion is indeterminate.

The following table is a comparison of the prior authorization requirements by state and plan.

Table: Comparison of Prior Authorization Service Types by State and CMO/MCO

Service Type	Georgia			Florida					Indiana	Michigan			Missouri			Pennsylvania			Virginia			
	AMERIGROUP	Peach State	WellCare	AMERIGROUP	Personal Health Plan	United	Vista	WellCare (HealthEase and Staywell)	Anthem	MHS (Centene)	Great Lakes Health Plan	Health Plan of Michigan	Molina Healthcare of MI	Harmony Health Plan (WellCare)	HealthCare USA	Mercy CarePlus	Americhoice of PA	Gateway	Keystone Mercy	AMERIGROUP	Optima Family Care	VA Premier Health Plan
Cardiac Rehabilitation	√	√	√	√				√	√				√		√			√	√	√	√	
Diagnostic Testing	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Dialysis (outpatient)	√	√	√	√				√		√	√		√		√	√				√		√
Durable Medical Equipment	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Home HealthCare	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Hospice	√	√	√			√	√	√	√	√	√	√	√	√	√		√	√	√	√	√	
Hospital Admissions (elective)	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Observation stays			√			√	√	√		√	√	√		√	√	√		√			√	√

	Georgia			Florida					Indiana		Michigan			Missouri			Pennsylvania			Virginia		
Service Type	AMERIGROUP	Peach State	WellCare	AMERIGROUP	Personal Health Plan	United	Vista	WellCare (HealthEase and Staywell)	Anthem	MHS (Centene)	Great Lakes Health Plan	Health Plan of Michigan	Molina Healthcare of MI	Harmony Health Plan (WellCare)	HealthCare USA	Mercy CarePlus	Americhoice of PA	Gateway	Keystone Mercy	AMERIGROUP	Optima Family Care	VA Premier Health Plan
Occupational, Physical and Speech therapies	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Out of Plan Care (non-emergency)	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Outpatient/Ambulatory Surgery	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Prosthetics/Orthotics	√	√		√	√	√	√	√	√	√	√	√	√	√	√	√	√		√	√	√	
Skilled Nursing Facility	√	√	√			√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	
Urgent Care Center																						

Notes:

1. The checkmark means there is some degree of Prior Authorization required, including only for certain place of services.
2. If Blank, either information not found, service is not listed as a covered benefit or service is listed as not requiring Prior authorization (may still require PCP referral).

Table: Comparison of Emergency Room Payment Policies by State and CMO/MCO

	Georgia			Florida				Indiana		Michigan			Missouri			Pennsylvania			Virginia				
	AMERIGROUP	Peach State	WellCare	AMERIGROUP	Personal Health Plan	United	Vista	WellCare (HealthEase and Staywell)	Anthem	MHS (Centene)	Great Lakes Health Plan	Health Plan of Michigan	Molina Healthcare of MI	Harmony Health Plan (WellCare)	HealthCare USA	Mercy CarePlus	Americhoice of PA	Gateway	Keystone Mercy	Plan 1 ³	Plan 2 ³	Plan 3 ³	
ICD-9/ CPT code list used to make ER payment determination	√	√	√	√			√		√	√						√					√		√
Claim reimbursed at full ER rate without medical review				√	√																		
Differential payments (e.g., Triage and full payments)	√	√	√				√						√			√	√			√			
ER Payment Determination Factors (Time/ Day of week/ Age of patient)		√								√												√	
Medical Review prior to payment									√	√													√

Notes:

1. The checkmark means information was available regarding emergency room payment determination.
2. If Blank, either information not found, or service is not listed as criteria utilized for emergency room payment determination.
3. State did not identify the names of these three plans.

SECTION IV

ANALYSIS OF THE REGULATORY AND CONTRACTUAL REQUIREMENTS OF REIMBURSEMENT FOR EMERGENCY MEDICAL SERVICES – COMPLETED BY KRIEG DEVAULT LLP

The report at Exhibit F analyzes the regulatory and contractual requirements of reimbursement for emergency medical services including federal law, regulation, and policies, and the Georgia Families model contract between the State of Georgia, Department of Community Health (“DCH”) and Care Management Organizations (“CMOs”) and contracts between health care providers and CMOs. Below is a summary of the key points included in that report. As used in this section, as well as the full report in Exhibit F, the term “we” refers to the law firm, Krieg DeVault LLP.

(1) Federal law, regulation and policies.

The Balanced Budget Act of 1997 set forth standards for Medicaid managed care companies to follow in paying providers for claims for emergency medical services provided to persons covered under Medicaid managed care plans. Essentially, the law required Medicaid managed care companies to cover emergency medical services without regard to prior authorization or the emergency care provider’s contractual relationship with the managed care company. The law also defined “emergency medical condition” to mean:

“...a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.”

Soon thereafter, the Department of Health and Human Services (“HHS”), Centers for Medicare and Medicaid Services (“CMS”) began issuing its interpretation of the meaning of the law through State Medicaid Director letters. The letters describe the requirements for States to implement in their contracts with Medicaid managed care companies. Several key points were clarified in the letters: (a) Emergency services were defined to mean a broad array of inpatient and outpatient services; (b) a Medicaid managed care company is to look to the presenting diagnosis and all other relevant information in determining whether a service constitutes an emergency medical condition according to the judgment of a prudent layperson; (c) a CMO is not to retroactively deny a claim for emergency services when the condition, which appeared for be emergent under the prudent layperson standard, is later determined to be non-emergent; (d) prior authorization is not to be required for treatment of emergency medical conditions; (e) payers may approve (but not deny) coverage on

the basis of an ICD-9 code; and (f) payers can not deny coverage on the basis of ICD-9 codes and then require the claim to be resubmitted as part of an appeals process.

Finally, federal regulations were promulgated providing further guidance regarding Medicaid managed care companies and their coverage of emergency medical services. The rules document the information provided in the State Medicaid Director letters and add clarification regarding a Medicaid managed care company's ability to require providers to notify the managed care company after providing emergency medical services, stating "Medicaid managed care companies may not refuse to cover emergency services based on the emergency room provider not notifying the enrollee's primary care provider, MCO, . . . or other State agency of the enrollee's screening and treatment within 10 calendar days of the presentation for emergency services."

(2) DCH's contract with the CMOs.

The next section of the report sets forth relevant provisions of the contract between DCH and the CMOs regarding the CMOs' coverage of emergency medical services. Please refer to the full report for the analysis of relevant provisions.

(3) Contracts between CMOs and Providers

We reviewed three provider contracts for each of the Georgia CMOs. The report contains a chart summarizing the relevant contractual provisions for each CMO relating to its coverage of emergency medical services and applicable appeals procedures found within each contract. Specifically, we reviewed four areas:

(a) Definition of Emergency Medical Services: We looked at each CMO's definition of emergency medical services and how the definition was utilized in processing emergency medical services claims. Generally, but not in all cases, we found each CMO to have a slightly different definition from the emergency medical services definition found in the DCH/CMO contract.

(b) Grievance/Complaints/Appeals and Arbitration procedures: We also looked at the contractual language regarding grievances, complaints, appeals and arbitration in each contract. We generally found that the contracts did not completely and adequately address available appeals processes for providers. In at least one contract, we found explicit language stating that providers had no appeals rights with respect to emergency medical services.

(c) Reimbursement for Emergency Medical Services: We reviewed the contractual language regarding reimbursement for emergency medical services. We found two of the three CMOs denied services as not being emergency medical services based upon lists of diagnosis codes or CPT codes, resulting in the automatic payment of certain diagnosis codes at the triage rate. These CMOs then required providers to

file reconsiderations or appeals of their claims for emergency medical services in order to have them processed for payment by the CMO at the emergency medical services rates.

(d) Notification by Providers of Patients Obtaining Emergency Medical Services. Finally, in two of the CMOs' contracts with providers, we found language indicating two CMOs' require providers to notify them of patients obtaining emergency medical services within 24 to 48 hours of the member's presentation at a provider's emergency department. It was unclear to us if these CMOs are conditioning payment of emergency medical services on providers by requiring notification within 24 to 48 hours of the member's presentation at a provider's emergency department. We were not able to confirm the CMOs' handling of these claims, specifically whether they deny the claims for notice.

Findings and Recommendations

The Myers and Stauffer LC findings and recommendations are included at the end of the full report. Please note that House Bill 1234 was passed by the 2007-2008 Georgia General Assembly on April 4, 2008, and was signed into law by Governor Perdue on May 13, 2008. Many of the provisions of House Bill 1234 appear to address the observations, findings, and recommendations included in this report. In addition, the Department of Community Health has informed us that they have incorporated the provisions of House Bill 1234 and many of our recommendations into the most recent CMO contract.

DCH AND CMO RESPONSES TO FINDINGS

Both DCH and each of the CMOs have prepared responses to the findings listed above. Please refer to Exhibits G through J for the complete responses.

BACKGROUND

In July 2005, the Georgia Department of Community Health (DCH or Department) contracted with AMERIGROUP Community Care (AMGP), Peach State Health Plan (PSHP) and WellCare of Georgia (WellCare), (hereinafter referenced as “CMOs”) to provide health care services under the Georgia Families care management program. This risk-based managed care program is designed to bring together private health plans, health care providers, and patients to work proactively to improve the health status of Georgia’s Medicaid and PeachCare for Kids™ members. Approximately 600,000 members in the Atlanta and Central regions of the state began receiving health care services through Georgia Families on June 1, 2006. Georgia Families was expanded statewide to the remaining four regions, and approximately 400,000 additional members, on September 1, 2006.

The objective of the Georgia Families program is to strengthen the state’s health care system by allowing members the option of choosing a health plan that best suits their needs; providing health education and prevention programs; and assisting members find doctors and specialists when necessary. When participating in the Georgia Families program, members are assigned a primary care provider, in part, to establish a medical home and to improve continuity and coordination of care.

Under the Georgia Families program, Medicaid and PeachCare For Kids™ members are eligible for many of the same health care services they received under the traditional fee-for-service Medicaid and PeachCare For Kids™ programs. They may also be eligible for additional services offered by the care management organizations.

DCH’s contract with the CMOs delineates the requirements to which each CMO must adhere, which are summarized below.

- The covered benefits and services that must be provided to the Medicaid and PeachCare For Kids™ members.
- The provider network and service requirements for the CMOs.
- Medicaid and PeachCare For Kids™ enrollment and disenrollment requirements.
- Allowed and disallowed marketing activities.
- General provider contracting provisions.
- Quality improvement guidance.
- Reporting requirements and other areas of responsibility.

As noted, each coverage region has at least two CMOs participating, while the Atlanta region includes all three plans.

Within each region, a participating CMO is required to build a network of health care providers sufficient to provide access to necessary services for its members. CMOs and providers develop contractual relationships, negotiating payment rates specific to each CMO and provider. Generally, CMOs reimburse hospitals with which they contract at rates that are a negotiated percentage above the Medicaid fee-for-service payment structure. The contracts between a CMO and its other non-hospital network providers are generally structured in a similar manner, with the exception of the negotiated payment rates, which typically vary by provider type. Some policy variations may also exist in the various contracts between CMOs and providers. For example, contracts may differ among plans and providers on the number of days a provider has to file a claim for reimbursement after a health care service is provided. Contracts between the CMO and provider are generally effective for one year with subsequent automatic renewals. Contracts typically may be terminated by either party upon receipt of a written notice if terminated for reasons other than a breach of contract.

PROJECT PURPOSE

Following the implementation by DCH of the Georgia Families program, hospitals and other providers began reporting negative experiences with the Georgia Families care management program. In particular, providers reported concerns with claims adjudication by the CMOs. These concerns were reported to the CMOs, the Department of Community Health, members of the Georgia General Assembly, the Office of the Governor, and to the hospital and other provider industry associations.

In part due to these provider concerns, the Department of Community Health engaged Myers and Stauffer LC to study and report on specific aspects of the GF program, including certain issues presented by providers, selected claims paid or denied by CMOs, and selected GF policies and procedures. The initial phase of the engagement includes an analysis of hospital related issues, claims payment and denial issues, and a review of certain GF and CMO policies and procedures. Subsequent phases of the engagement will include similar reviews related to other provider categories.

SCOPE OF REPORT

The scope of our analyses was developed by the Department of Community Health considering the issues and concerns raised by the hospital provider industry. The report includes the following four sections:

- I. Comparison of the GF Model Contract to Other State Medicaid Managed Care Contracts
- II. Comparison of the GF Model Contract Requirements to the Written Policies and Procedures of the Georgia CMOs
- III. Comparison of GF CMO Written Policies and Procedures to Policies and Procedures to Medicaid MCOs in Other States
- IV. Analysis of the Regulatory and Contractual Requirements of Reimbursement for Emergency Medical Services - Completed by Krieg Devault LLP

Myers and Stauffer analyzed the documentation provided by the three CMOs operating in Georgia and available online documentation to confirm if their policies and procedures met the contractual requirements set forth in the GF model contract. Our assessment did not include confirmation of the CMO's operational practice of the procedures as written. Our findings are based on the documentation provided to us by the CMOs and the information available online. There may be other information regarding the CMOs' practices that was not available to us.

In consultation with the Department of Community Health, 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".

In addition to the analyses completed by Myers and Stauffer, applicable to this report only, we engaged the law firm of Krieg Devault LLP to assist us with the analysis of the federal prudent layperson standard and certain other contractual requirements. A summary of the research and analysis completed by Krieg Devault LLP is included in Section IV of this report while the full analysis is included in Exhibit F.

Other reports regarding hospital providers' claim experience will be issued at a later date. You may also refer to our prior report of Georgia Families Hospital

Issues and Concerns dated January 14, 2008. This report is available on DCH's website at:

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

POLICY AND PROCEDURE ANALYSIS

SECTION I

COMPARISON OF GF MODEL CONTRACT TO OTHER STATE MEDICAID MANAGED CARE CONTRACTS

We compared the model contracts of six states with Medicaid managed care plans to the contract between the three Georgia Medicaid CMOs and DCH. DCH has a single model contract that is utilized between DCH and each of the three CMOs.

The states included in our analysis are Florida, Indiana, Michigan, Missouri, Pennsylvania, and Virginia. These states were selected for inclusion in this comparison based on the following factors:

- Common ownership by one of the parent companies of the three Georgia CMOs: AMGP, PSHP, and WellCare.
- Member enrollment volume similar to GF.
- Benefit packages similar to the GF CMO plans.
- Mandatory (rather than voluntary) enrollment into managed care.
- Health plan provides coverage in large geographic area or in multiple geographic areas.
- The administration of the managed care plan is performed by a privately owned-company rather than by a governmental entity.

Please refer to Exhibit A for the list of Medicaid managed care health plans contracted in each of the six states included in this analysis.

The Medicaid managed care contracts utilized for these analyses were obtained directly from State Medicaid Agencies or from documents available on the states' websites. Each document was analyzed for similarities and comparability with the GF model contract.

We selected nine key areas of the GF model contract to compare to the contract provisions of the six aforementioned States, which included the following categories:

- A. Provider Complaints Process
- B. Case Management/Care Coordination
- C. Disease Management
- D. Quality Improvement – General

- E. Quality Improvement – Quality Assessment Performance Improvement (QAPI) Program
- F. Quality Improvement – Performance Improvement Projects
- G. Quality Improvement – External Quality Improvement
- H. Quality Improvement – Other Requirements
- I. Physician Incentive Plan

ANALYSIS

Each of the nine provisions analyzed is listed separately below.

A. Provider Complaint System

The provider complaint process is a method that allows providers to file a complaint, reconsideration, grievance, appeal or expedited review. Information for this provision is separated into four categories: 1) state approval requirements; 2) standards for publication of procedures; 3) process; and 4) reporting requirements.

The Georgia contract mandates that complaint policies be included in the provider manual and for CMOs to submit a quarterly report on provider complaints to include at minimum: the number of complaints by type, the assistance provided and the administrative disposition of case.

Georgia's process is similar to Florida's process in that they each allow the provider 45 days to file a complaint and require dedicated staff assigned to handle and respond to complaints and appeals. Georgia and Virginia both require the provider to exhaust the CMO internal appeal process before seeking additional recourse with the state.

Although all of the state contracts contain a basic process for providers to file appeals, most of the states in our comparison assign the initial steps/informal appeals process to the contractor (MCO) and then accept responsibility for the remaining steps. For the State of Michigan, however, responsibility for the entire appeals process is assigned to the managed care contractor, including arbitration and final resolution of the matter.

From the Michigan DCH managed care organization model contract:

“Contractor must develop and maintain an appeal system to resolve claim and authorization grievances and appeals in a timely manner. Contractor will cooperate with providers who have exhausted the Contractor's internal appeal process by entering into arbitration or other alternative dispute resolution process. When a provider requests arbitration, Contractor is required to participate in a binding arbitration process. DCH will provide a list of neutral arbitrators that can be made available to resolve billing disputes. These arbitrators will be organizations with the appropriate expertise to analyze medical claims and supporting documentation available from medical record reviews

and determine whether a claim is complete, appropriately coded, and should or should not be paid. A model agreement will be developed by DCH that both parties to the dispute will be required to sign. This agreement will specify the name of the arbitrator, the dispute resolution process, a timeframe for the arbitrator's decision, and the method of payment for the arbitrator's fee. The party found to be at fault will be assessed the cost of the arbitrator. If both parties are at fault, the cost of the arbitration will be apportioned."

Pennsylvania requires the managed care contractor to establish a committee made up of at least one-fourth of health care providers/peers to process formal provider appeals. Pennsylvania also requires detailed and frequent reports from the contractor regarding appeals statistics as indicated in the following provisions:

"Establishment of a PH-MCO Committee to process formal provider disputes/appeals which must include:

- *At least ¼ of the membership must be composed of health care providers/peers;*
- *Committee members who have the authority, training, and expertise to address and resolve provider dispute/appeal issues;*
- *Access to data necessary to assist committee members in making decisions; and*
- *Documentation of meetings and decisions of the Committee.*

Contractor must submit quarterly Complaint, Grievance and Provider Appeals reports no later than 45 days from the end of the quarter that conform to the Department's and DOH's specifications, utilizing the Department's standardized report and including at a minimum: 1.) Total # complaints by level and nature of complaint and resolution; 2.) Total # of expedited complaints by level and nature of complaint and resolution; 3.) Total # grievances by level and nature of grievance and resolution; 4.) Total # expedited grievances by level and nature of grievance and resolution; 5.) Total # provider appeals by nature of issue and resolution."

B. Case Management/Care Coordination

Case Management is a collaborative process that accesses, plans, implements, coordinates, monitors, and evaluates an individual's health needs to ensure the individual receives necessary services in an effective, helpful, efficient, timely, and cost-effective manner. Information for this provision is separated into two categories: 1) requirements, and 2) state approval.

Four states, Georgia, Florida, Missouri, and Virginia, include fairly extensive case management/care coordination standards within their contracts, while the other three states include very little information on this topic.

In general, the results of our analysis revealed considerable variation between state contracts regarding specific case management requirements, standards, terms and functions. While there are some references of specific target

populations that should receive case management, none appear to emphasize case management of well-known high risk, high expense populations or conditions. As a result, there is not enough comparability to identify best practices in this area based on contract analysis only. A comprehensive analysis of the selected MCOs case management/care coordination programs, which would include an analysis of tools used for case management stratification and internal case management policies, would provide this information; however, this type of analysis is not included in the scope of this report.

C. Disease Management

Disease management is a system of coordinated health care interventions and communications for patients with certain illnesses, such as diabetes, asthma, and heart disease. Information for this provision is separated into three categories: 1) covered conditions; 2) other requirements; and 3) reporting.

Three of the state managed care contracts in our analysis include specific requirements for establishment of disease management programs.

Georgia requires the development of four specific disease management programs:

“At a time to be determined by DCH, Contractor shall develop disease management programs for individuals with chronic conditions. Contractor shall have programs for members with diabetes and asthma, and for at least two additional conditions:

- 1.) Perinatal case management*
- 2.) Obesity*
- 3.) Hypertension*
- 4.) Sickle cell disease*
- 5.) HIV/AIDS”*

Indiana requires the managed care contractor to develop one specific program, but includes a frequent reporting requirement regarding the efficacy and results of the program, which is not similarly included in other state contracts. This provision reads as follows:

“Contractor must develop one program: asthma disease management. OMPP reserves the right to require Contractor to have disease management programs for additional conditions, such as diabetes or childhood obesity in the future. Contractors are encouraged to implement disease management programs beyond those required.

Contractor must report at least quarterly to the OMPP regarding the efficacy and results of the program.”

Virginia’s disease management requirements appear to be the most rigorous of the states we compared, requiring development of a minimum of five disease

management programs, provisions for reporting prior to implementation, as well as very specific annual reporting of program results. The provisions state:

“A minimum of five programs that focus on improving the health status of enrollees diagnosed with:

Asthma;

Coronary artery disease (CAD);

Congestive heart failure (CHF);

COPD;

Diabetes; and

With a special focus on pediatric asthma and pediatric diabetes programs.

Contractor must supply to DMAS prior to implementation a description of each disease management program, outlining specific goals and benchmarks, and samples of materials to be sent to enrollees.

Program results must be reported annually to the Department and include prior year’s outcomes, including results of HEDIS and other performance measures.

Contractor shall provide separate reports for: 1.) Children with asthma; 2.)

Children with diabetes; 3.) Adults with asthma; and 4.) Adults with diabetes.”

D. Quality Improvement - General

Quality improvement is an approach to the study and improvement of the processes of providing health care services to meet the needs of members.

Information for this provision is separated into three categories: 1) goals and general requirements; 2) quality improvement committee; and 3) reporting requirements.

All of the state managed care contracts, including Georgia’s contract, contain general quality improvement requirements, guidelines, committee requirements and reporting standards. Several states, however, stood out for specific provisions that are not commonly shared among managed care contracts that we compared. For instance:

Indiana requires the managed care contractor to develop incentive programs:

“As a key component of its QMIP, Contractor will develop incentive programs for both providers and members that are based on OMPP-designated quality improvement targets, with the ultimate goal of improving the health outcomes of members.”

The Michigan managed care contract requires the contractor’s quality assurance committee to specifically include the contractor’s key management staff, possibly with the intent to assure that the quality assurance functions cross all departmental functions.

“The QIC must be comprised of Contractor staff, including but not limited to the quality improvement director and other key management staff, as well as health professionals providing care to enrollees.”

The Pennsylvania contract establishes a similar expectation, but goes on to require the contractor to provide specific evidence of interdepartmental collaboration and coordination:

“Contractor must provide evidence of ongoing collaboration and coordination between its QM and UM Departments and its SNU regarding quality initiatives, case management and/or Disease Management activities directed toward or involving care of special needs populations. Collaboration must include but not be limited to: quality improvement studies; UM referrals; discharge planning/case management; and identification of and outreach to recipients with special needs and special needs populations.”

The Missouri managed care contract includes specific quality assurance functions that include a mechanism for reporting back to providers and members:

“Contractor shall have a written quality assessment and improvement program composed of:

- a) *An internal system of monitoring, analysis, evaluation, and improvement of the delivery of care that includes care provided by all providers;*
- b) *Designated staff with expertise in quality assessment, utilization management and continuous quality improvement;*
- c) *Written policies and procedures for quality assessment, utilization management, and continuous quality improvement that are periodically analyzed and evaluated for impact and effectiveness;*
- d) *Results, conclusions, team recommendations, and implemented system changes which are reported to the Contractor’s governing body at least quarterly, and*
- e) *Reports that are evaluated, recommendations that are implemented when indicated, and feedback provided to providers and members.”*

E. Quality Improvement - Quality Assessment Performance Improvement (QAPI) Program

A QAPI program monitors, analyzes, evaluates and attempts to improve the delivery, quality and appropriateness of health care furnished to all members. Additionally, a QAPI also should include reporting and performance improvement projects focused on specific clinical and non-clinical areas.

The GF model contract states that the CMO must have an ongoing QAPI program in agreement with Federal regulations at 42 CFR 438.240.

Information included in this provision addresses specific program requirements. All of the states in the analysis, including Georgia, include specific requirements related to their quality improvement programs. Florida is, however, the only state

of those we compared that requires the contractor to have in place a prescriptive peer review process.

“Contractor shall have a Peer Review process which:

- a) Reviews a provider’s practice methods and patterns, morbidity/mortality rates, and all grievances filed against the provider relating to medical treatment.*
- b) Evaluates the appropriateness of care rendered by providers.*
- c) Implements corrective action(s) when Contractor deems it necessary to do so.*
- d) Develops policy recommendations to maintain or enhance the quality of care provided to enrollees.*
- e) Conducts reviews, which include the appropriateness of diagnosis and subsequent treatment, maintenance of a provider’s medical records, adherence to standards generally accepted by a provider’s peers and the process and outcome of a provider’s care.*
- f) Appoints a Peer Review Committee, as a Sub-Committee to the QIP Committee, to review provider performance when appropriate. The Medical Director or his/her designee shall chair the Peer Review Committee, and its membership shall be drawn from the provider network and include peers of the provider being reviewed.*
- g) Receive and review all written and oral allegations of inappropriate or aberrant service by a provider.*
- h) Educate enrollees and Contractor staff about the Peer Review process, so that enrollees and the Contractor staff can notify the Peer Review authority of situations or problems relating to providers.”*

The Michigan managed care contract requires the contractor to perform and report on its own effectiveness review:

“Contractor will conduct an annual effectiveness review of its QAPI program. The review must include analysis of whether there have been improvements in the quality of health care and services for enrollees as a result of quality assessment and improvement activities and interventions carried out by the contractor. The analysis should take into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives. Information on the effectiveness of the Contractor’s QAPI program must be provided annually to network providers and to enrollees upon request. Information on the effectiveness of Contractor’s QAPI program must be provided to DCH annually during the on-site visit and upon request.”

Missouri requires its managed care contractor to designate a Quality Assessment and Improvement and Utilization Management Coordinator(s) who must perform a number of specific quality assurance program functions. This is in contrast to the other states we compared, which assign quality assurance functions to the contractor’s Medical Director or quality assurance committee.

Finally, the Virginia managed care contract specifies that the contractor must ensure that its grievance system is tied to its quality improvement program. This ensures that the quality assurance program will be able to identify specific provider problems and undesirable trends through the grievance system that may not be as readily identifiable through other quality assurance processes.

F. Quality Improvement - Performance Improvement Projects

Performance improvement projects attempt to attain continuous quality improvement in health outcomes and member satisfaction by utilizing tools such as ongoing measurements or interventions. These tools are implemented and utilized in clinical and non-clinical care areas that are identified as areas that may need improvement and the health plan believes improvement can be achieved through these projects.

Information for this provision is separated into two categories: 1) description of the project(s) and 2) state approval requirements.

The GF model contract requires the contractor to perform five clinical performance improvement projects. This is in contrast to most of the other states we compared, which are not specific regarding the number and type of projects that must be performed. DCH's contract states:

“Contractor shall perform the following required clinical performance improvement projects, ongoing for the duration of the GHF contract period:

- *One in the area of health check screens*
- *One in the area of immunizations*
- *One in the area of blood lead screens*
- *One in the area of detection of chronic kidney disease*

Contractor shall perform one optional clinical performance improvement project from the following areas:

- *Coordination/continuity of care*
- *Chronic care management*
- *High volume conditions*
- *High risk conditions”*

Similarly, Florida requires their managed care contractors to perform no less than six performance improvement projects, but is not as specific as Georgia in the area of focus:

“Contractor shall perform no less than six Agency-approved PIPs.

- (1) Each PIP must include a statistically significant sample of enrollees.*
- (2) At least one of the PIPs must focus on language and culture, clinical health care disparities, or culturally and linguistically appropriate services.*
- (3) At least two of the PIPs must relate to behavioral health services.*
- (4) All PIPs by the Contractor must achieve, through ongoing measurements and intervention, significant improvement to the quality of care and service delivery, sustained over time, in both clinical care and non-clinical care areas*

that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

(5) The PIPs must be completed in a reasonable time period so as to allow the Contractor to evaluate the information drawn from them and to use the results of the analysis to improve quality of care and service delivery every year.”

Finally, the Virginia managed care contract requires the contractor to complete twelve specific HEDIS performance studies:

“Contractor shall at a minimum complete the following twelve HEDIS performance studies/measures. Contractor will assure annual improvement in its HEDIS scores until such time that the Contractor is performing at least the national average HEDIS benchmark. Thereafter, Contractor is to sustain at the national average or increase its performance:

- 1) Childhood immunization status*
- 2) Adolescent immunization status*
- 3) Breast cancer screening*
- 4) Prenatal and postpartum care*
- 5) Most current version HEDIS/CAHPS adult survey*
- 6) Well-child visits in the first 15 months of life*
- 7) Well-children visits in the third, fourth, fifth, and sixth year of life*
- 8) Adolescent well-care visit*
- 9) Comprehensive diabetes care (pediatric and adult ages 18-75)*
- 10) Asthma – appropriate use of medication (pediatric and adult)*
- 11) Beta blocker treatment after a heart attack*
- 12) Cholesterol management for patients with cardiovascular conditions.”*

G. Quality Improvement – External Quality Improvement

Per 42 CFR 438.310, an annual external quality review is required for contracting MCOs.

Per section 4.12.8.1 of the DCH contract,

DCH will contract with an External Quality Review Organization (EQRO) to conduct annual, external, independent reviews of the Quality outcomes, timeliness of, and access to, the services covered in this Contract. The Contractor shall collaborate with DCH’s EQRO to develop studies, surveys and other analytic activities to assess the Quality of care and services provided to Members and to identify opportunities for CMO plan improvement. To facilitate this process the Contractor shall supply data, including but not limited to Claims data and Medical Records, to the EQRO.

This provision is generally and comparably addressed by all state managed care contracts. Provisions appear to reflect specific standards required by Federal regulations, which focus on compliance rather than innovation or development of best practices.

H. Quality Improvement - Other Requirements

This provision includes practice guidelines, performance measures, and provider surveys all of which are designed to improve the quality of patient care.

Practice guidelines are developed to assist physicians and/or patients in making determinations regarding the screening, treatment or prevention of a particular disease or condition.

A commonly used tool to measure quality and performance is the Healthcare Effectiveness Data and Information Set (HEDIS). Some examples of HEDIS performance measures are asthma medication use, comprehensive diabetes care, and prenatal care.

The GF CMO model contract is the only state contract we analyzed that requires its contractor to adopt three clinical practice guidelines and meet a compliance standard. Specifically,

“Contractor shall adopt a minimum of three evidence-based clinical practice guidelines, one of which shall be for chronic kidney disease

Contractor shall disseminate the guidelines to all affected providers and shall encourage providers to utilize the guidelines and shall measure compliance with the guidelines until 90 percent or more of the providers are consistently in compliance.”

Virginia, as previously stated, requires its managed care contractor to complete the following twelve specific HEDIS performance measures:

“Contractor shall at a minimum complete the following twelve HEDIS performance studies/measures. Contractor will assure annual improvement in its HEDIS scores until such time that the Contractor is performing at least the national average HEDIS benchmark. Thereafter, Contractor is to sustain at the national average or increase its performance:

- 1) Childhood immunization status*
- 2) Adolescent immunization status*
- 3) Breast cancer screening*
- 4) Prenatal and postpartum care*
- 5) Most current version HEDIS/CAHPS adult survey*
- 6) Well-child visits in the first 15 months of life*
- 7) Well-children visits in the third, fourth, fifth, and sixth year of life*
- 8) Adolescent well-care visit*
- 9) Comprehensive diabetes care (pediatric and adult ages 18-75)*
- 10) Asthma – appropriate use of medication (pediatric and adult)*
- 11) Beta blocker treatment after a heart attack*
- 12) Cholesterol management for patients with cardiovascular conditions.”*

Additionally, Virginia is the only state that we analyzed to require its contractor to conduct a provider satisfaction survey every other year, according to specific requirements. Specifically,

“Contractor shall conduct a provider satisfaction survey every other year that is specific to Medicaid. The survey shall include a statistically valid sample of its participating Medicaid providers utilizing the latest version of the CAHPS survey available at the time the survey is conducted. Contractor shall submit a copy of the survey instrument and methodology to the Department. Contractor shall communicate the findings of the survey to the Department in writing within 120 days after conducting the survey. The written report shall also include identification of any corrective measures that need to be taken by Contractor as a result of the findings, a time frame in which such corrective action will be taken by Contractor and recommended changes as needed for subsequent use. The first survey shall be completed during the 2007-2008 contract year. Results of the first survey shall be submitted no later than October 1, 2008, and bi-annually thereafter.”

I. Physician Incentive Plan

A physician incentive plan is defined in the DCH contract as follows:

“Any compensation arrangement between a Contractor and a physician or physician group that may directly have the effect of reducing or limiting services furnished to Members.”

The DCH contract mandates the CMO disclose all physician incentives to DCH and provide reporting at the request of DCH. The CMO is also required to disclose physician incentive arrangements to members upon request.

Information for this provision is separated into four categories: 1) disclosure; 2) reporting; 3) risk/other requirements; and 4) limitations. All of the state Medicaid managed care contracts in this comparison include general physician incentive plan provisions.

SECTION II

COMPARISON OF GF MODEL CONTRACT REQUIREMENTS TO WRITTEN POLICIES AND PROCEDURES OF THE GEORGIA CMOs

This analysis provides a comparison of select GF model contract provisions to the policy and procedures used by the GF CMOs. The analyses include the following categories:

- A. Medical Management Policies
- B. Provider Complaints Process
- C. Administrative Policies and Procedures That Impact Claims Payment
- D. Electronic Data Interchange
- E. Emergency Department Payment Policies
- F. Claim Coding Requirements
- G. 72-hour Rule Policies
- H. Capacity of Local Health Plans to Address Provider Concerns
- I. Global Charges
- J. Adjudication of Claims With Third Party Payments
- K. Timeliness Edits/Admission Dates on Claims
- L. Recoupments and Repayments

The information in this section was derived from information obtained from provider and member manuals of the various health plans. However, the information contained in these documents appeared to indicate that in order to adequately address the above subjects and compare each of the policies and procedures desired, additional information would be needed from the CMOs. Therefore, a brief survey was developed and designed to solicit specific information from the health plans in the targeted areas.

Please refer to Exhibit B for the list of questions posed to the three GF CMOs. Responses to these questions are included in Exhibit C.

It is important to note that while a CMO may have met a particular contractual provision within its published policies, procedures and other documentation, we have not verified that the CMO is applying its own policies and procedures in its day-to-day operations. Conversely, if we indicate that we could not confirm that a CMO met the contractual requirement, the CMO may have additional information that if obtained, would have yielded a different conclusion.

In each section below, we identify the specific contract requirement and indicate one of three designations for each CMO (1) Requirement Met; or (2) Unable to Confirm [that the Requirement was Met].

ANALYSIS

A. Medical Management Policies

Our comparison of medical management policies was based on three subcomponents: member handbook; provider manual; and internal policies and procedures. The analysis of each component follows below.

1. Member Handbook Requirements

The medical management elements required by the GF model contract to be included in each CMO's member handbook are prescribed in sections 4.3.3.2.12-15, 19, and 24.

All three (3) CMOs met the requirements in sections 4.3.3.2.12-15.

4.3.3.2.12 - The Medical Necessity definition used in determining whether services will be covered;	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

4.3.3.2.13 - A description of all pre-certification, prior authorization or other requirements for treatments and services;	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

4.3.3.2.14 - The policy on Referrals for specialty care and for other Covered Services not furnished by the Member's PCP;	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

4.3.3.2.15 - Information on how to obtain services when the Member is out of the Service Region and for after-hours coverage;	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

For section 4.3.3.2.19, which states the contractor must include a description of utilization policies and procedures used in the member handbook, we were unable to locate this description in PSHP's member handbook and therefore, it does not appear that PSHP met this requirement. The required description was found in the WellCare and AMGP member handbooks.

4.3.3.2.19 - A description of Utilization Review policies and procedures used by the Contractor;	Requirement Met	Unable to Confirm
AMGP	√	
PSHP		√
WellCare	√	

For section 4.3.3.2.24, which contains several requirements related to emergency room services, it does not appear that WellCare expressly states in their member handbook that prior authorization is not required for emergency services. Requirements listed in section 4.3.3.2.24 were found in both PSHP and AMGP's member handbooks.

4.3.3.2.24 - Information on the extent to which, and how, after-hours and emergency coverage are provided, including the following:	Requirement Met	Unable to Confirm
<ul style="list-style-type: none"> i. What constitutes an Urgent and Emergency Medical Condition, Emergency Services, and Post-Stabilization Services; ii. The fact that Prior Authorization is not required for Emergency Services; iii. The process and procedures for obtaining Emergency Services, including the use of the 911 telephone systems or its local equivalent; iv. The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Services covered herein; and v. The fact that a Member has a right to use any hospital or other setting for Emergency Services; 		
AMGP	√	
PSHP	√	
WellCare		√

2. Provider Manual Requirements

The medical management elements required by the GF model contract to be included in the provider manual are prescribed in sections 4.9.2.1.3, 7, and 11.

All three (3) CMOs appear to have met all these requirements of including this information in their provider manuals.

4.9.2.1.3 - Emergency Service responsibilities;	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

4.9.2.1.7 - Medical Necessity standards and practice guidelines;	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

4.9.2.1.11 - Prior Authorization, Pre-Certification, and Referral procedures;	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

3. Post Stabilization Services

Myers and Stauffer requested from AMERIGROUP, PSHP, and WellCare, a description of each CMOs' policy for Post Stabilization services in order to determine if the required DCH Model contract language for Post Stabilization services was included.

PSHP responded on 3/28/08:

“Post-stabilization services do not require prior authorization for participating facilities/providers. Prior authorization for post-stabilization services is required for non-participating facilities/providers for the purpose of discharge planning and care coordination.”

For the post-stabilization requirements listed in 4.6.2, we were unable to locate 4.6.2.1 and 4.6.2.6 in any of the documentation provided to us by PSHP.

AMGP responded on 3/26/08:

“If the member is in the ER, and post-stabilization is performed within the ER or during an observation stay, no authorization is required by A[M]GP. If post-stabilization is required in an inpatient

setting, provider must notify A[M]GP within one business day for authorization of inpatient services. “

For the post-stabilization requirements listed in 4.6.2, AMGP met one of the five requirements. One of the requirements was partially met and the other three requirements were not found in the documentation provided to us by AMGP. Please refer to the tables below for the list of requirements.

WellCare provided their internal policy for Post Stabilization. WellCare’s policy for Post-Stabilization contained all contract requirements set forth by the GF CMO model contract.

4.6.2.1 - The Contractor shall be responsible for providing Post-Stabilization care services twenty-four (24) hours a day, seven (7) days a week, both inpatient and outpatient, related to an Emergency Medical Condition, that are provided after a Member is stabilized in order to maintain the stabilized Condition, or, pursuant to 42 CFR 438.114(e), to improve or resolve the Member’s Condition.	Requirement Met	Unable to Confirm
AMGP		√
PSHP		√
WellCare	√	

4.6.2.2 - The Contractor shall be responsible for payment for Post-Stabilization Services that are Prior Authorized or Pre-Certified by an In-Network Provider or organization representative, regardless of whether they are provided within or outside the Contractor’s network of Providers.	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

<p>4.6.2.4 - The Contractor is financially responsible for Post-Stabilization Services obtained from any Provider, regardless of whether they are within or outside the Contractor's Provider network, that are not prior authorized by a CMO plan Provider or organization representative but are administered to maintain, improve or resolve the Member's stabilized Condition if:</p> <p>4.6.2.4.1 The Contractor does not respond to the Provider's request for pre-certification or prior authorization within one (1) hour;</p> <p>4.6.2.4.2 The Contractor cannot be contacted; or</p> <p>4.6.2.4.3 The Contractor's Representative and the attending physician cannot reach an agreement concerning the Member's care and a CMO plan physician is not available for consultation. In this situation the Contractor shall give the treating physician the opportunity to consult with an In-Network physician and the treating physician may continue with care of the Member until a CMO plan physician is reached or one of the criteria in Section 4.6.2.5 are met.</p>	<p>Requirement Met</p>	<p>Unable to Confirm</p>
AMGP		√
PSHP	√	
WellCare	√	

<p>4.6.2.5 - The Contractor's financial responsibility for Post-Stabilization Services it has not approved will end when:</p> <p>4.6.2.5.1 An In-Network Provider with privileges at the treating hospital assumes responsibility for the Member's care;</p> <p>4.6.2.5.2 An In-Network Provider assumes responsibility for the Member's care through transfer;</p> <p>4.6.2.5.3 The Contractor's Representative and the treating physician reach an agreement concerning the Member's care; or</p> <p>4.6.2.5.4 The Member is discharged.</p>	<p>Requirement Met</p>	<p>Unable to Confirm</p>
AMGP		√
PSHP	√	
WellCare	√	

<p>4.6.2.6 - In the event the Member receives Post-Stabilization Services from a Provider outside the Contractor's network, the Contractor is prohibited from charging the Member more than he or she would be charged if he or she had obtained the services through an In-Network Provider.</p>	<p>Requirement Met</p>	<p>Unable to Confirm</p>
AMGP		√
PSHP		√
WellCare	√	

4. Toll-Free Telephone Hotline

The GF model contract requires in section 4.9.5.5 that each CMO have a toll-free telephone hotline staffed and available 24 hours a day, 7 days a week to respond to prior authorization and pre-certification requests and also a hotline available 7 am to 7 pm EST, Monday through Friday to respond to all other provider questions. AMGP and PSHP appear to have this information available, but it does not appear that WellCare included their hours of operation for prior authorization and pre-certification in their documentation.

4.9.5.5 - Pursuant to OCGA 30-20A-7.1, the telephone hotline shall be staffed twenty-four (24) hours a day, seven (7) days a week to respond to Prior Authorization and Pre-certification requests. This telephone hotline shall have staff to respond to Provider questions in all other areas, including the Provider complaint system, Provider responsibilities, etc. between the hours of 7:00am and 7:00pm EST Monday through Friday, excluding State holidays.	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare		√

5. Utilization Management

Section 4.11.1.1.3 of the GF CMO model contract requires the contractor to have a utilization management policy and procedure that describes the mechanisms in place to ensure consistent application of review criteria for authorization decisions. This requirement appears to be met by all three (3) CMOs who each have a policy on Inter-rater Reliability. We noted that WellCare’s inter-rater reliability is set at a 90 percent compliance threshold, while an 80 percent compliance threshold is set by AMGP and PSHP.

4.11.1.1.3- Describe mechanisms in place that ensure consistent application of review criteria for authorization decisions.	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

Section 4.11.1.1.4 of the GF model contract requires that all medical necessity determinations be made in accordance with DCH’s medical necessity definition as stated in Section 4.5.4. We are not able to confirm compliance with this contractual requirement without performing an internal chart audit of each CMO. The purpose of this section is to confirm that the CMOs state in their policies the medical necessity definition found in the GF model contract.

4.11.1.1.4- Require that all Medical Necessity determinations are made in accordance with DCH's Medical Necessity definition as stated in Section 4.5.4.	Requirement Met	Unable to Confirm
AMGP		√
PSHP		√
WellCare		√

We were able to locate this medical necessity definition in the provider manuals for WellCare and PSHP. The medical necessity definition used by AMGP appears to contain components from the GF CMO model contract definition stated in Section 4.5.4. However, there are additional items included in AMGP's definition that are noted below:

- “ Reasonable and necessary to prevent illness or medical conditions;*
- Provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a member or endanger life;*
- Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;*
- Consistent with the diagnosis of the conditions and the severity of the symptoms;*
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency”*

4.5.4.1.1	4.5.4.1 Based upon generally accepted medical practices in light of Conditions at the time of treatment, Medically Necessary services are those that are: Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Member's medical Condition;	Requirement Met	Unable to Confirm
4.5.4.1.2	Compatible with the standards of acceptable medical practice in the community;		
4.5.4.1.3	Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;		
4.5.4.1.4	Not provided solely for the convenience of the Member or the convenience of the Health Care Provider or hospital; and		
4.5.4.1.5	Not primarily custodial care unless custodial care is a covered service or benefit under the Members evidence of coverage.		
	AMGP		√
	PSHP	√	
	WellCare	√	

6. Proposed Action

Model contract language in section 4.14.3.1, 4.14.3.3, and 4.14.3.4.4 was found in the documentation provided for all three CMOs.

4.14.3.1 - All Proposed Actions shall be made by a physician, or other peer review consultant, who has appropriate clinical expertise in treating the Member's Condition or disease.	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

<p>4.14.3.3 - The notice of Proposed Action must contain the following:</p> <p>4.14.3.3.1 The Action the Contractor has taken or intends to take.</p> <p>4.14.3.3.2 The reasons for the Action.</p> <p>4.14.3.3.3 The Member's right to file an Appeal through the Contractor's internal Grievance System as described in Section 4.14.</p> <p>4.14.3.3.4 The Provider's right to file a Provider Complaint as described in Section 4.9.7;</p> <p>4.14.3.3.5 The requirement that a Member exhaust the Contractor's internal Grievance System and a Provider exhaust the Provider Complaint process prior to requesting a State Administrative Law Hearing;</p> <p>4.14.3.3.6 The circumstances under which expedited review is available and how to request it; and</p> <p>4.14.3.3.7 The Member's right to have Benefits continue pending resolution of the Appeal with the Contractor or with the State Administrative Law Hearing, how to request that Benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.</p>	<p>Requirement Met</p>	<p>Unable to Confirm</p>
<p>AMGP</p>	<p>√</p>	
<p>PSHP</p>	<p>√</p>	
<p>WellCare</p>	<p>√</p>	

Section 4.14.3.4.1 of the model contract language was only noted in available internal policies and procedures for PSHP. We are unable to confirm whether the policies of WellCare or AMGP are consistent with these contractual requirements.

Section 4.14.3.4.5 of the GF model contract was located in available internal policies and procedures for both PSHP and AMGP, However, we were not able to locate this language in the available internal policies for WellCare. We are therefore unable to confirm whether WellCare's policies are consistent with the contractual requirements.

<p>4.14.3.4 - The Contractor shall mail the Notice of Proposed Action within the following timeframes:</p> <p>4.14.3.4.1 For termination, suspension, or reduction of previously authorized Covered Services at least ten (10) Calendar Days before the date of Proposed Action or not later than the date of Proposed Action in the event of one of [exceptions]:</p> <p>4.14.3.4.2 For denial of payment, at the time of any Proposed Action affecting the Claim.</p> <p>4.14.3.4.3 For standard Service Authorization decisions that deny or limit services, within the timeframes required in Section 4.11.2.5.</p> <p>4.14.3.4.4 If the Contractor extends the timeframe for the decision and issuance of notice of Proposed Action according to Section 4.11.2.5, the Contractor shall give the Member written notice of the reasons for the decision to extend Grievance if he or she disagrees with that decision. The Contractor shall issue and carry out its determination as expeditiously as the Member's health requires and no later than the date the extension expires.</p> <p>4.14.3.4.5 For authorization decisions not reached within the timeframes required in Section 4.11.2.5 for either standard or expedited Service Authorizations, Notice of Proposed Action shall be mailed on the date the timeframe expires, as this constitutes a denial and is thus a Proposed Action.</p>	<p>Requirement Met</p>	<p>Unable to Confirm</p>
AMGP		√
PSHP	√	
WellCare		√

B. Provider Complaint Process

A provider complaint process is an important function in the managed care delivery system. Not only does it give providers a voice when they do not agree with a decision, it also provides a monitoring tool to assess the prior authorization and other operational aspects of the plan. These issues would include, but are not limited to, payment reconsiderations, timely filing denials, benefit denials, and prior authorization denials. The following results do not include member grievance and appeal provisions.

Each plan in Georgia has a defined process for submitting provider claim reconsiderations or disputes and appeals. The CMOs differ on the stated timelines to file a reconsideration or appeal, timelines for a response from the CMO, the intake process, and the administrative law hearing process.

The GF model contract states in Section 4.9.7.5.1 that the provider appeal process must allow providers 45 calendar days to file an appeal. Both AMGP and

PSHP allow the minimum of 45 days, while WellCare allows 60 days for a provider to file a complaint.

4.9.7.5.1 - Allow Providers forty-five (45) Calendar Days to file a written complaint;	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

There is no specific provider complaint timeline outlined in the GF model contract regarding when the CMO must respond back to the provider with a decision. Both AMGP and PSHP have a 30-day response time stated in their policy for provider complaints. WellCare has a 60-day response time per their provider manual.

The plans differ in the form of communication they take regarding provider complaints. We evaluated the following types: written, mail-in form, electronic mail, facsimile transmission (fax), web-based intake process, or in person.

- Written, mail-in form: All three CMOs have a form available to providers.
- Electronic mail (e-mail): Only WellCare indicates they will accept e-mail as a method to receive provider complaints.
- Fax transmission: WellCare accepts fax transmissions per their provider manual.
- Web-based intake process: PSHP and WellCare both indicate this is an acceptable process in their respective documentation. AMGP's documentation states this service is not yet available.
- In person: Both AMGP and WellCare will accept a complaint received in person at their offices.

The GF model contract requires language in the CMO's policies regarding the administrative law process. All of the Georgia CMOs have language in their policies regarding this process. However, PSHP's policy for their contracted providers requires the provider to waive their rights to an administrative law hearing while participating with the plan. This appears to be contrary to the requirement set forth in the Georgia Model Contract in 4.9.7.6.

4.9.7.6 In the event the outcome of the review of the Provider Complaint is adverse to the Provider, the Contractor shall provide a written Notice of Adverse Action to the Provider. The Notice of Adverse Action shall state that Providers may request an Administrative Law Hearing in accordance with OCGA § 49-4-153.	Requirement Met	Unable to Confirm
AMGP	√	
PSHP		√
WellCare	√	

In addition to our analysis of each CMO's documentation, the CMOs were asked to describe how each CMO monitors the provider reconsideration and appeal process and whether changes have been made in policies and procedures based on the results. The following responses were received from each of the CMOs:

AMGP, dated 3/26/08:

"Please see the attached policy and procedure regarding the provider appeal process. We have not made specific changes to the policy, but we have identified enhancements to our claims processing procedures. For example, the response to TFR1 below indicates a process that was implemented as a result of reviewing appeals trends."

PSHP, dated 3/28/08:

"Peach State monitors appeal volumes and timeliness and reports statistics to DCH on a quarterly basis. Yes, changes have been made to this process based on monitoring."

WellCare, dated 3/27/08:

"Appeal statistics are reviewed monthly by Appeals management team in preparation for the cross-divisional CSQIW (Customer Service Quality Improvement Workgroup). The workgroup identifies areas of needed quality improvement through analysis of trends found in member satisfaction surveys, complaint and appeal data and requests for PCP changes and member disenrollment. Once the CSQIW determines that an issue should be researched further, a subgroup representing all appropriate departments is created to brainstorm and present solutions to the CSQIW. The sub-group will present routine, timely, progress reports and results to the CSQIW until it is determined that the issue no longer requires the attention of the CSQIW. The CSQIW reports to the MAC (Medical Advisory Committee). The MAC reports results to the QIC (Quality

Improvement Council). And the QIC reports results to the Board of Directors. Though no changes have been made to Appeals Policies and Processes resulting from CSQIW sub-work activities, Appeals data has been key information when reviewing prior auth activities, configuration, and claims payment policies and procedures. Attached you will find a copy of the management summary report used to monitor activity, turn around time, reason and high volume providers.”

C. Administrative Policies and Procedures That Impact Claims Payments

There are health plan administrative policies and procedures designed to ensure the operations of the health plan have the proper components to service the members and providers in an efficient and appropriate manner. Components of the analysis included requirements for clean claims, processes for check payment, and other related items.

A clean claim is a claim received from a provider that requires no additional information to make a payment decision. The GF model contract requires the CMOs to process a clean claim within 15 days of receipt. All three CMOs have this language in their policies.

A check payment process is the generation of payment via a check and Explanation of Payment. The GF model contract requires at least one check payment cycle per week, per 4.16.1.3. AMGP and PSHP have two check payment cycles per week, while WellCare has three cycles per week.

4.16.1.3 - At a minimum, the Contractor shall run one (1) Provider payment cycle per week, on the same day each week, as determined by the Contractor.	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

D. Electronic Data Interchange

The components of the electronic data interchange (EDI) process analyzed included enrollment files (form 834), claim files (form 837), rejection files (form 997), and electronic remittance advice (form 835). The GF model contract has basic language regarding HIPAA compliance. This language was found in the documentation for all three CMOs, except that for WellCare, we found no language regarding the rejection file (form 997) in the documentation provided by WellCare.

4.16.1.5 -The Contractor shall encourage that its Providers, as an alternative to the filing of paper-based Claims, submit and receive Claims information through electronic data interchange (EDI), i.e. electronic Claims. Electronic Claims must be processed in adherence to information exchange and data management requirements specified in Section 4.17. As part of this Electronic Claims Management (ECM) function, the Contractor shall also provide on-line and phone-based capabilities to obtain Claims processing status information.	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

E. Emergency Department Payment Policies

Contract section 4.6.1.1 states that emergency care services must be available 24 hours a day, seven days a week. We found that all three plans, AMGP, PSHP and WellCare, provide information in their internal policies and procedures regarding emergency care coverage.

4.6.1.1-Emergency Services shall be available twenty-four (24) hours a day, seven (7) Days a week to treat an Emergency Medical Condition.	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

Contract language in section 4.6.1.2 includes a definition of an emergency medical condition and a statement indicating that an emergency medical service shall not be defined or limited based on a list of diagnoses or symptoms. This information was found in internal policies and procedures for WellCare and PSHP. This language was also found in an internal policy for AMGP, however AMGP, when asked to explain their emergency room claim payment policy, responded that ER claims are reimbursed based on CPT code billed by the provider. AMGP further indicated that the prudent layperson definition was not applicable to AMGP.

<p>4.6.1.2- An Emergency Medical Condition shall not be defined or limited based on a list of diagnoses or symptoms. An Emergency Medical Condition is a medical or mental health Condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:</p> <p>4.6.1.2.1 Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;</p> <p>4.6.1.2.2 Serious impairment to bodily functions;</p> <p>4.6.1.2.3 Serious dysfunction of any bodily organ or part;</p> <p>4.6.1.2.4 Serious harm to self or others due to an alcohol or drug abuse emergency;</p> <p>4.6.1.2.5 Injury to self or bodily harm to others; or</p> <p>4.6.1.2.6 With respect to a pregnant woman having contractions: (i) that there is adequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.</p>	<p>Requirement Met</p>	<p>Unable to Confirm</p>
<p>AMGP</p>	<p>√</p>	
<p>PSHP</p>	<p>√</p>	
<p>WellCare</p>	<p>√</p>	

Contract section 4.6.1.3 states emergency services shall be covered when provided by a qualified provider, regardless of network participation status, and prior authorization is not required. In addition, the contractor is required to pay for all medically necessary emergency services until the member is stabilized and any screening examination performed to determine if an emergency medical condition exists is also a coverage requirement. This language was found in available internal policies and procedures for AMGP, PSHP, and WellCare.

4.6.1.3 - The Contractor shall provide payment for Emergency Services when furnished by a qualified Provider, regardless of whether that Provider is in the Contractor's network. These services shall not be subject to prior authorization requirements. The Contractor shall be required to pay for all Emergency Services that are Medically Necessary until the Member is stabilized. The Contractor shall also pay for any screening examination services conducted to determine whether an Emergency Medical Condition exists.	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

The required contract language or similar language in contract section 4.6.1.6, was found in available internal policies and procedures for AMGP, PSHP, and WellCare.

4.6.1.6 - The Contractor shall not retroactively deny a Claim for an emergency screening examination because the Condition, which appeared to be an Emergency Medical Condition under the prudent layperson standard, turned out to be non-emergency in nature. If an emergency screening examination leads to a clinical determination by the examining physician that an actual Emergency Medical Condition does not exist, then the determining factor for payment liability shall be whether the Member had acute symptoms of sufficient severity at the time of presentation. In this case, the Contractor shall pay for all screening and care services provided. Payment shall be at either the rate negotiated under the Provider Contract, or the rate paid by DCH under the Fee for Service Medicaid program.	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

Contract language in 4.6.1.4 requires that a CMO base coverage decisions for Emergency Services on the severity of the symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a prudent layperson. This language was noted in the PSHP Emergency policy.

Only the prudent layperson emergency definition was found in AMGP and WellCare's available policies. We were not able to identify policies and procedures for AMGP and WellCare that states coverage decisions for emergency room services are based on the severity of presenting symptoms for AMGP and WellCare. As noted above, AMGP has confirmed they reimburse emergency room services based on CPT code billed by provider. Therefore, we are unable to confirm that the policies of these two CMOs are consistent with contract requirements.

4.6.1.4 - The Contractor shall base coverage decisions for Emergency Services on the severity of the symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a prudent layperson.	Requirement Met	Unable to Confirm
AMGP		√
PSHP	√	
WellCare		√

The contract requirement 4.6.1.7 was identified for AMGP. PSHP and WellCare each had timelines for submittal of notification of emergency services, but we were unable to locate language that the contractor shall not refuse to cover an emergency service based on the failure of the provider to notify the contractor, PCP, or DCH of member's screening and treatment within said timeframes.

4.6.1.7 - The Contractor may establish guidelines and timelines for submittal of notification regarding provision of emergency services, but, the Contractor shall not refuse to cover an Emergency Service based on the emergency room Provider, hospital, or fiscal agent's failure to notify the Member's PCP, CMO plan representative, or DCH of the Member's screening and treatment within said timeframes.	Requirement Met	Unable to Confirm
AMGP	√	
PSHP		√
WellCare		√

Contract provision 4.6.1.8 states that if a representative of the contractor instructs a member to seek emergency care services, then the contractor will pay for medical screening examination and other medical necessary emergency services without regard to if the prudent layperson standard was met. This provision was found in AMGP and PSHP's emergency policies. WellCare emergency services policy states that the company provides payment for any screening examination to determine if an emergency medical condition exists, however, language or similar language to that in 4.6.1.8 was not found in available policies.

4.6.1.8 - When a representative of the Contractor instructs the Member to seek Emergency Services the Contractor shall be responsible for payment for the Medical Screening examination and for other Medically Necessary Emergency Services, without regard to whether the Condition meets the prudent layperson standard.	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare		√

Below is a summary of the emergency department policies and procedures for each of the CMOs.

AMGP

Myers and Stauffer requested that AMGP describe their emergency room coverage and payment policies.

Per information received from AMGP on 03/26/08:

“If the provider is billing only ER and no other higher level of care (99281-99285) then the claim pays based on the CPT code billed per the provider contract. If the provider is billing ER and Observation, then the higher level of care would pay and the ER would not pay per AMGP policies and provider contract. In this scenario, [AMGP] would pay the observation rate.”

Health plans were also asked if they use a list of diagnoses or symptoms to identify emergent conditions for payment purposes. According to AMGP’s response received via email on 03/26/08:

”[AMGP] does not use a diagnosis or symptoms listing to identify emergent conditions for claims payment. [AMGP] pays based on CPT code and revenue code billed by provider.”

Myers and Stauffer asked, in instances when an ER claim does not have an “autopayable” diagnosis, what is process for determining whether the claim should pay at the triage rate, or does the claim pend/deny for medical records?

AMGP responded on 3/26/08 that this is not applicable to them as their payment is based on the CPT code billed unless a higher level of care applies, then payment would be at the higher level of care and not the emergency room rate.

AMGP was also asked whether the time of day or day of the week, as well as the age of the patient, is a factor in determining payment for emergency room claims. AMGP responded on 3/26/08 that this question did not apply to them due to their payment policies.

Additionally, AMGP was asked to describe their process for applying the prudent layperson standards and the qualifications of personnel involved in this process. The response received on 3/26/08 from AMGP stated that this process was not applicable to the CMO.

AMGP was asked to describe the policies and procedures they utilize to monitor and reduce emergency room utilization. AMGP's response received on 03/26/08 is listed below:

- *"[AMGP] reviews ER claims reports to identify [high utilization members]. Contact is then made to this member type through case management for those members identified with a targeted diagnosis for intervention and assessment for additional case management needs.*
- *Daily ER reports are sent directly to the health plan from five (5) high volume ER hospitals. Contact is then made to this member type through case management for those members identified with a targeted diagnosis for intervention and assessment for additional case management needs.*
- *Review of a bi-weekly report generated from the nurse helpline of those members sent to the ER. Contact is then made to this member type through case management for those members identified with a targeted diagnosis for intervention and assessment for additional case management needs.*
- *Educational mailers for those members identified as frequent flyers for coordination back to their medical home or an urgent care center for routine non-ER level of care.*
- *Review of monthly utilization data to identify trends of ER utilization by product and region. Based on analysis, [AMGP] will make adjustments to its ER program."*

PSHP

Myers and Stauffer received the following information on 03/28/08 regarding PSHP's emergency claim payment process.

"PSHP pays emergency room (ER) claims using two (2) different methods, an automated process and a non-automated process. At the time of contracting with PSHP, each hospital makes an independent decision based on its own preference as to which process it prefers for the adjudication of ER claims.

The automated process addresses the concerns of providers who want to be paid sooner and also relieves them from the time and expense involved in gathering and submitting medical records and other supporting documentation. Under the automated process and to facilitate administrative simplicity, PSHP has established specific ICD-9 codes that are automatically approved for payment. The provider manual explains the process for billing under the automated process. Emergency room claims are not denied under

the automated process. Under this process all claims are paid at the full-negotiated rate for ER services or a lower emergency administrative fee. In addition, the provider has the ability to appeal claims paid at the emergency administrative fee rate.

For non-contracted providers and contracted provider who elect not to participate in the automated process, claims are paid at the full emergency services rate (i.e., network or non-network rate), an emergency administrative fee or denied. Consistent with the automated process, the non-automated process pays claims that have the specified ICD-9 codes in the primary diagnosis field at the applicable emergency services rate. For claims not coded with one of the specified ICD-9 codes, the hospital is sent a request for applicable medical records and supporting documentation. This information enables PSHP to perform a manual, prudent lay person review to determine eligibility for coverage, the applicable payment rate or if the claim should be denied. “

PSHP also confirmed that they are using DCH's version of the diagnosis code list for reimbursement of emergency room claims, however they do not deny an emergency room claim based on the diagnosis code list. There are no CPT codes on this list. PSHP also confirmed that the time of day, day of the week and/or age of the patient are taken into consideration when making a determination regarding an emergent condition either in the claims adjudication or the appeal process.

Myers and Stauffer asked PSHP to describe how they apply the prudent layperson criteria when adjudicating claims and also to provide a description of staff resources and qualifications used in this process. The PSHP response received on 03/28/08 is as follows:

“The claim is reviewed by a non-clinical CCM analyst. The CCM analyst reviews the ED record, specifically evaluating the member's presenting symptoms (at the time of triage in the ER) and whether or not they meet the PLP definition of an emergency as defined in the contract agreement between Georgia DCH and PSHP. The CCM analyst works under the supervision of a registered nurse in order to ensure correct interpretation of the medical record and facilitate the decision with respect to the presence or absence of an obvious medical emergency.”

PSHP also provided their policy on emergency room diversion, which is briefly summarized below.

- PSHP will generate monthly claims reports on all members with two (2) or more emergency department claims during the preceding 9 months.

- PSHP Case Manager will review report and research to determine if member(s) should be assigned to case management.
- Case Manager or designee will attempt to contact members to assess reasons for numerous or inappropriate emergency department visits and provide education and assistance as needed. Additionally, contact will be made with the PCP for those members with significant usage of emergency department services.
- Provider Relations department will follow up with PCPs who have a disproportionate number of members seeking non-emergent care in the emergency department.
- Case Manager is responsible to report any PCP access or potential quality issues to the Quality Department.
- PSHP may ask for network hospitals to participate in the post-emergency department notification program.

WellCare

Based on the information received from WellCare, we do not have sufficient information to provide a detailed description of the emergency room payment policies. Some of the information received from WellCare included calculations regarding their emergency room claims payment. This information could not be independently confirmed and therefore, is not included in this report.

Regarding the use of a “presumptive emergency or autopayable” list, WellCare stated the following on 3/27/08:

“As independently validated by the FourThought Group, ‘Specifically, WellCare does not use a fixed list of diagnosis (DX) codes to determine what is considered an emergent versus non-emergent condition’ (FourThought Group, Emergency Room Claims Monitoring, pg 14).”

Additionally, when asked if the presumptive emergency or autopayable list is identical to the list utilized by DCH for traditional Medicaid or a list of their own development and if the list includes CPT codes, their response was “N/A”.

Myers and Stauffer asked WellCare the following question “For an ER claim that does not have an “autopayable” diagnosis, what process does the claim go through? Is the claim paid at the triage rate or does the claim pend/ deny for medical records?” WellCare provided the following response on 3/27/08:

“WellCare has developed an automated ‘presumptive’ list of DX codes that does not limit what will be considered an emergent condition, but instead, ‘presumptively’ or automatically treats certain claims as an emergency condition. This facilitates automated, systematic payment of a claim at the ER rate.’ (FourThought Group, Emergency Room Claims Monitoring, pg. 12) ‘Hospitals

billing non-emergent DX codes in the admitting, primary, secondary and tertiary diagnosis fields which may have been considered emergencies under the Medicaid FFS program...are not specific enough to warrant an emergency determination in the WellCare system' 'These claims would need to be resubmitted via the reconsideration process, with additional documentation, in order to be further classified as emergency claims' (FourThought Group, Emergency Room Claims Monitoring, p. 12-13). Claims not considered as an emergency condition are adjudicated and paid at the individual contracted rate for non-emergent claims."

WellCare was also asked whether the time of day, day of the week or the age of patient is a factor in determining payment for emergency room claims. The response provided by WellCare on 3/27/08 is below:

"The WellCare System does not currently consider day of the week (weekend vs. weekday, time of day of presentation to the ER, or member age' (FourThought Group, Emergency Room Claims Monitoring, p 13), during the claim adjudication process, unless the medical records are provided with the initial claim submission. These factors are taken into consideration when medical records and documents are submitted during the ER reconsideration and appeals process, but can not be considered as a sole determining factor when assessing the condition."

Finally, WellCare was asked to describe their process for applying prudent layperson criteria and the qualifications of personnel involved in this process. The response received on 3/27/08 from WellCare stated:

"WellCare has developed an automated 'presumptive' list of DX codes that does not limit what will be considered an emergent condition, but instead, 'presumptively' or automatically treats certain claims as an emergency condition. This facilitates automated, systematic payment of a claim at the ER rate.' (FourThought Group, Emergency Room Claims Monitoring, p.12) 'Hospitals billing non-emergent DX codes in the admitting, primary, secondary and tertiary diagnosis fields which may have been considered emergencies under the Medicaid FFS program are not specific enough to warrant an emergency determination in the WellCare system' 'These claims would need to be resubmitted via the reconsideration process, with additional documentation, in order to be further classified as emergency claims.' (FourThought Group, Emergency Room Claims Monitoring, p.12-13). Claims not considered as an emergency condition are adjudicated and paid at the individual contracted rate for non-emergent claims."

To address high utilization of ER services, WellCare performs member and provider outreach, which is summarized below. Per information received from WellCare on 03/28/08, WellCare provided information regarding the “WellCare of Georgia ER Program Experience” and listed the following as effective care coordination initiatives:

•Member Outreach

- Daily follow-up calls for ER visits
- Member data review for frequent utilization
- Re-direct to urgent care centers

•Provider Outreach

- Physician data review for ER utilization
- Provider Tools
- Accessibility after hours
- Sick Visit Availability”

WellCare indicated that they receive a daily ER report from hospitals and follow-up telephone calls to members are done within 1-2 days after receiving the ER report.

Members with continuing issues following their ER visit are referred to an ER Case Manager. Also, a monthly review of claims identifies members who utilize the ER frequently and follow-up calls are made to members by an Outreach Coordinator and referred to Case Management if complex or continuing needs are found. WellCare also works with providers to identify barriers to care and provide education on provider responsibilities and available resources to members.

F. Claim Coding Requirements

Claim coding requirements are rules utilized to apply standard coding to claims billing. These rules include, for example, bundling and unbundling of codes, use of modifiers, and assistant surgeon billing guidelines. The internal policies and procedures, provider and member manuals were researched for information regarding claim coding.

There are no requirements in the GF model contract related to claim coding. However, the model contract does require the CMOs to make this information available to its network providers. Each CMO has unique policies related to claim coding to meet their system configuration requirements.

G. 72-hour Rule Policies

The 72-hour rule is defined as diagnostic services (including clinical diagnostic laboratory tests) provided to a member by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital, within three days prior

to, and including, the date of the member's admission are deemed to be inpatient services and are thus included in the inpatient payment.

We attempted to ascertain whether the CMOs considered services received within 72 hours (before or after) an inpatient stay as part of the inpatient payment.

There was insufficient data in the internal policies and procedures, provider and member manuals available to draw conclusions regarding policies on the 72-hour rule.

H. Capacity of Local Health Plan to Address Provider Concerns

Health plan staffing, fraud and abuse provisions, translation services, credentialing services, and NCQA accreditation requirements, are a number of the items analyzed for this section.

Credentialing services and translation services all are addressed in the GF model contract. The CMOs have language indicating that all of these services exist within their plans.

<p>4.8.14.1 The Contractor shall maintain written policies and procedures for the Credentialing and Re-Credentialing of network Providers, using standards established by National Committee Quality Assurance (NCQA), Joint Commission on Accreditation Healthcare Organization (JCAHO), or American Accreditation Healthcare Commission/URAC. At a minimum the Contractor shall require that each Provider be credentialed in accordance with State law. The Contractor may impose more stringent Credentialing criteria than the State requires.</p> <p>4.8.14.2 Such policies and procedures shall include: the verification of the existence and maintenance of credentials, licenses, certificates, and insurance coverage of each Provider from a primary source; a methodology and process for Re-Credentialing Providers; a description of the initial quality assessment of private practitioner offices and other patient care settings; and procedures for disciplinary action, such as reducing, suspending, or terminating Provider privileges.</p> <p>4.8.14.3 Upon the request of DCH, The Contractor shall make available all licenses, insurance certificates, and other documents of network Providers.</p> <p>4.8.14.4 The Contractor shall submit its Provider Credentialing and re-Credentialing Policies and Procedures to DCH within sixty (60) Calendar Days of Contract Award.</p>	<p>Requirement Met</p>	<p>Unable to Confirm</p>
<p>AMGP</p>	<p>√</p>	
<p>PSHP</p>	<p>√</p>	
<p>WellCare</p>	<p>√</p>	

4.3.10.1 The Contractor is required to provide oral translation services of information to any Member who speaks any non-English language regardless of whether a Member speaks a language that meets the threshold of a Prevalent Non-English Language. The Contractor is required to notify its Members of the availability of oral interpretation services and to inform them of how to access oral interpretation services. There shall be no charge to the Member for translation services.	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

Fraud and abuse information, per GF model contract 4.13.2.1.11, is required to be included in the provider manuals. All three CMOs in Georgia appear to have this information listed in their provider manuals, as required.

4.13.2.1.11 - Inclusion of information about Fraud and Abuse identification and reporting in Provider and Member materials.	Requirement Met	Unable to Confirm
AMGP	√	
PSHP	√	
WellCare	√	

There is no NCQA accreditation requirement currently in the DCH model contract. All three of the CMOs are in various stages of accreditation with the NCQA currently. AMGP has achieved a New Health Plan Accreditation. PSHP and WellCare have surveys scheduled later in 2008.

I. Global Charges

There was insufficient data available to draw conclusions regarding policies on global charges.

J. Adjudication of Claims With Third Party Payments

Third party payments are reimbursements from entities other than Medicaid, including commercial health insurance, workers compensation, and other types of insurance.

The GF model contract includes provisions for third party liability and coordination of benefits. Expectations of different filing limits and precertification requirements are commonly seen for claims with third party liability. The model contract, however, does not speak specifically toward either of those items. PSHP has specific language addressing both filing limits and precertification. AMGP and WellCare have information regarding the timeline for submission of these types of claims.

<p>8.4.1 Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the Health Care expenses of the Member.</p> <p>8.4.1.1 Pursuant to Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D, DCH hereby authorizes the Contractor as its agent to identify and cost avoid Claims for all CMO plan Members, including PeachCare for Kids Members.</p>	<p>Requirement Met</p>	<p>Unable to Confirm</p>
<p>AMGP</p>		<p>√</p>
<p>PSHP</p>	<p>√</p>	
<p>WellCare</p>		<p>√</p>

K. Timeliness Edits/ Admission Dates On Claims

This issue relates to a provider's filing of claims with the CMOs in a timely manner and how the determination of timeliness is made for inpatient hospital claims. A state agency will commonly mandate what the filing time limit should be for the providers to submit claims. The CMOs can also mandate via the contract with the provider a timeframe less than the state requirement.

The GF model contract gives the CMOs the ability to deny claims for failure to meet timely filing requirements after 120 days from the date of service. The contract requires the CMO to deny the claim if the claim is received after 180 days from the date of service. The contract does not specify which date, admission or discharge date, is used to calculate the filing time limit on an inpatient claim.

The documentation from all three of the CMOs in Georgia indicates each plan is following this mandate regarding 120 and 180 days filing limit.

<p>4.16.1.12 The Contractor may deny a Claim for failure to file timely if a Provider does not submit Claims to them within one hundred and twenty (120) Calendar Days of the date of service but must deny any Claim not initially submitted to the Contractor by the one hundred and eighty-first (181st) Calendar Day from the date of service, unless the Contractor or its vendors created the error. If a Provider files erroneously with another CMO plan or with the State, but produces documentation verifying that the initial filing of the Claim occurred within the one hundred and twenty (120) Calendar Day period, the Contractor shall process the Provider's Claim without denying for failure to timely file.</p>	<p>Requirement Met</p>	<p>Unable to Confirm</p>
<p>AMGP</p>	<p>√</p>	
<p>PSHP</p>	<p>√</p>	
<p>WellCare</p>	<p>√</p>	

Many hospital providers reported to us issues and problems associated with claims that denied due to timely filing limits because the CMOs used the admission date on the claim as the “date of service” when determining compliance with timely filing. We followed up on this matter with the CMOs and the CMOs responded as indicated below.

AMGP confirmed, via e-mail on 3/26/08, the use of the discharge date on an inpatient hospital stay for calculation of the filing time limit. However, due to system limitations, this is a manual process. This policy was effective 2/1/07, as indicated by AMGP.

PSHP responded on 3/28/08 that they also use discharge date for their filing limit calculation on an inpatient claim.

Based on information received on 3/27/08, WellCare indicated that initially they used the admission date for this calculation, but have since reprogrammed their system to use the discharge date. This change was implemented in September 2007.

L. Policies for the Tracking and Dispositioning of Provider Recoupments and Repayments

The GF model contract describes the criteria required for the CMO’s recoupment process in 4.10.4.5. We noted that PSHP and WellCare have language in their documentation regarding the criteria for their respective recoupment processes. Similar criteria were not found in AMGP’s documentation.

4.10.4.5 - Upon receipt of notice from DCH that it is due funds from a Provider, the Contractor shall reduce payment to the Provider for all claims submitted by that Provider by one hundred percent (100%), or such other amount as DCH may elect, until such time as the amount owed to DCH is recovered. The Contractor shall promptly remit any such funds recovered to DCH in the manner specified by the DCH. To that end, the Contractor’s Provider Contracts shall contain a provision giving notice of this obligation to the Provider, such that the Provider’s execution of the Contract shall constitute agreement with the Contractor’s obligation to DCH.	Requirement Met	Unable to Confirm
AMGP		√
PSHP	√	
WellCare	√	

In summary, we compared sixty-five DCH Model contract requirements with the policies and procedures of each of the CMOs. Eighty-three percent of the Model contract requirements reviewed were located in the available documentation for PSHP. We were also able to locate 82percent of the Model contract

requirements in the available documentation for WellCare and 65 percent in the available documentation for AMGP.

SECTION III

COMPARISON OF GF CMO WRITTEN POLICIES AND PROCEDURES TO MEDICAID CMOs IN OTHER STATES

This section provides a comparison of selected GA CMO policies and procedures to the policies and procedures of managed care organizations in other State Medicaid programs. The analysis includes the following policies and procedures:

- A. Medical Management Policies
- B. Provider Complaints Process
- C. Administrative Policies and Procedures That Impact Claims Payment
- D. Emergency Department Payment Policies
- E. Timeliness Edits/Admission Dates on Claims

Preliminary findings were determined based on the provider and member manuals of the various health plans included our analysis. However, after an initial analysis of the information contained in these documents, it appeared that in order to adequately address the above subjects and compare each of the policies and procedures desired, additional information would be required from the CMOs, State Medicaid Agencies, and Medicaid managed care health plans in other states. Therefore, a brief survey was developed and designed to solicit specific information in the targeted areas. In addition to the key areas identified above, we also requested that each state provide information about implementation issues they experienced during the transition to managed care.

Please refer to Exhibit D for the list of questions posed to the Medicaid MCOs in other states.

The information regarding background and implementation issues was obtained during numerous interviews conducted with state Medicaid managed care program personnel as well as health plan representatives.

These comparisons attempted to:

1. Compare GF CMO policies and procedures to the policies and procedures of similar Medicaid health plans in other states; and,
2. When possible, compare the policies and procedures of the GF CMOs to the policies and procedures of Medicaid plans in other states that are operated by the parent companies of the three Georgia CMOs.

Participation in Interview Process

Indicated on the chart below are the state agencies and health plans from which we received responses to specific policy and procedure questions. Exhibit A identifies the plans selected from each state. The plans are not referred to by name on this chart.

Participation in Interview Process							
	GA	FL	IN	MI	MO	PA	VA
State agency	√	√	√	√	√		√
Plan A	√	√	√	√			√
Plan B	√	√	√	√			√
Plan C	√	√		√			√
Plan D (FL only)		*					

*Plan declined to participate in interview process regarding the plans policies in FL.

ANALYSIS

Implementation Issues

During the interviews with individual State Agencies and health plans, we inquired about the implementation timelines of the managed care initiatives and any transition issues encountered during the implementation period. In all cases, the comparison states implemented managed care utilizing a phased-in approach, for instance, expanding the coverage either by region or program area over a pre-determined period of time. A number of the states interviewed are still in the process of implementing managed care throughout their state.

The table below presents each state included in our comparison, their managed care implementation period, and the number of members transitioned from other programs to managed care during that period.

STATE	IMPLEMENTATION OF MANAGED CARE	MEMBERS TRANSITIONED (Approximately)
Florida	1982 ***	600,000
Georgia	June 2006 – September 2006	1,000,000
Indiana	1996 – 2005*	500,000
Michigan	October 1997 – April 1999**	880,000
Missouri	September 1995 – January 1997	250,000
Pennsylvania	February 1997***	900,000
Virginia	1996***	450,000

*Mandatory enrollment began in 2000

**Additional recipient groups have been in varying stages of implementation since this time.

***Based on current information, future managed care expansion is indeterminate.

Upon implementation of Medicaid risk-based managed care delivery systems, certain provider feedback was common among the states we interviewed. The common feedback that states received from providers was as follows:

- The burden of prior authorization process falling on providers due to the new rules of the health plans and the overall greater administrative burden resulting from the additional policies.
- Additional reporting, submitting more paperwork, and functioning as a “gatekeeper” for the member’s comprehensive health care needs.
- Managed care organizations were not adequately prepared for the level of acuity and utilization of the population.
- Conflicting contractual provision interpretation resulting in inappropriate and/or inaccurate payments to providers.
- Different credentialing process for providers, which could include a credentialing process for each plan the provider contracts instead of a one-time credentialing process with the state.

DCH also requested that Myers and Stauffer research and provide a brief overview of the Tennessee Medicaid managed care program (TennCare) and any problems identified as a result of its recent managed care procurements. Myers and Stauffer summarized the implementation problems and provided to DCH on February 5, 2008 a brief overview of the history and background of TennCare. This summary is included in Exhibit E.

A. Medical Management Policies

We analyzed selected medical management policies and procedures and compared them across a number of state Medicaid managed care plans. We obtained the information included in this section either through research of the selected health plans’ online literature, analysis of Georgia CMOs’ online literature and/or internal policies, or responses obtained from the health plan’s participation in surveys and interviews conducted for this initiative. For each selected component, we listed the policy or procedure located for each GF CMO as well as corresponding information found in the comparison health plans’ literature. Additionally, in the section titled Utilization Management Processes, there is a comparison between AMGP, PSHP, and WellCare with health plans in other states that are owned by the same parent company as one of the Georgia plans. A total of 23 health plans were analyzed: the three plans participating in GF and 20 plans from other comparison states.

Utilization Management Processes

Prior authorization requirements for each of the CMO’s and the comparison states’ health plans were analyzed and the following table shows the comparison of requirements for the service types shown.

Table: Comparison of Prior Authorization Service Types by State and CMO/MCO

Service Type	Georgia			Florida				Indiana		Michigan			Missouri			Pennsylvania			Virginia			
	AMERIGROUP	Peach State	WellCare	AMERIGROUP	Personal Health Plan	United	Vista	WellCare (HealthEase and Staywell)	Anthem	MHS (Centene)	Great Lakes Health Plan	Health Plan of Michigan	Molina Healthcare of MI	Harmony Health Plan (WellCare)	HealthCare USA	Mercy CarePlus	Americhoice of PA	Gateway	Keystone Mercy	AMERIGROUP	Optima Family Care	VA Premier Health Plan
Cardiac Rehabilitation	√	√	√	√				√	√				√		√			√	√	√	√	
Diagnostic Testing	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Dialysis (outpatient)	√	√	√	√				√	√	√		√		√	√					√		√
Durable Medical Equipment	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Home HealthCare	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Hospice	√	√	√			√	√	√	√	√	√	√	√	√	√		√	√	√	√	√	
Hospital Admissions (elective)	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Observation stays			√			√	√	√		√	√	√		√	√	√		√			√	√
Occupational, Physical and Speech therapies	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Out of Plan Care (non-emergency)	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Outpatient/ Ambulatory Surgery	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Prosthetics/ Orthotics	√	√		√	√	√	√	√	√	√	√	√	√	√	√	√	√		√	√	√	
Skilled Nursing Facility	√	√	√			√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	
Urgent Care Center																						

Note:

1. The checkmark means there is some degree of Prior Authorization required, including only for certain place of services.
2. If Blank, either information not found, service is not listed as a covered benefit or service is listed as not requiring Prior authorization (may still require PCP referral).

Specific prior authorization requirements for each of the CMO's and health plans were analyzed and the following items were noted:

a. *Diagnostic Testing*

- The following testing was the most frequently listed for the CMOs and health plans as requiring prior authorization: PET scans, MRI scans, CT scans and sleep studies.
- Specifically, of the three CMOs in Georgia:
 - All three require prior authorization for PET scans, MRI scans, and CT scans.
 - Only AMGP Georgia expressly states that sleep studies require prior authorization, although WellCare's Quick Reference Guide states all services performed in an outpatient hospital require prior authorization.
- For the 20 health plans analyzed:
 - 16 plans expressly state PET scans require prior authorization.
 - 12 plans expressly state MRI scans require prior authorization, while we also noted that one plan of the 12 only requires prior authorization for certain types of MRI.
 - 10 plans expressly state CT scans require prior authorization, while we also noted one plan of the 10 only requires prior authorization for certain types of CT scans.
 - Five plans expressly state sleep studies require prior authorization.
- Comparison of Georgia CMOs with health plans in other states owned by same parent company
 - **AMGP**
AMGP Georgia, Florida, and Virginia have the same prior authorization requirements for diagnostic testing, which includes MRA, MRI, CAT scans, nuclear cardiac, PET scans, and sleep studies.
 - **PSHP**
PSHP and the Centene-owned health plan in Indiana both require prior authorization for MRA, MRI, CT, PET scans. PSHP also requires prior authorization for obstetrical ultrasounds (ultrasounds after 2 per pregnancy require prior authorization). However, while the Centene plan in Indiana lists the cardiac nuclear scan as requiring prior authorization, this scan was not found on the PSHP prior authorization list.

PSHP's prior authorization requirements for diagnostic testing appear to be comparable with Centene-owned plan in Indiana.

o **WellCare**

We found that WellCare Georgia requires prior authorization for OB ultrasounds (up to two per pregnancy with no authorization required; CPT 76801 or 76805 for routine pregnancies, as appropriate), CAT, MRI, PET scans and other radiology services, as well as, plain x-rays performed in an outpatient hospital setting. However, no authorization is required for plain x-rays done in rural hospitals, freestanding imaging center, provider office or clinic. WellCare Florida plans (Staywell and HealthEase) both require prior authorization for PET, SPECT and MRA scans, as well as, radiology services performed in an outpatient hospital or ambulatory surgery center. The WellCare plan in Missouri requires prior authorization for PET, SPECT, MRI, MRA, CT and Level 2 ultrasounds.

Based upon available information, it appears WellCare Georgia may utilize more stringent requirements for prior authorization of diagnostic testing than the WellCare plans in Florida (Staywell and HealthEase) and Missouri.

b. *Rehabilitation Services (Physical, Occupational and Speech Therapies)*

- All three CMOs in Georgia and all 20 health plans analyzed require some degree of prior authorization for physical, occupational and speech therapies.
- Specifically, of the three CMOs in Georgia, WellCare requires prior authorization for all outpatient physical, occupational and speech therapies per their website, while PSHP and AMGP require notification only for the initial evaluation and prior authorization for all subsequent visits.
- Of the 20 health plans analyzed:
 - o Five health plans require no prior authorization for the first visit but prior authorization is required for any additional visits.
 - o One plan does not require prior authorization until after the first six visits.
 - o One plan does not require prior authorization until after the first 24 visits.
- Comparison of Georgia CMOs with health plans in other states owned by same parent company:

- **AMGP**
AMGP Georgia and AMGP Virginia both require notification only of the initial visit for physical, occupational or speech therapy and then prior authorization for any additional therapy. For AMGP Florida it appears that all therapy visits require prior authorization.

AMGP Georgia's prior authorization requirements for physical, occupational and speech therapy appear comparable with the AMGP plan prior authorization requirements in Virginia and slightly less stringent than requirements for AMGP Florida.

- **PSHP**
PSHP and Centene-owned health plan in Indiana both require prior authorization after the initial evaluation.
- **WellCare**
Per WellCare Georgia's Quick Reference Guide it appears that prior authorization is required for all physical, occupational and speech therapies, while the WellCare plan in Missouri allows for notification only for the initial three (3) visits and then requires prior authorization for subsequent visits. WellCare Florida plan requirements are not known as a contracted third party vendor manages this benefit.

WellCare Georgia's prior authorization requirements for physical, occupational and speech therapy appear to be more stringent than WellCare's Missouri plan.

c. Hospital Admissions

- All three Georgia CMOs and 20 health plans analyzed require prior authorization for elective admissions.
- Notification requirement(s) for unplanned (includes urgent or emergent) admissions for the three Georgia CMOs are as follows:
 - AMGP requires notification of emergency admission within 24 hours or the next business day.
 - PSHP Prior Authorization guide states notification of unplanned admissions is required within 24 hours or the next business day, however the Provider Manual states notification for emergent and urgent admissions is required within two business days.
 - WellCare requests notification of unplanned hospital admission within 24 hours of admission.
 - Of the 20 health plans analyzed:

- i. Four health plans expressly state notification is required within 24 hours of admission or next business day;
 - ii. One health plan expressly stated notification is required within one business day;
 - iii. One health plan expressly stated notification is required within 24 hours of admission; and,
 - iv. Two health plans expressly stated notification is required within two business days of admission.
- Comparison of Georgia CMOs with health plans in other states owned by same parent company
 - **AMGP**
The AMGP plans in Georgia, Florida and Virginia all require notification of emergency admission within 24 hours or the next business day.
 - **PSHP**
The Centene-owned plan in Indiana requires notification of emergency admission within two business days, while it is not clear if the notification requirements for unplanned (emergent and urgent) admissions for PSHP are within 24 hours or the next business day or within two business days.
 - **WellCare**
WellCare Georgia and WellCare Florida require providers to notify them of unplanned hospital admission within 24 hours of admission. Similar notification information was not found for the WellCare Missouri plan.

d. Outpatient/Ambulatory Surgery

- All three Georgia CMOs and all 20 health plans analyzed have some level of prior authorization required for outpatient/ ambulatory surgery.
- Comparison of Georgia CMOs with health plans in other states owned by same parent company
 - **AMGP**
AMGP Georgia and AMGP Virginia list the same prior authorization requirements for outpatient/ambulatory surgery: Preauthorization required for the coverage of the following service types regardless of the specialty of the provider: chiropractic, dermatology, ENT, gastroenterology, neurology, ophthalmology, oral maxillofacial, pain management, plastic/cosmetic, podiatry, and any out-of-area/out-of-plan outpatient or ambulatory surgery. The

AMGP Florida Quick Reference Guide prior authorization list states prior authorization and plan of care are required for the coverage of outpatient and ambulatory surgery and refers the reader to a code-specific prior authorization list which is available online.

AMGP Georgia prior authorization requirements for outpatient/ambulatory surgery appear comparable to requirements of the AMGP Florida and AMGP Virginia plans.

- **PSHP**
PSHP prior authorization list shows that prior authorization is required for all surgical services performed in an outpatient hospital or ambulatory surgery setting. The Centene-owned plan in Indiana requires prior authorization for the following outpatient/ ambulatory surgeries: all plastic surgery and potentially cosmetic procedures, including, but not limited to, Blepharoplasty, Mammoplasty, Varicose or Spider Veins, Scar Revision, Septoplasty/Rhinoplasty. Prior Authorization also required for Hysteroscopy, implantable devices and sterilization procedures.

Based on available documentation, it appears if PSHP has more stringent requirements for outpatient/ambulatory surgery than the Indiana-based Centene plan.

- **WellCare**
WellCare Georgia requires prior authorization for all services performed in an outpatient hospital or ambulatory surgery setting. The WellCare plan in Missouri states prior authorization is required for ambulatory surgery, while the WellCare Florida plans also state prior authorization is required for procedures performed in an outpatient hospital or ambulatory surgery setting, except the following CPT code ranges 43200-43258, 44360-44397.

WellCare Georgia and WellCare Missouri prior authorization requirements are comparable, while WellCare Florida appears to have less stringent requirements than the other two WellCare-owned plans.

Additional prior authorization processes/provider resources

Health plans were asked whether, when granting authorizations, the authorization is for a specific procedure code or a family of related procedure codes.

One Virginia health plan reported that they use both specific codes and family related codes for prior authorizations. A second Virginia health plan stated that both specific codes and family related codes are used depending on the type of service rendered. Inpatient and certain outpatient services are pre-certified based on a range of codes, while services such as diagnostic tests (MRI or CT scan for example) require specific coding. A third Virginia health plan responded that both authorization types are given – either by specific codes or to a family of codes for the requested service. The claims department reviews family of codes for payment in many of the cases.

Molina Health Plan in Michigan advised authorizations are given based on the service requested, if there is no specific code for that service, a range may be authorized. An example cited by Molina was outpatient therapy. Great Lakes Health Plan in Michigan configures their authorization system by procedure code. Health Plan of Michigan does not authorize by specific code. The claims examiner will verify the claim coding information with the written description in the authorization.

On-line submission of authorization

Of the 23 health plans included in our analysis, 10 plans allow providers to submit authorization requests on-line. All three of the CMOs in Georgia indicated that they allow providers to submit authorization requests online.

Of the 23 plans analyzed, 10 plans allow providers to check authorization status on-line. While PSHP and AMGP Georgia allow providers to check authorizations status on-line, it was unclear if this functionality is available on the WellCare website.

Of the 20 comparison health plans analyzed, four plans provided a CPT list either on-line or in the provider manual showing prior authorization requirements for selected CPT codes. In Georgia, all three CMOs indicate that they offer this provider resource. Per the AMGP Georgia website, providers can use an on-line system to submit the CPT code and the place of service code. Once codes are entered the system, the system will then indicate whether authorization is required. WellCare has a list of CPT codes that do not require prior authorization posted on their website as a resource for providers. PSHP allows providers to enter CPT codes in Clear Claims Connection in the secure web area to determine whether a particular service is covered or requires review.

Periodic Review/Modification of Prior Authorization List

AMGP, PSHP, and WellCare were asked whether they evaluated pre-certification approval and denial rates and if they consider process improvements or policy changes as a result of pre-certification approval/denial/reconsideration rate.

AMGP responded, “Yes” to both questions and added that they work in collaboration with their corporate partners. For example, they recently removed the requirement for notification of an observation stay.

PSHP responded “Yes” to both questions.

WellCare responded “Yes” to both questions as well. WellCare indicated they use approval and denial rates, along with other metrics, to monitor trends and to detect issues. They stated they use a variety of factors including claims review, coding changes, feedback from providers, denial rates, and analysis of procedures. WellCare provided examples of policy changes for services, such as allergy testing and dermatology services.

One Virginia health plan stated that they perform a review at least annually and upon request by members or providers. The health plan has a committee consisting of Medical Management, claims, network management and IT that meet on a quarterly basis to discuss coding, prior authorization impact and trends and if needed modifications to the prior authorization list are made. A second Virginia health plan responded that they have a committee comprised of members from diverse functional areas, which meets quarterly to review policies and processes. The committee evaluates the policies and procedures as to how services are reviewed, utilized and authorized and makes changes as appropriate. A third Virginia health plan stated that they review procedure codes that have not been routinely denied and remove the code from the prior authorization process.

Molina Health Plan annually reviews approval and denial rates among other data, when considering changes to authorization requirements. Great Lakes Health Plan’s compliance committee reviews denial trends for accuracy and for identification of changes to policies and procedures. They also annually review the prior authorization code list for changes, if appropriate. Health Plan of Michigan performs reviews of approval and denial rates and makes changes to authorization requirements, as needed.

Criteria used to evaluate Medical Necessity

Many of the health plans analyzed listed several different types of criteria used to assist in medical necessity review. Below is a listing of the most frequently listed criteria found in the online literature of the health plans and in the internal policies of the GF CMOs.

- Of the 23 health plans analyzed:
 - 19 plans stated they use Interqual® criteria to assist with decision making.
 - Four plans stated they use Milliman® Care Guidelines criteria to assist with decision making.

- Three plans stated they use Hayes Inc. Technology Review criteria to assist with decision-making.
- Two plans stated they use Apollo criteria to assist with decision-making.
- Comparison of Georgia CMOs with health plans in other states owned by same parent company.
 - **AMGP**
Per the AMGP Georgia online documentation, AMGP utilizes Interqual®, Milliman® and Apollo criterion while AMGP Florida lists Interqual® Clinical Decision Support Criteria, the State Medicaid Handbook and “other recognized Standards of Care guidelines” per their Provider Manual. AMGP Virginia lists Milliman® Guidelines, Hayes, government regulations, research studies, benefits committee review as the criterion used in their provider manual.
 - **PSHP**
The PSHP provider manual lists the following criterion used as: Interqual®, internal Medical policies and Hayes Inc. technology review. The Centene-owned health plan in Indiana uses Interqual® and McKesson Health Solutions criterion per their provider manual.
 - **WellCare**
Per WellCare’s internal policy on the application of criteria, all WellCare plans in this report use the same criteria. Criteria used to assist in decision-making is as follows: Interqual®, St. Anthony’s Medicare Guidelines, State Medicaid Provider Handbooks, Medicare Carrier and Intermediary Coverage Decisions, Center for Health Dispute Resolution (as needed), Medicare National Coverage Decisions, State Statutes, Laws and Regulations, WellCare Inc.’s Coverage and Referral Guidelines.

Criteria used to perform Concurrent Review

All three Georgia CMOs and 17 of the 20 health plans state that Interqual® criteria is utilized to assist with concurrent review, while two plans indicate they utilize Milliman® (this includes one plan that indicated it utilizes both Interqual and Milliman®).

B. Provider Complaint Process

All of the states in our comparison require a written provider appeal process. The states each differ on the name for the process (provider appeal, provider complaint, claims dispute process, etc.). Each state has their own unique

timelines for submitting an appeal and other requirements in their contracts, such as response timelines and intake process provisions.

In Florida and Virginia, the providers have a provision in their contract that allows for the state to accept formal provider appeals if the provider is not satisfied with final decision from health plan.

In Indiana, one plan utilizes arbitration for their external review process.

In Michigan, only members are allowed to file with the state formal complaints or appeals. The state agency does receive provider complaints about the health plans informally.

C. Administrative Policies and Procedures That Impact Claims Payments

Georgia's Prompt Pay adjudication requirement for clean claims is 15 days. The Prompt Pay guidelines found in comparison states are less stringent. Indiana requires no more than 21 days to adjudicate a clean claim, while Michigan requires 95 percent of claims to be adjudicated within 30 days.

The check payment cycle information for the other plans was only available for one plan in Missouri, which utilizes a twice-weekly payment cycle.

D. Emergency Department Payment Policies

Please refer to Section II for the emergency department payment policies of the three Georgia CMOs.

The table on the following page includes a summary of emergency department payment policies for the plans in this analysis.

	Georgia			Florida				Indiana	Michigan		Missouri		Pennsylvania		Virginia							
	AMERIGROUP	Peach State	WellCare	AMERIGROUP	Personal Health Plan	United	Vista	WellCare (HealthEase and Staywell)	Anthem	MHS (Centene)	Great Lakes Health Plan	Health Plan of Michigan	Molina Healthcare of MI Harmony Health Plan (WellCare)	HealthCare USA	Mercy CarePlus	Americhoice of PA	Gateway	Keystone Mercy	Plan 1 ³	Plan 2 ³	Plan 3 ³	
ICD-9/ CPT code list used to make ER payment determination	√	√	√	√			√		√	√					√				√			√
Claim reimbursed at full ER rate without medical review				√	√																	
Differential Payments (e.g., Triage and full payments)	√	√	√				√						√		√	√		√				
ER Payment Determination Factors (Time/ Day of week/ Age of patient)		√								√										√		
Medical Review prior to payment									√	√												√

Notes:

1. The checkmark means information was available regarding emergency room payment determination.
2. If Blank, either information not found, or service is not listed as criteria utilized for emergency room payment determination.
3. State did not identify the names of these three plans.

Other States

Florida

We interviewed state Medicaid managed care personnel and staff from three health plans in the State of Florida. The information gathered from these encounters is summarized below:

AMGP Florida's policy for ER claims is as follows:

- Services are reimbursed line by line, not at header level of claim.
- If additional services are billed, the reimbursement may not be line item based.
- Claims are not subject to medical review or pended for medical records as plan feels "patient knows best" as applies to EMTALA and prudent layperson.
- No auto payable list.
- No authorization process in place.
- Hospitals use ICD-9 coding and physicians use CPT coding for reimbursement.

Personal Health Plan policy for ER claims is as follows:

- Facilities are contracted with a per diem rate.
- No medical review is performed unless an outlier is identified.

Vista policy for ER claims is as follows:

- Place of service determines ER, and then the diagnosis code is reviewed.
- Only follow-up visits are required to be reviewed.
- If claim includes more than one revenue code, then a review of the claim is completed to determine level of payment.
- Plan uses an autopayable list.
- Triage rates are based on provider's contract.
- Claims are pended for medical record review with no payment to provider until decision is made.
- The plan utilizes Interqual® criteria.
- Plan contracts with hospitalists to evaluate members in emergency room.

Indiana

We interviewed state Medicaid managed care personnel and staff from two health plans in Indiana. The information gathered from these interviews is summarized here.

The Indiana Scope of Work states:

"The MCO may not deny or pay less than the allowed amount for the CPT code on the claim without a medical record review."

MHS' policy for ER claims is as follows:

- Plan uses an autopay list, but certain codes pend for review.

- If provider is in the plan's network, there is a broader list of ICD-9 codes used.
- Non-emergent codes are reimbursed at a flat rate.
- Non-participating providers are required to submit medical records when submitting ER claims for payment.
- For medical necessity review, prudent layperson standards are applied.
- MHS has a unit in St Louis (ED Unit) that reviews ER claims and applies prudent layperson standards and reviews for medical necessity. After the non-clinical unit completes its review, a recommendation is sent to the Medical Director for final determination.
- If a claim needs to be reviewed, there is no interim payment. Rather, the entire claim is pended.
- The health plan indicated that the time of day, day of the week and/or age of the patient are factors that are considered when making determinations on emergency room claims.

Anthem's policy for ER claims is as follows:

- An autopay list is built into their system.
- If an ICD-9 code is not on auto payable list, then the claim is pended and sent for review and/or medical records are requested from the provider.
- Once the medical records are received, they are reviewed and nurses and physicians, who are part of the medical management team, apply criteria.

Michigan

We interviewed state Medicaid managed care personnel and submitted written questions to three health plans. The information gathered from our interviews and questions is summarized here.

According to Great Lakes Health Plan, payment of emergency room claims is determined by the revenue code and/or procedure code submitted on the claim. The time of day, day of the week, and/or age of patient do not affect payment of these claims.

Health Plan of Michigan indicated that they do not use an autopayable diagnosis list to review emergency room claims. Neither time of the day nor the patient's age affect payment. Payments are based on the level of care billed by the provider.

Molina Healthcare of Michigan has the following emergency room payment policies:

- The health plan utilizes the MDCH 051 edit list of diagnosis codes, supplemented with the plan's proprietary list. This list represents common diagnosis codes that would not support an emergency room visit.
- All facility emergency room claims are reimbursed.
- The reimbursement level for facility claims varies depending upon the ICD-9 diagnosis code on claim.
 - The plan pays emergency room claims based upon the principal diagnosis code, at the Medicaid rate, if determined to be an emergent condition.
 - Diagnoses considered non-emergent are reimbursed as the low level ER visit (CPT code 99281). In addition, ancillary services and professional fees are reimbursed for all emergency room claims including the low level ER visit (99281).
- Providers may appeal lower-level/non-emergent Emergency Room reimbursement.

Missouri

Myers and Stauffer interviewed the state Medicaid managed care personnel but was unable to obtain information directly from any of the health plans in the state. The information gathered from the interviews with the state personnel is summarized below:

Online documentation for Harmony Health Plan and HealthCare USA did not indicate that they have any applicable emergency room information related to the comparison criteria for this project.

The MercyCare Plus provider manual states:

“Emergency room claims received with a primary diagnosis code on the administrative approved list are paid according to the contract. Claims that do not have an approved code are paid at the medical screening rate. The approved list of primary diagnosis codes is used to determine the level of reimbursement of emergency room services for participating providers. At no time does the health plan determine what constitutes a medical emergency. Claims from in-state but non-participating hospital emergency room services are reimbursed at the correct percent of billed charges determined by the State.”

Pennsylvania

Myers and Stauffer was not able to speak directly with either the state Medical managed care personnel or any of the health plan representatives. Therefore, the summary below is based on the documentation gathered from the websites of the health plans selected for the comparison.

- Keystone Mercy Health Plan has the following policies regarding emergency room claim submissions:
 - Reimbursement for emergency services is made at the contracted rate.
 - The plan reserves the right to request the emergency room medical record to verify services rendered.
 - If a claim has been reimbursed at the lower rate, and the original claim submission did not include medical records or the Emergency Room Summary, the hospital provider may resubmit the claim along with medical records (or Emergency Room Summary) for payment level reconsideration.
 - Plan's clinical staff review the medical records and make a decision based on the nature of treatment provided to treat presenting symptoms.
 - Hospital providers are notified via the remittance advice of any decisions to pay at the higher rate.
 - If review of the medical records does not indicate services should be paid at the higher payment rate, a letter is sent to the hospital provider.
 - If the hospital provider disagrees with this determination, the hospital provider may file a Formal Provider Appeal for further consideration of the level of payment.

- AmeriChoice of Pennsylvania pays a triage fee for screenings performed in the emergency room.

- Gateway Health Plan's online documentation did not indicate that they have any applicable emergency room information related to the comparison criteria for this project.

Virginia

Myers and Stauffer interviewed the state Medicaid managed care personnel and provide them with survey questions to distribute to the 3 health plans selected for the comparison. The information gathered is summarized as follows:

One health plan has the following ER policies:

- The plan follows EMTALA guidelines.
- The level of reimbursement is based on the DMAS autopayable list.
- Utilization is monitored on a monthly basis.
- Outreach is performed as needed.

A second health plan has the following ER policies:

- The plan uses the DMAS autopayable list to identify cases that would not meet emergent conditions.
- Time of day, day of the week and the patient's age are factors used in determining coverage.
- The medical director makes denial decisions.
- The plan uses a monthly key-indicator report to identify over-utilization of services.
- A Special Investigation Unit (SIU) has been established to detect under and over utilization.

A third health plan has the following ER policies:

- The plan uses autopayable diagnosis code list
- If the diagnosis code is not on list, then claim is pended for medical record review.
- The medical record is reviewed based on admitting symptoms and the prudent layperson standard.

E. Timeliness Edits/ Admission Dates On Claims

Florida requires the health plans to deny inpatient claims filed after 180 days from date of service and to use the discharge date on inpatient claims for the filing limit determination. During the interview process, three of the five plans indicated they use the discharge date for their determinations.

Indiana requires health plans to deny inpatient claims filed after 180 days from the date of service but is silent in the contract regarding which date to use on an inpatient claim. The plans in Indiana are split in how they make the timely filing determination. One plan uses admission date and the other plan uses discharge date.

Michigan defaults to their fee-for-service language and allows for the filing of claims within 12 months of the date of service. The use of the discharge date is required for filing time limit determinations on inpatient claims. Only one plan in Michigan had documentation related to the use of the discharge date. Another plan uses the admission date for their determination.

Missouri requires plans to deny inpatient claims filed after 180 days from the date of service but also is silent in the contract regarding which date to use on an inpatient claim. Only one plan had documentation related to the use of the discharge date.

Pennsylvania also requires health plans to deny inpatient claims filed after 180 days from the date of service and is also silent in the contract regarding which

date to use on an inpatient claim. Only one plan in Pennsylvania had documentation related to the use of the discharge date.

Virginia defaults to their fee-for-service language and allows for filing of claims within 12 months of the date of service. The use of the discharge date is required for filing time limit determinations on inpatient claims. Two of the three plans in Virginia use the discharge date on inpatient claims for their filing time limit determinations.

In no case was there any provision in the documentation for the waiving of the filing time limit, however when asked this question during the interview process, some plans indicated that these limits could and had been waived when implementation or payment issues arose.

All plans included in this analysis, including the plans in Georgia, have comparable provisions for timely filing of inpatient claims. Michigan and Virginia had the longest filing time limits of within 12 months of the date of service, with both states defaulting to their fee-for-service filing time limit. All the other states required inpatient claims to be timely filed within 180 days of the date of service.

Florida, Michigan, and Virginia's contracts contained language requiring the use of the discharge date for filing time limit determinations. The other states are silent in their contracts regarding this issue. The information found on plans in other states indicates the use of the discharge date with only one plan using admission date.

SECTION IV

ANALYSIS OF THE REGULATORY AND CONTRACTUAL REQUIREMENTS OF REIMBURSEMENT FOR EMERGENCY MEDICAL SERVICES - COMPLETED BY KRIEG DEVAULT LLP

The report at Exhibit F evaluates the regulatory and contractual requirements of reimbursement for emergency medical services including federal law, regulation, and policies, and the Georgia Families model contract between the State of Georgia, Department of Community Health (“DCH”) and Care Management Organizations (“CMOs”) and contracts between health care providers and CMOs. Below is a summary of the key points included in that report. As used in this section, as well as the full report in Exhibit F, the term “we” refers to the law firm, Krieg DeVault LLP.

(1) Federal law, regulation and policies.

The Balanced Budget Act of 1997 set forth standards for Medicaid managed care companies to follow in paying providers for claims for emergency medical services provided to persons covered under Medicaid managed care plans. Essentially, the law required Medicaid managed care companies to cover emergency medical services without regard to prior authorization or the emergency care provider’s contractual relationship with the managed care company. The law also defined “emergency medical condition” to mean:

“...a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.”

Soon thereafter, the Department of Health and Human Services (“HHS”), Centers for Medicare and Medicaid Services (“CMS”) began issuing its interpretation of the meaning of the law through State Medicaid Director letters. The letters describe the requirements for States to implement in their contracts with Medicaid managed care companies. Several key points were clarified in the letters: (a) Emergency services were defined to mean a broad array of inpatient and outpatient services; (b) a Medicaid managed care company is to look to the

presenting diagnosis and all other relevant information in determining whether a service constitutes an emergency medical condition according to the judgment of a prudent layperson; (c) a CMO is not to retroactively deny a claim for emergency services when the condition, which appeared to be emergent under the prudent layperson standard, is later determined to be non-emergent; (d) prior authorization is not to be required for treatment of emergency medical conditions; (e) payers may approve (but not deny) coverage on the basis of an ICD-9 code; and (f) payers can not deny coverage on the basis of ICD-9 codes and then require the claim to be resubmitted as part of an appeals process.

Finally, federal regulations were promulgated providing further guidance regarding Medicaid managed care companies and their coverage of emergency medical services. The rules document the information provided in the State Medicaid Director letters and add clarification regarding a Medicaid managed care company's ability to require providers to notify the managed care company after providing emergency medical services, stating Medicaid managed care companies "may not refuse to cover emergency services based on the emergency room provider, hospital or fiscal agent not notifying the enrollee's primary care provider, MCO, . . . or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services."

(2) DCH's contract with the CMOs.

The next section of the report sets forth relevant provisions of the contract between DCH and the CMOs regarding the CMOs' coverage of emergency medical services. It also discusses contractual remedies available to DCH should DCH determine that the CMOs are not in compliance with the contract and federal and state law, regulation, and policies. Please refer to Exhibit F for the analysis of the relevant provisions.

(3) Contracts between CMOs and Providers

We reviewed three provider contracts for each of the Georgia CMOs. The report contains a chart summarizing the relevant contractual provisions for each CMO relating to its coverage of emergency medical services and applicable appeals procedures found within each contract. Specifically, we reviewed four areas:

(a) Definition of Emergency Medical Services: We looked at each CMO's definition of emergency medical services and how the definition was utilized in processing emergency medical services claims. Generally, but not in all cases, we found each CMO to have a slightly different definition from the emergency medical services definition found in the DCH/CMO contract. The definition of Emergency Medical Services in the DCH/CMO contract is in compliance with federal law and regulation.

(b) Grievance/Complaints/Appeals and Arbitration procedures: We also looked at the contractual language regarding grievances, complaints, appeals and arbitration in each contract. We generally found that the contracts did not completely and adequately address available appeals processes for providers. In at least one contract, we found explicit language stating that providers had no appeals rights with respect to emergency medical services. We also reviewed the CMOs' Provider Manuals regarding appeals rights and found the language to be somewhat vague, without providing a clear process for provider appeals. In two of the three CMOs' Provider Manuals, there was no language notifying providers of their rights to seek administrative law judge hearings with DCH after exhaustion of the CMOs' internal appeals processes, as required in the DCH/CMO contracts.

(c) Reimbursement for Emergency Medical Services: We reviewed the contractual language regarding reimbursement for emergency medical services. We found two of the three CMOs denied services as not being emergency medical services based upon lists of diagnosis codes or CPT codes, resulting in the automatic payment of certain diagnosis codes at the triage rate. These CMOs then required providers to file reconsiderations or appeals of their claims for emergency medical services in order to have them processed for payment by the CMO at the emergency medical services rates.

(d) Notification by Providers of Patients Obtaining Emergency Medical Services. Finally, in two of the CMOs' contracts with providers, we found language indicating two CMOs' require providers to notify them of patients obtaining emergency medical services within 24 to 48 hours of the member's presentation at a provider's emergency department. It was unclear to us if these CMOs are conditioning payment of emergency medical services on providers by requiring notification within 24 to 48 hours of the member's presentation at a provider's emergency department. We were not able to confirm the CMOs' handling of these claims, specifically whether they deny the claims for notice.

Federal regulation does not permit a managed care entity to deny payment for emergency services based upon timely notification if such notification is required within 10 days after a patient presents for services at the provider's emergency department. The DCH/CMO contract would also prohibit CMOs from denying payment based upon the failure of a provider to provide timely notification of an emergency medical services claim.

FINDINGS AND RECOMMENDATIONS

FINDING ONE: CMO accreditation and notification requirements

DCH's contract with the GF CMOs requires accreditation with a choice of several agencies. The contract does not mandate retention of accreditation or disclosure to DCH of any deficiencies found by an accrediting agency.

The Georgia Department of Insurance (DOI) requires in regulation 120-2-92-.04 that an HMO notify the Commissioner of Insurance of the loss of accreditation within 15 days of such occurrence. It is unclear if there is a communication process related to this loss of accreditation in place between DOI and DCH.

In Virginia, the contract between the Department of Medical Assistance Services (DMAS) and the health plans requires the plans be accredited by the NCQA, to retain accreditation, and to report to DMAS any deficiencies noted within 30 days of notification from the NCQA.

RECOMMENDATION RELATED TO FINDING ONE

Based on the finding regarding accreditation, Myers and Stauffer LC recommends that DCH consider amending the CMO model contract to require accreditation with one specific accrediting agency.

OPTIONS RELATED TO RECOMMENDATION ONE

- 1) DCH may wish to consider a requirement that CMOs be accredited by NCQA.
- 2) DCH may wish to require CMOs to notify DCH of a loss of accreditation within 15 days of such an occurrence.
- 3) DCH may also wish to require CMOs to report to DCH within 30 days any deficiencies found by the accrediting agency.
- 4) Finally, DCH may wish to require CMOs to submit a corrective action plan to DCH within 60 days of receiving a notice of deficiency regarding steps to address the deficiencies found and timeframes for resolution. This

information could be beneficial to DCH by providing information regarding processes that could be improved or clarified in a contractual context or by means of other collaborative efforts between DCH and the CMOs.

FINDING TWO: Comprehensive managed care resource for providers

The Virginia DMAS has developed a Managed Care Resource Guide that is sent annually to providers participating in Medicaid managed care. This resource guide includes a summary of the Medicaid managed care programs, a comprehensive list of staff, including case managers at each plan, customer service information, carve-out vendor information, a grid outlining the prior authorization process for therapies, and a mental health matrix. The guide, according to DMAS, has received a positive response from the provider community. The positive response received from the provider community in Virginia suggests this type of guide may be well received in Georgia's provider community as well.

RECOMMENDATION RELATED TO FINDING TWO

We recommend that DCH consider publishing such a resource guide for GF providers.

OPTIONS RELATED TO RECOMMENDATION TWO

- 1) DCH may wish to consider publishing a yearly resource guide for the provider community.
- 2) DCH may also want to consider including a comprehensive list of staff, including case managers, at each plan, customer service information, an outline of the prior authorization process at each plan, and any other pertinent information that would be helpful for the provider in their interaction with the CMOs.

FINDING THREE: Emergency Medical Condition Definition Listed In the DCH Model Contract Contains An Inaccuracy

Section 4.6.1 of the contract between DCH and the CMOs provides a basis of coverage and reimbursement requirements for the CMOs. The provisions of the contract closely correlate to the Federal Regulations defining emergency medical conditions at 42 CFR 438.114 and 42 CFR 489.24. However, the DCH model contract in section 4.6.1.1 defines an Emergency Medical Condition. Specifically, 4.6.1.2.6 states:

With respect to a pregnant woman having contractions: (i) that there is adequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

The language in 4.6.1.2.6(i) is inconsistent with the language found in 42 CFR 489.24 which states in definition of an Emergency Medical Condition under (2) (i) "... that there is inadequate time to effect a safe transfer to another hospital before delivery, or...". The difference between this language and the language found in the DCH contract 4.6.1.2.6(i) is the word "adequate" (i.e., missing "in").

RECOMMENDATION RELATED TO FINDING THREE

We recommend DCH consider updating 4.6.1.2.6(i) to match the language in 42 CFR 489.24 listed above by changing the word "adequate" to "inadequate".

OPTION RELATED TO RECOMMENDATION THREE

- 1) DCH may wish to consider updating their Emergency Medical Condition definition as recommended above in their contract with each CMO.

FINDING FOUR: CMOs Utilize Different Methodologies To Process Emergency Room Claims

Section 4.6.1 of the contract between DCH and the CMOs provides a basis of coverage and reimbursement requirements for the CMOs. The provisions of the contract closely correlate to the Federal Regulations defining emergency medical conditions at 42 CFR 438.114 and 42 CFR 489.24. Our analyses indicate that the CMOs use different methodologies, policies and procedures of both applying the definition of emergent medical conditions and reimbursement of emergent and non-emergent conditions. This variation has caused confusion on the part of hospitals and inconsistent treatment of hospitals across the state.

Hospital claims submitted to the CMOs include the emergency levels of screening and treatment. These levels range from CPT code 99281 ("Straightforward medical decision making") to CPT code 99285 ("Medical decision making of high complexity"). These codes reflect not only the complexity of the treatment but also the time required and difficulty of making a diagnosis. In an April 2000 letter to State Medicaid Directors, CMS advised that absent provider up-coding, CPT codes 99283 - 99285 "very likely" meet the federal prudent layperson standard of a true "emergency".

The Georgia Families Program CMOs pay non-emergency visits to the ER at a contracted triage rate, usually \$50. The CMOs generally reimburse claims for which the services are determined to be for a true "emergency" at a higher emergency rate as specified by the individual provider contracts.

Two of the three CMOs pay a significant number of claims with CPT codes 99283 – 99285 at the triage rate. In one case, the data suggest that a high percentage of these claims are eventually paid at the emergency room rate but only after provider reconsideration and or appeal. One of the three CMOs does not consider the time of day, day of the week or the age of patient when determining payment for emergency room claims, while one CMO will consider these factors if medical records are included with the initial claims submission.

Section 33-21A-4 of HB 1234 includes the following provisions regarding the processing of claims for emergency health care services:

In processing claims for emergency health care services, a care management organization shall consider, at the time that a claim is submitted, at least the following criteria:

- (1) The age of the patient;
- (2) The time and day of the week the patient presented for services;
- (3) The severity and nature of the presenting symptoms;
- (4) The patient's initial and final diagnosis; and

(5) Any other criteria prescribed by the Department of Community Health, including criteria specific to patients under 18 years of age.

Furthermore, HB 1234 gives DCH additional authority to...” develop and publish a list of additional standards to be used by...” the CMOs “...to maximize the identification and accurate payment...” of ER claims.

Based on feedback from Georgia hospital providers, it appears that certain hospitals may not have performed an adequate or thorough review of the contracts with the CMOs prior to signing the contracts. Furthermore, some hospitals indicated to us that, in certain cases they relied on information, terms, discussion, and agreements with CMOs representatives that were not specified in the executed contracts.

RECOMMENDATION RELATED TO FINDING FOUR

We recommend that DCH consider significant changes to the policies and procedures used by the CMOs to identify, process, and pay emergency room claims.

OPTIONS RELATED TO RECOMMENDATION FOUR

- 1) DCH may wish to consider requiring CMOs to use a standardized approach for reimbursing emergency department claims. The standardized approach could be based on either CPT code or diagnosis code. Utilizing a standardized approach would minimize confusion with hospitals and variation among plans, and would reduce the cost of both hospitals and CMOs in managing and reviewing a significant volume of medical records, reconsiderations, and appeals.

Should DCH consider a “CPT” list approach, all emergency department claims would be treated as true emergent situations that meet the prudent layperson standard. Hospital providers would code the appropriate procedure code considering all conditions and factors consistent with standard coding principles, HB 1234, and their contract with the CMOs. Medical charts would not be required to be submitted to or reviewed by the CMOs. CMOs could utilize post payment review to confirm correct coding by hospitals.

Should DCH consider a “diagnosis” list approach, all claims using a diagnosis on the list would represent a presumed emergent condition. DCH would provide a minimum list of presumed conditions. CMOs could add additional diagnoses to the minimum list. Claims with a diagnosis on

the presumed list would automatically be paid as a true emergency. For any diagnosis not on the presumed list, the hospital would be required to submit medical charts at the time of the claim submission. The CMOs would be required to complete a prudent layperson review of the claim, considering all necessary factors and conditions in compliance with HB 1234 and the DCH contract, and determine reimbursement either at the true emergency rate or the triage rate. The following three recommendations apply only if DCH considers a diagnosis code approach:

DCH may wish to consider requiring CMOs to publish and make available to hospitals the list of “presumed” emergent medical conditions.

DCH may wish to consider a requirement that any changes that would reduce the list of “presumed” emergent medical conditions would require DCH approval.

DCH may wish to consider requiring CMOs to use the definition of emergency health care services described in the DCH model contract, the prudent layperson provisions of Federal law, and the provisions of HB 1234 in the emergency room claim adjudication process, as well as in contracts with their network providers. The same definition should be used by each CMO and CMO/provider contract.

- 2) DCH may wish to consider requiring CMOs to evaluate emergency room reimbursement and coverage policies and modify their criteria based on reconsideration and appeal overturn rates.
- 3) Hospitals have ultimate responsibility for the contracts they execute and should exercise greater due diligence before signing off on contracts with CMOs. Hospital providers should review contracts with managed care entities 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.
- 4) DCH may wish to consider updating and completing an annual evaluation and assessment of the list of presumed emergency diagnoses codes used in the fee-for-service program.
- 5) We would encourage the Georgia hospital associations to develop tools that can be used by its membership, such as a guide to ensure that certain contract terms and specificity are included in the contract between CMO and provider. These tools or guides should not include or address CMO proprietary information.

- 6) DCH may wish to require CMOs to meet with hospital providers on a quarterly basis to discuss methods of reducing over-utilization of emergency room services. We would encourage Georgia hospital providers to become partners in reducing unnecessary emergency room utilization.

FINDING FIVE: Lack Of Uniformity Of Prior Authorization Processes

Hospital providers reported to us a number of issues with prior authorization including:

- Claims impacted by the application of the “72-hour rule” (i.e., when the readmission claim is merged with the original claim, one PA record is also deleted);
- Issues related to not understanding the services that require PA;
- Issues related to add-on procedures performed during the service (e.g., surgery);
- Issues related to data entry of authorizations; and
- Issues related to authorizing a specific procedure rather than a family of procedures.

Florida’s state agency, Agency for Health Care Administration (AHCA), is studying ways to streamline the prior authorization process, which may include utilizing a standard prior authorization request form or protocol.

Michigan utilizes a standardized prior authorization form and a standard credentialing form. These forms are used by all of the Medicaid managed care health plans in Michigan.

Currently, each CMO operating in Georgia has its own process for obtaining prior authorization.

RECOMMENDATION RELATED TO FINDING FIVE

Based on the high volume of claim denials for prior authorization issues, we recommend that DCH consider changes to the prior authorization policies and procedures. DCH may wish to consider streamlining the prior authorization process in order to decrease provider confusion and reduce administrative burden of the provider community.

OPTIONS RELATED TO RECOMMENDATION FIVE

- 1) DCH may wish to consider requiring CMOs to collaboratively develop and utilize a standard prior authorization form. Standardization of forms, as observed in Michigan, should alleviate confusion regarding the number and types of forms provider must submit.

- 2) We would encourage providers and provider associations to train their staff and association members on procedures to track prior authorization requests and responses, better understand CMO prior authorization policies and policy changes, and the differences between CMO prior authorization requirements and traditional Medicaid prior authorization requirements.
- 3) DCH may wish to consider requiring CMOs to provide electronic confirmation to the providers that include all relevant information regarding the authorization request.
- 4) DCH may wish to consider requiring CMOs to update, publish, and maintain a comprehensive list of services that require prior authorization. Updates made to the lists should be communicated to the provider community and DCH within a specified time period determined by DCH. This resource should identify the categories of service that require submission of medical records along with the prior authorization form.
- 5) DCH may wish to require that the CMOs provide a designated CMO staff person, such as the provider relations and/or medical management designee, to assist providers with questions regarding the plan's prior authorization policies and procedures. CMO provider relations staff should be able to accurately relay prior authorization requirements to providers.
- 6) DCH may also wish to require CMOs to conduct periodic training for hospitals regarding the prior authorization requirements, policies and procedures of the CMO.
- 7) DCH may wish to consider requiring CMOs to permit payment of medically necessary add-on or additional procedures completed during medical procedures. Providers should be required to notify the CMOs when an additional procedure is completed so that the CMOs can complete a pro-forma change to the authorization request. The CMOs should utilize post payment review to confirm the medical necessity of questionable procedures.
- 8) DCH may wish to consider requiring CMOs to authorize a family or range of procedure codes rather than a specific code or procedure. This process would improve claims processing efficiency, as the claim billed would more likely be approved based on the criteria in the authorization and less likely to suspend for claims examiner intervention. The decision to authorize a family of procedures or a specific procedure may be specific to the category of service requested.

- 9) DCH may wish to consider requiring CMOs to evaluate and/or modify prior authorization requirements for categories of service that exceed a pre-determined threshold level of approvals and report specific findings to DCH.
- 10) DCH may wish to consider requiring CMOs to develop automated processes to properly merge and update authorization records when the “72-hour rule” is applied.
- 11) DCH may wish to consider requiring CMOs to accept prior authorizations from other plans when members change health plans, based on parameters established by DCH medical staff.

FINDING SIX: Recoupment Process Not Adequately Addressed In the DCH Model Contract

There was not an abundant amount of information available regarding CMO recoupment initiatives. The DCH model contract does not address this subject. However, based on feedback from the provider community, we believe it is a topic that could be expanded. One state that we interviewed required the health plans to notify the state of their intent to recover monies from the providers.

RECOMMENDATION RELATED TO FINDING SIX

DCH may wish to consider addressing recoupments in the model contract.

OPTIONS RELATED TO RECOMMENDATION SIX

- 1) DCH may wish to consider requiring a time limit on recoupments based on the date of service of the claim. The time limit should provide adequate time for the CMO to conduct post-payment review activities, as necessary.
- 2) DCH may also want to consider a requirement that the contracts between the CMO and provider to address recoupments and to identify policies and procedures. In addition, provider contracts should include information regarding how the provider will be notified and the rights of providers to file an appeal when the provider disagrees with the recoupment. Specifically, the policies and procedures should describe how the CMO will notify the provider of the overpayment, the timeframe for the provider to reimburse the CMO, the methods of repayment available to providers. The CMO should include a sufficient level of detail with recoupments including the identification of the patient, claim(s) numbers, service dates, payment dates, reason(s) for recoupment, and dollars associated with the recoupment.
- 3) Appeal language regarding recoupments should also be considered by DCH as a requirement in the model contract and in the contracts between the CMO and provider.

FINDING SEVEN: Providers Require Access To Explanation Of Payment Disposition Codes

Hospital providers reported to us that they oftentimes did not understand the payment disposition codes, or there was insufficient information included with the disposition code. During our analysis, we identified denied claims that did not include an explanation of benefit (EOB) code.

The three Pennsylvania health plans Myers and Stauffer analyzed each have their Explanation of Payment disposition codes available online for the providers. These disposition codes can be accessed without a password. Other state health plans may have this functionality on the secure side of their websites, as well. Currently, PSHP is the only plan in Georgia that has comparable functionality available on their website.

RECOMMENDATION RELATED TO FINDING SEVEN

DCH may wish to require the CMOs to provide their Explanation of Payment codes on their websites. This provides an additional explanation to the provider on claim adjudication rationale.

OPTIONS RELATED TO RECOMMENDATION SEVEN

- 1) DCH may want to consider requiring CMOs to provide explanation of payment disposition codes on their website or in their provider manual.
- 2) DCH may wish to add this information to a provider resource manual as discussed in Recommendation Two.
- 3) DCH may also want to require that each denied claim include an EOB with a sufficient level of information to the provider, such that the provider can understand the reason for the denial and how to correct the claim for payment, as applicable.

FINDING EIGHT: Confusion Regarding The Provider Appeal Process

The DCH model contract gives the CMOs provisions for their provider appeals processes. However, further specifications in the model contract appear to be needed to direct the CMOs to have standard language and transparent processes related to provider appeals.

RECOMMENDATIONS RELATED TO FINDING EIGHT

Currently, there is considerable variation among CMOs and provider contracts with respect to the reconsideration and appeals processes. In order to alleviate confusion regarding the appeal process, DCH should consider developing a standardized process. This process should include the internal CMO processes that should be exhausted prior to a request for an administrative hearing.

The CMO provider contracts and provider manuals do not clearly describe the grievance, complaints, arbitration, and internal and external appeal processes. DCH might consider requiring each CMO to adequately describe all complaint/ grievance/ arbitration and appeals' processes in each provider contract to ensure they comply with the requirements in the DCH CMO model contract, and that all CMO provider notices include an appropriate notice of appeal rights. One CMO requires providers to waive their right to a hearing with an Administrative Law Judge (ALJ).

While the CMOs describe their grievance and appeal processes in their respective Provider Manuals, we generally found the descriptions to be too vague to provide meaningful guidance to providers as to their rights to file appeals or complaints regarding the CMOs. We also found that the CMOs are not adequately describing in their Provider Manuals, a provider's right to an ALJ hearing.

OPTIONS RELATED TO RECOMMENDATION EIGHT

- 1) We recommend that DCH consider using the NCQA definitions related to the grievance and appeal process and align the contract language to follow the verbiage used by this accreditation agency. Standard language (i.e., terminology) would allow DCH, the CMOs and the provider community to better understand reports, processes, and contract requirements.
- 2) DCH may wish to consider requiring each CMO to permit appeals in accordance with the DCH/CMO contract.

- 3) DCH may wish to develop requirements that would ensure a timely and fair appeals process for providers to utilize and permit providers to consolidate appeals on common issues.
- 4) DCH may also wish to require CMOs to provide for a complaint process for providers with DCH investigators who follow-up on such complaints.

FINDING NINE: DCH Model Contract Does Not Address the Date That Initiates the Start Of Filing Time Limit Calculation

Currently, the DCH model contract does not specify which date, admission or discharge, on inpatient claims is to be used for the filing time limit calculation. From our research, we found that one half of the states reviewed mandate the health plans use the discharge date of an inpatient admission for the determination of the filing time limit. This allows the providers more time to file an inpatient claims for a complex case where the patient is admitted for an extended period of time. It also makes it clear to the CMOs how the calculation is to be done and allows for consistent application across all hospitals.

RECOMMENDATIONS RELATED TO FINDING NINE

We recommend that DCH consider including the discharge date as part of the filing time limit calculation in the DCH model contract with the CMOs.

OPTION RELATED TO RECOMMENDATION NINE

- 1) DCH may wish to modify the model contract to include the date of discharge on inpatient claims as part of the criteria for filing time limit calculations.

FINDING TEN: INCONSISTENT DEFINITION OF EMERGENCY MEDICAL SERVICES IN CMO CONTRACTS

It appears that each of the CMOs are using a different definition for “Emergency Medical Services” in their contracts with the providers and that the definitions used by the CMOs in their contracts with providers are not the same as the definition in the DCH CMO model contract. These variations in definition could allow the CMOs to more narrowly or broadly define emergency services for providers.

RECOMMENDATION RELATED TO FINDING TEN

DCH may wish to consider requiring each CMO to use the same definition of Emergency Medical Services as stated in the DCH CMO model contract. This common definition should be used ubiquitously in all contracts, provider manuals, and update bulletins.

FINDING ELEVEN: Lack Of Direction As To How To Apply The “72-Hour Rule”

We were not able to identify information available to providers and hospital billing personnel regarding the application of this reimbursement policy in the DCH model contract or the CMOs’ documentation. The Georgia Fee For Service Provider Manual- Part II Policies and Procedures for Hospital Services has some general guidelines in Sections 904 and 906.

RECOMMENDATION RELATED TO FINDING ELEVEN

We recommend that DCH consider using these guidelines to amend the model contract with the CMOs to include information regarding this rule.

OPTIONS RELATED TO RECOMMENDATION ELEVEN

- 1) DCH may wish to modify the DCH CMO model contract to include information and guidelines for utilization of the “72-hour rule”.

Additionally, DCH may wish to require the CMOs to use these guidelines to develop policies and procedures regarding the “72-hour rule” and include in the CMOs’ provider manuals. The policy should clearly describe the services for which the policy applies and the specific criteria used to merge, adjudicate, and reimburse claims.

- 2) In addition, as stated above in the Prior Authorization section, DCH may also wish to require the CMOs to develop processes to properly merge and update authorization records when the “72-hour rule” is applied. Understanding of how the policy will be applied for claims payment will allow for more transparency of the CMOs claims payment determination decisions.

FINDING TWELVE: DCH Model Contract Provides Limited Information Regarding The Handling Of Third Party Liability (TPL) Claims

The information currently available is limited and not specific regarding claims with third party liability. Many hospital providers reported to us issues on claims with TPL, specifically that CMOs deny claims with TPL and require providers to resubmit claims or appeal the payment decision after the TPL payment is received.

RECOMMENDATION RELATED TO FINDING TWELVE

We suggest that DCH consider evaluating whether the model contract should include additional requirements regarding the handling of third party liability claims.

FINDING THIRTEEN: Innovative Incentive Plan Found in Comparison State

During the contract comparison phase of this analysis, we found that Indiana has a unique plan for incentivizing not only physicians, but also the MCOs and the members. The plan utilizes a three-stage approach. The State provides financial or non-financial incentives to the MCO. If financial, then the MCO must reinvest at least 50 percent of the incentive in a physician or member incentive program, which must be approved by the State. The State chooses the priority areas around which the MCOs must establish incentive plans. These areas must have associated, easily quantifiable, and health-promoting measures. Emergency room utilization, blood lead screening, and prenatal care are some examples of priority areas the state has focused on in the recent past.

The second stage is the physician incentive plan, which is developed by the MCO with state approval. These incentive plans can also be financial or non-financial and must be utilized for, at a minimum, the top ten percent of high-volume, contracted primary care providers, based on member enrollment. Financial examples include increased reimbursement rates based on performance as well as bonus payments for selected services. The MCO is also responsible for the third stage of the incentive program relating to members. The goal for these member incentive plans is to increase member responsibility by rewarding health-promoting behavior. The incentives for members can be financial or non-financial and must be approved by the State. The financial incentives cannot exceed \$50 per member per year. The MCO is subject to penalties on both the federal and state levels if determined they provided inappropriate inducements. Appropriate rewards include gift certificates for groceries and new baby “welcome” kits.

RECOMMENDATION RELATED TO FINDING THIRTEEN

We recommend DCH consider implementing a similar incentive plan to improve the quality of care and health outcomes of their Medicaid managed care members.

OPTIONS RELATED TO RECOMMENDATION THIRTEEN

- 1) DCH may wish to consider developing an incentive plan for the CMOs, providers, and members.
- 2) DCH may also wish to establish compliance parameters and include in the model contract.

HB 1234

House Bill 1234 was passed by the 2007-2008 Georgia General Assembly on April 4, 2008, and was signed into law by Governor Perdue on May 13, 2008. Many of the provisions of House Bill 1234 appear to address the observations, findings, and recommendations included below. In addition, the Department of Community Health has informed us that they have incorporated the provisions of House Bill 1234 and many of our recommendations into the most recent CMO contract.

DCH AND CMO RESPONSES TO FINDINGS

Both DCH and each of the CMOs have prepared responses to the findings listed above. Please refer to Exhibits G through J for the complete responses. These responses include detailed descriptions of initiatives undertaken to address the issues identified as well as additional information provided after the completion of our analyses that may provide clarification related to certain issues.

EXHIBITS

Georgia Department of Community Health
Division of Managed Care and Quality
Exhibit A

**Georgia Department of Community Health
CMO Project**

Proposed Medicaid Managed Care Plans for Comparison

State	Alabama ¹	Florida	Indiana	Michigan	Missouri	Pennsylvania	Virginia
CMO/MCOs to include		Amerigroup ²	Anthem	Great Lakes	Harmony ²	Keystone Mercy	Amerigroup ²
		HealthEase ³	Managed Health Services ⁴	Molina	HealthCare USA	AmeriChoice of PA	Optima Family Care
		Staywell ³		Health Plan of Michigan	Mercy Care Plus	Gateway Health Plan	VA Premier Health
		Personal Health Plan					
		United HealthCare					
	Buena Vista						
CMO/MCOs excluded		Citrus Health Care	Advantage	BlueCaid	Missouri Care	Amerihealth Mercy	Anthem Health Keepers
		Freedom	CareSource (no longer participating)	Community Choice	Blue-Advantage Plus	Unison Health Plan	CareNet Southern
		Evercare	Harmony (no longer participating) ³	HealthPlus Partners	Childrens Mercy Family	Health Partners	
		Humana Family	Molina	McLaren Health Plan		UPMC Health	
		Jackson Memorial	MDwise	Midwest Health Plan			
		Preferred Medical		Omnicare Health Plan			
		Total Health Choice		PHP-MM Family Care			
		Universal Health Care		Total Health Care			
		Vista South		Upper Peninsula Health			
				Priority Health Gov't			
			ProCare				

¹ It has been determined that Alabama does not use private managed care plans (MCO's or CMO's) to administer the state's Medicaid Managed Care program and it has, therefore, been removed from our list of recommended states to use for comparison to the Georgia plans. The number of comparison states will be reduced to 6.

² Part of Amerigroup family of plans

³ Part of WellCare family of plans

⁴ Part of Centene family of plans

Factors used in determining which managed care plans to include in comparison:

- * Common ownership by one of the parent companies of the 3 Georgia CMO's: WellCare, Amerigroup or Centene
- * Larger member enrollments
- * Comparable services/member benefits to Georgia plans
- * Mandatory managed care rather than voluntary enrollment
- * Larger geographic coverage versus restricted to single, small area
- * Private company administration rather than government operated plans

Exhibit B

Reconsiderations & Appeals (provider focused)

R&A1) Tell us how health plan management monitors reconsideration & appeal process? Have you ever made changes to policies and procedures as a result of this process?

Emergency Room Services

ER1) Describe the emergency room coverage and payment policies, describing each step in the process for an ER claim once it is received..

ER2) Does health plan use a list of diagnoses or symptoms to identify emergent conditions for payment purposes?

- a) If so, are you using DCH's version or your own?
- b) Are there CPT codes on the list?

ER3) For an ER claim that does not have an "autopayable" diagnosis, what process does the claim go through? Is the claim paid at the triage rate or does the claim pend/ deny for medical records?

ER4) Do the time/ day of week and/or age of the patient affect the determination of an emergent condition either in claims adjudication or the appeal process?

ER5) Please describe how the health plan applies prudent layperson criteria when adjudicating claims? Please describe the staff resources and qualifications used in this process.

ER6) Please describe the policies and procedures the plan has used to monitor and reduce emergency room utilization.

Medical Management

MM1) Please tell us your policy for post-stabilization services.

MM2) Do you evaluate pre-certification approval and denial rates?

MM3) Does the health plan consider process improvements or policy changes as a result of pre-certification approval/denial/reconsideration rates?

Timely Filing Requirements

TFR1) For inpatient hospital claims, do filing limit edits use admission date or discharge date?

Exhibit C: Amerigroup

Reconsiderations & Appeals (provider focused)

R&A1) Tell us how health plan management monitors reconsideration & appeal process? Have you ever made changes to policies and procedures as a result of this process? **Please see the attached policy and procedure regarding the provider appeal process. We have not made specific changes to the policy, but we have identified enhancements to our claims processing procedures. For example, the response to TFR1 below indicates a process that was implemented as a result of reviewing appeals trends.**

Emergency Room Services

ER1) Describe the emergency room coverage and payment policies, describing each step in the process for an ER claim once it is received..

- **If the provider is billing only ER and no other higher level of care (99281-99285) then the claim pays based on the CPT code billed per the provider contract.**
- **If the provider is billing ER and Observation, then the higher level of care would pay and the ER would not pay per AGP policies and provider contract. In this scenario, AGP would pay the observation rate.**

ER2) Does health plan use a list of diagnoses or symptoms to identify emergent conditions for payment purposes? **AGP does not use a diagnosis or symptoms listing to identify emergent conditions for claims payment. AGP pays based on CPT code and revenue code billed by provider.**

- a) If so, are you using DCH's version or your own? **Not applicable to AGP**
- b) Are there CPT codes on the list? **Not applicable to AGP**

ER3) For an ER claim that does not have an "autopayable" diagnosis, what process does the claim go through? Is the claim paid at the triage rate or does the claim pend/ deny for medical records? **Not applicable to AGP, AGP pays based on the billed CPT code unless higher level of care applies then the higher level of care would pay and not the ER.**

ER4) Do the time/ day of week and/or age of the patient affect the determination of an emergent condition either in claims adjudication or the appeal process? **Not applicable to AGP**

ER5) Please describe how the health plan applies prudent layperson criteria when adjudicating claims? Please describe the staff resources and qualifications used in this process. **Not applicable to AGP**

ER6) Please describe the policies and procedures the plan has used to monitor and reduce emergency room utilization.

- **AGP reviews ER claims reports to identify "frequent flyers". Contact is then made to this member type through case management for those members identified with a targeted diagnosis for intervention and assessment for additional case management needs.**
- **Daily ER reports are sent directly to the health plan from five (5) high volume ER hospitals. Contact is then made to this member type through case management for those members identified with a targeted diagnosis for intervention and assessment for additional case management needs.**

- Review of a bi-weekly report generated from the nurse helpline of those members sent to the ER. Contact is then made to this member type through case management for those members identified with a targeted diagnosis for intervention and assessment for additional case management needs.
- Educational mailers for those members identified as frequent flyers for coordination back to their medical home or an urgent care center for routine non-ER level of care.
- Review of monthly utilization data to identify trends of ER utilization by product and region. Based on analysis, AGP will make adjustments to its ER program.

Medical Management

MM1) Please tell us your policy for post-stabilization services. **If the member is in the ER, and post-stabilization is performed within the ER or during an observation stay, no authorization is required by AGP. If post-stabilization is required in an inpatient setting, provider must notify AGP within one business day for authorization of inpatient services.**

MM2) Do you evaluate pre-certification approval and denial rates? **Yes**

MM3) Does the health plan consider process improvements or policy changes as a result of pre-certification approval/denial/reconsideration rates? **Yes, in collaboration with our corporate partners. For example, AGP recently eliminated the requirement for notification of an observation stay.**

Timely Filing Requirements

TFR1) For inpatient hospital claims, do filing limit edits use admission date or discharge date? **AGP's system calculates by admission date, but because our claims processing system cannot be set up to adjudicate based on discharge date, AGP has a pend on inpatient claims so that the processor will adjudicate the inpatient claim based on the discharge date and the timely filing requirement for the provider. Should a processor error occur and the claims processor does not pay the inpatient claim based on the discharge date, then AGP would reprocess the claim and apply interest based on the received date of the claim.**

PSHP Responses

DCH and Myers & Stauffer Audit Research Request

Question	PSHP Response
Reconsiderations & Appeals (provider focused)	
R&A1) Tell us how health plan management monitors reconsideration & appeal process? Have you ever made changes to policies and procedures as a result of this process?	Peach States monitors appeal volumes and timeliness and reports statistics to DCH on a quarterly basis. Yes, changes have been made to this process based on monitoring.
Emergency Room Services	
ER1) Describe the emergency room coverage and payment policies, describing each step in the process for an ER claim once it is received..	See attached documentation, ER1
ER2) Does health plan use a list of diagnoses or symptoms to identify emergent conditions for payment purposes?	Yes; however, PSHP does not deny emergency room claims based on this list of ICD-9 codes. See response to question E1 regarding how this list of ICD-9 codes is used in the automated versus non-automated process.
a) If so, are you using DCH's version or your own?	Yes, Centene utilizes the DCH's version of the diagnosis code list for ED claims reimbursement.
b) Are there CPT codes on the list?	No.
ER3) For an ER claim that does not have an "auto payable" diagnosis, what process does the claim go through? Is the claim paid at the triage rate or does the claim pend/ deny for medical records?	See response to question E1 regarding the claim process for the non-automated process. These claims will be pended for medical record review
ER4) Do the time/ day of week and/or age of the patient affect the determination of an emergent condition either in claims adjudication or the appeal process?	Yes.
ER5) Please describe how the health plan applies prudent layperson criteria when adjudicating claims? Please describe the staff resources and qualifications used in this process.	The claim is reviewed by a non-clinical CCM analyst. The CCM analyst reviews the ED record, specifically evaluating the member's presenting symptoms (at the time of triage in the ER) and whether or not they meet the PLP definition of an emergency as defined in the contract agreement between Georgia DCH and PSHP. The CCM analyst works under the supervision of a registered nurse in order to ensure correct interpretation of the medical record and facilitate the decision with respect to the presence or absence of an obvious medical emergency.
ER6) Please describe the policies and procedures the plan has used to monitor and reduce emergency room utilization.	See attached documentation, ER6

PSHP Responses

Medical Management	
MM1) Please tell us your policy for post-stabilization services.	Post-stabilization services do not require prior authorization for participating facilities/providers. Prior authorization for post-stabilization services is required for non-participating facilities/providers for the purpose of discharge planning and care coordination.
MM2) Do you evaluate pre-certification approval and denial rates?	Yes.
MM3) Does the health plan consider process improvements or policy changes as a result of pre-certification approval/denial/reconsideration rates?	Yes.
Timely Filing Requirements	
TFR1) For inpatient hospital claims, do filing limit edits use admission date or discharge date?	Timely filing edits use the discharge date for inpatient hospital claims.



Philip J. Wasden
Vice President - Operations

March 26, 2008

Kathy Haley, MPL
Myers & Stauffer LC
9265 Counselors Row, Suite 200
Indianapolis, IN 46240
317-846-9521 ext 371

Re: Policy Follow-up Questions

Dear Kathy:

In response to your questions we have pulled together a number of internal documents and policies to help explain how we administer the items noted in your letter. One document in particular that you may find useful is the FourThought Group's audit performed on Emergency Room Claims as directed by DCH. This document summarizes the exhaustive review they completed and provides insight into our administration of that policy. That audit was done on-site by the FourThought Group in May 2007. You will also find a summary of 2007 ER PLP appeals and statistics showing that only 20% are overturned upon appeal and highlighting some of the specific rates for a number of hospitals .

Please find the answers to your questions as follows:

R&A1) Tell us how health plan management monitors reconsideration & appeal process? Have you ever made changes to policies and procedures as a result of this process?

Appeal statistics are reviewed monthly by Appeals management team in preparation for the cross-divisional CSQIW (Customer Service Quality Improvement Workgroup). The workgroup identifies areas of needed quality improvement through analysis of trends found in member satisfaction surveys, complaint and appeal data and requests for PCP changes and member disenrollment. Once the CSQIW determines that an issue should be researched further, a subgroup representing all appropriate departments is created to brainstorm and present solutions to the CSQIW. The sub-group will present routine, timely, progress reports and results to the CSQIW until it is determined that the issue no longer requires the attention of the CSQIW. The CSQIW reports to the MAC (Medical Advisory Committee). The MAC reports results to the QIC (Quality Improvement Council). And the QIC reports results to the Board of Directors. Though no changes have been made to Appeals Policies and Processes

WELLCARE OF GEORGIA, INC.
211 Perimeter Center Parkway
Suite 800
Atlanta, Georgia 30346
Telephone: (678) 327-0939
866-300-1141
Fax (678) 327-0944

WellCare Health Plans, Inc.
WellCare Group of
Companies



March 27, 2008

Page 2 of 4

resulting from CSQIW sub-group activities, Appeals data has been key information when reviewing prior auth activities, configuration and claims payment policies and procedures.

Attached you will find a copy of the management summary report used to monitor the activity, turnaround time, reason and high volume providers.

ER1) Describe the emergency room coverage and payment policies, describing each step in the process for an ER claim once it is received..

Refer to PowerPoint Presentation, specifically page 16-21, which summarizes the process. If you have questions we can set up a call to discuss.

ER2) Does health plan use a list of diagnoses or symptoms to identify emergent conditions for payment purposes?

As independently validated by the FourThought Group, "Specifically, WellCare does not use a fixed list of diagnosis (DX) codes to determine what is considered an emergent versus non-emergent condition." (FourThought Group, Emergency Room Claims Monitoring, p.14)

a) If so, are you using DCH's version or your own? N/A

b) Are there CPT codes on the list? N/A

ER3) For an ER claim that does not have an "autopayable" diagnosis, what process does the claim go through? Is the claim paid at the triage rate or does the claim pend/ deny for medical records?

"WellCare has developed an automated 'presumptive' list of DX codes that does not limit what will be considered an emergent condition, but instead, 'presumptively' or automatically treats certain claims as an emergency condition. This facilitates automated, systematic payment of a claim at the ER rate." (FourThought Group, Emergency Room Claims Monitoring, p.12)
"Hospitals billing non-emergent DX codes in the admitting, primary, secondary and tertiary diagnosis fields which may have been considered emergencies under the Medicaid FFS program...are not specific enough to warrant an emergency determination in the WellCare system" "These claims would need to be re-submitted via the reconsideration process, with additional documentation, in order to be further classified as emergency claims." (FourThought Group, Emergency Room Claims Monitoring, p.12-13). Claims not considered as an emergency condition are adjudicated and paid at the individual contracted rate for non-emergent claims.



March 27, 2008

Page 3 of 4

ER4) Do the time/ day of week and/or age of the patient affect the determination of an emergent condition either in claims adjudication or the appeal process?

“The WellCare system does not currently consider day of the week (weekend vs. weekday), time of day of presentation to the ER, or member age” (FourThought Group, Emergency Room Claims Monitoring, p.13), during the claim adjudication process, unless the medical records are provided with the initial claim submission. These factors are taken into consideration when medical records and documents are submitted during the ER reconsideration and appeals process, but can not be considered as a sole determining factor when assessing the condition.

ER5) Please describe how the health plan applies prudent layperson criteria when adjudicating claims? Please describe the staff resources and qualifications used in this process.

“WellCare has developed an automated ‘presumptive’ list of DX codes that does not limit what will be considered an emergent condition, but instead, ‘presumptively’ or automatically treats certain claims as an emergency condition. This facilitates automated, systematic payment of a claim at the ER rate.” (FourThought Group, Emergency Room Claims Monitoring, p.12)
“Hospitals billing non-emergent DX codes in the admitting, primary, secondary and tertiary diagnosis fields which may have been considered emergencies under the Medicaid FFS program..are not specific enough to warrant an emergency determination in the WellCare system” “These claims would need to be re-submitted via the reconsideration process, with additional documentation, in order to be further classified as emergency claims.” (FourThought Group, Emergency Room Claims Monitoring, p.12-13). Claims not considered as an emergency condition are adjudicated and paid at the individual contracted rate for non-emergent claims.

ER6 Please describe the policies and procedures the plan has used to monitor and reduce emergency room utilization.

Refer to attached PowerPoint presentation which summarizes WellCare activities to monitor and reduce ER utilization. If you have any questions about it we will be happy to set up a call to review.

MM1) Please tell us your policy for post-stabilization services.

Attached is a copy of our policy as it relates to post-stabilization services.

WELLCARE OF GEORGIA, INC.
211 Perimeter Center Parkway
Suite 800
Atlanta, Georgia 30346
Telephone: (678) 327-0939
866-300-1141
Fax (678) 327-0944



March 27, 2008

Page 4 of 4

MM2) Do you evaluate pre-certification approval and denial rates?

Yes, these and other metrics are monitored to trend and identify issues.

MM3) Does the health plan consider process improvements or policy changes as a result of pre-certification approval/denial/reconsideration rates?

Yes, changes to services requiring pre-certification are changed occasionally based on a detailed review and a number of factors including analysis of the procedures, claim data, coding changes, provider feedback and denial rates. Attached is a file containing several policy changes as examples.

TFR1) For inpatient hospital claims, do filing limit edits use admission date or discharge date?

Initially, Wellcare's timely filing calculation for inpatient claims was set up incorrectly as it was based off of the admission date. This error was identified and corrected in September 2007.

Please let me know if you have any questions upon review.

Sincerely,

A handwritten signature in black ink, appearing to read "Philip J. Wasden", with a long horizontal flourish extending to the right.

Philip J. Wasden

cc: Mike Cotton
Susan Kohler

Exhibit D

Background

BG1) How and over what span of time was Medicaid managed care implemented within the state?

BG2) What issues did you face when the Medicaid Managed Care Program was implemented?

BG3) How does the state agency and the health plan coordinate member eligibility information?

Reconsiderations & Appeals (focus on provider)

R&A1) Describe the provider complaints (reconsiderations and appeals) process overview.

R&A2) How does the health plan accept reconsiderations and appeals?

R&A3) What are the timelines for a response?

R&A4) How is the state agency involved in this process?

R&A5) How does health plan management monitor reconsideration & appeal process and how does health plan make changes to policies and procedures as a result of this process?

R&A6) In regards to provider reconsiderations and appeals:

- What are the top issues provider are asking for reconsideration or appealing?
- What types of issues are frequently overturned?
- What is the most common complaint regarding the reconsideration and appeal process?

Emergency Room Services

ER1) Describe the emergency room coverage and payment policies.

ER2) Does health plan use a list of diagnoses to identify emergent conditions?

ER3) Does the health plan have differential payment amounts for emergent/non emergent conditions?

ER4) Does the time/ day of week and/or age of the patient affect the determination of an emergent condition?

ER5) How does the health plan apply the prudent layperson criteria when determining emergent situations?

ER6) What resolutions are available to hospitals if they do not agree with the payment amount?

ER7) When are medical records required to be submitted for payment of an emergency room claim?

**Department of Community Health
Georgia Families Program
Research of Medicaid Risk-Based Managed Care Policies and Procedures
January 29, 2008**

ER8) How do you identify excessive emergency room utilization? If identified, what process is used to address the issue?

Medical Management

MM1) Describe the services that are subject to pre-certification/ prior authorization.

MM2) Describe your medical management policies and procedures for medical necessity determinations.

MM3) Describe your medical management policies and procedures for emergency room services.

MM4) Describe your medical management policies and procedures for post-stabilization services.

MM5) Describe your medical management policies and procedures for identifying and addressing utilization and access issues.

MM6) Are diagnosis/procedural codes that are pre-certified specific to a particular code, or is the authorization given to the family of related codes?

MM7) If health plans use claim grouping or bundling, what is the process for merging claims with potentially multiple pre-certifications?

MM8) Do health plans evaluate pre-certification approval and denial rates in order to modify pre-certification requirements and/or for process improvement?

MM9) What are timeframes for standard and expedited prior authorization requests?

Provider Relations

PRL1) Are health plans part of national corporation, if so which?

PRL2) Is local provider relations staff empowered to make changes to claim processing system, contract etc, or are those issues addressed by national corporation?

PRL3) Are telephone provider hotline staff local or part of national corporation?

PRL4) Have you experienced any situations where health plans' provider relations staff contribute to issues with providers (i.e., such as miscommunications etc)?

PRL5) Do health plans experience high turnover rates among provider relations staff?

Administrative Policies and Procedures

APP1) What are the interest requirements, if any, for untimely adjudicated claims? What are the timely adjudication requirements for the health plans?

APP2) Does the health plan use claim validation software such as McKesson's ClaimCheck?

**Department of Community Health
Georgia Families Program
Research of Medicaid Risk-Based Managed Care Policies and Procedures
January 29, 2008**

APP3) Does health plan accept both paper and electronic claims for both original claim submissions as well as claim corrections and adjustment requests?

APP4) In situations where it is determined that claims should be reprocessed, do the health plans reprocess all affected claims for all providers, or is reprocessing limited to those providers that presented the situation?

Electronic Data Interchange

EDI1) Do health plans submit electronic confirmations (i.e., file acceptance) of received claim batches?

EDI2) Do health plans use standard HIPAA EOB codes, or crosswalk HIPAA EOB codes to local EOB codes?

Claim Coding Requirements

CCR1) Are there specific coding requirements of the health plans that cause concern and/or complaints from the provider community?

CCR2) Do health plans use bundling of claims, such as a 72-hour rule?

CCR3) If so, are these limited to one service type (e.g., inpatient to inpatient) or are they applied across service types (e.g., inpatient to outpatient)?

CCR4) Please explain the health plans' policies as they relate to global fee payments and what services are to be included in that global fee

Claims with Third-Party Coverage

TPC1) Are there special handling procedures for claims with third party coverage, such as initially denying claims and requesting that providers resubmit claims after third party payments have been made)?

TPC2) Do health plans permit electronic billing of claims with third party coverage?

Timely Filing Requirements

TFR1) What are the filing limits for claims and do these vary by provider or by participating / non-participating providers (i.e., in network vs. out-of-network)?

TFR2) For inpatient hospital claims, do filing limit edits use admission date or discharge date?

TFR3) Does the health plan ever suspended filing limit edits due to claims payment issues?

**Department of Community Health
Georgia Families Program
Research of Medicaid Risk-Based Managed Care Policies and Procedures
January 29, 2008**

Recoup/Repay

RR1) Do health plans recoup payments based on post-payment reviews?

RR2) If yes, is claims history corrected to reflect the recouped amount?

RR3) Are checks sent by providers to refund claims during post payment reviews tied back to individual claims and documented by the health plan?

RR4) Are providers made aware of claims identified as incorrectly paid as a result of post-payment review?

RR5) Do providers have grievance and appeal rights on these claims?

Overview of TennCare, Tennessee’s Medicaid Program And Its “Reform” Managed Care Procurements

Exhibit E

Historical Background

In 1994, Tennessee implemented TennCare, a managed care model health care reform program that replaced its traditional Medicaid program. It was implemented as a five-year demonstration (Section 1115 Waiver), and has received several extensions since that date. The most recent extension was approved in 2007 and remains effective through June 30, 2010.

TennCare’s core population consists of two major eligibility groups: TennCare Medicaid, which is for individuals eligible for Medicaid under the Medicaid State Plan, and TennCare Standard, which is for persons who are not eligible for Medicaid and are either uninsured or uninsurable.

The original TennCare MCO contractors provided both physical and behavioral health services in one contract; however, in 1996 mental health and substance abuse services were “carved-out” into a separate contract, and TennCare contracted with two BHOs, beginning the TennCare Partners Program.

TennCare MCOs initially operated under a full-risk capitation arrangement, but that ended in 1999-2000 when some MCOs lost financial stability and left the program. In an effort to stabilize the program, TennCare implemented a Stabilization Plan, in which by July 2002, all MCOs were paid an administrative fee based on an enrollee’s eligibility category and were not at risk for the cost of medical services. In addition, the State developed a plan called TennCare Select, to serve as a backup if other MCOs failed or if there was inadequate MCO capacity in any area of the state. TennCare Select also serves as the MCO for certain populations statewide, including children in state custody and children eligible for SSI. TennCare Select’s risk is backed by the State.

Both before and after the implementation of TennCare, Tennessee’s Medicaid Program was plagued by several class action lawsuits. These lawsuits resulted in the imposition of many additional obligations on the program, which went beyond the state and federal program requirements and appear to have contributed to the eventual “de-stabilization” of the TennCare Program.

A significant program reform effort was initiated in 2003 by newly-elected Governor Phil Bredesen. This effort resolved many of the outstanding lawsuits, secured the support of Tennessee’s lawmakers, stabilized the program, and facilitated approval for the return of the MCOs to a risk-sharing arrangement. It also, however, included the removal in 2005

Overview of TennCare, Tennessee’s Medicaid Program And Its “Reform” Managed Care Procurements

of most of the TennCare expansion population recipients, about 170,000 adult residents, in an effort to control rapidly escalating state costs.¹

First Reform Procurement

In April 2006, the State issued an RFP to procure two MCOs to provide managed care services for TennCare enrollees and other populations in the middle region of Tennessee under a “reform” managed care model. Two key features of this model are that the MCOs are at full-risk and are required to integrate the delivery of physical health and behavioral health services. The two winning MCOs were Americhoice and Amerigroup. This model was implemented April 1, 2007.

Reported problems identified with implementation of this first “reform” procurement are summarized as follows:

- The move to a true managed care model was confusing for many enrollees.²
- The new MCOs did not sign up enough doctors and hospitals in their networks by the implementation date, resulting in serious coverage gaps.^{1,3}
- The new MCOs randomly assigned enrollees to primary care doctors (but allowed them 30 days to switch).¹
- Advocacy groups were/are worried that the State Medicaid Agency will not supervise the MCOs closely enough to ensure that the companies provide care rather than routinely deny claims to save money.¹
- Reimbursements are lower than from TennCare Select, which prompted some doctors to opt out of the new MCO’s networks.¹
- Emergency department denials of care generate referrals to follow-up clinics, which are already overloaded and may result in care delays that then may generate more emergency department visits.⁴
- Both plans’ websites and provider manuals were outdated at the time of implementation, which made it difficult to find out which doctors were accepting the new plans.²
- Tennessee does not have medical malpractice award caps on compensatory or punitive damages, unlike all of its surrounding states. Malpractice premiums are high, and 82% of cases filed in the state of Tennessee are settled without payment.⁵

¹“TennCare Reform, One Year Later: An Assessment of the Impact of the 2005-2006 Changes in the TennCare Program”, by Ione Farrar, David Eichenhal, Chad Reese, and Benjamin Coleman of the Community Research Council, Chattanooga Tennessee, May 2007, p.1.

²“TennCare Returning risk to MCOs”, Marilyn Wilson, TennCare Bureau spokeswoman and Emily Berry, staff writer, April 6, 2007.

³“NC5 Investigates: Consumer Alert - TennCare Switch Worries Families”, updated March 26, 2007.

⁴“Plan to Reduce TennCare ED Visits Irks EPs”, *EMN*, March 2007, pp. 43-44.

⁵“Unfavorable Environment: Malpractice, TennCare Make Recruiting Difficult”, *Memphis Business Journal*, Toby Sells, November 30, 2007.

Overview of TennCare, Tennessee’s Medicaid Program And Its “Reform” Managed Care Procurements

- Some physicians still haven’t recovered from historical TennCare losses and have therefore been unwilling to re-enroll with the new MCOs.⁴

Conversely, one particular TennCare program has been highlighted on CMS’s website under “Medicaid and SCHIP Promising Practices”.⁶ Namely, to resolve a class-action lawsuit brought against the state in 1998, TennCare developed a consensus strategy for improving access to Medicaid dental services for children, which resulted in a carve-out of dental services from the Medicaid managed care contracts, appropriation of additional state funds for dental services, the competitive selection of Doral Dental to administer the Medicaid dental benefit, and an increase in fee-for-service reimbursement to participating dentists. These efforts have increased participation of dentists by 112%, and the number of eligible children who have received at least one dental service has reached 37.4%.

Second Reform Procurement

On January 8, 2008, the Tennessee Bureau of TennCare issued a new RFP to secure four new contracts to provide managed care services: two contracts for the eastern part of the state and two for the western part of the state. Services for the western part of the state are expected to begin on November 1, 2007, and services for the eastern part of the state are expected to begin on January 1, 2009. The RFP is intended to replicate the managed care services procured for the middle of the state in 2007.

Winners will be announced on April 22, 2008.

⁶“TennCare Dental Program (TN0701), 10/31/2007.

Overview of TennCare, Tennessee's Medicaid Program And Its "Reform" Managed Care Procurements

Additional Resources

The RFP is 1054 pages long and can be found online at:

<http://www.tennessee.gov/tenncare/forms/RFP%20318.66-053.pdf>.

The press released issued by the Bureau of TennCare can be found at:

<http://www.state.tn.us/tenncare/forms/EastWestRFPRleased2007Jan08.pdf>.

A number of other resources to support this procurement can be found at:

<http://www.tennessee.gov/tenncare/news-rfpeastwest.html>.

KRIEG · DEVAULT LLP
ATTORNEYS AT LAW
Solutions, not obstacles[®]

TO: MYERS AND STAUFFER LC
FROM: LEAH MANNWEILER AND KRISTEN GENTRY
**RE: GEORGIA FAMILIES PROGRAM: PAYMENT OF EMERGENCY
MEDICAL SERVICES**
DATE: APRIL 28, 2008

Introduction:

This report evaluates the regulatory and contractual requirements of reimbursement for emergency medical services including (1) federal law, regulation, and policies, and (2) the Georgia Families model contract between the State of Georgia, Department of Community Health (“DCH”) and Care Management Organizations (“CMOs”) and contracts between health care providers and CMOs. Part (3) of the report provides observations regarding the CMOs’ policies and procedures and recommendations DCH might consider to strengthen the Georgia Families Program.

I. Federal law, regulation and policy.

(A) Federal law.

Federal law requires the following with respect to a state’s obligation to contract with managed care organizations to provide coverage for emergency services:

(A) In general.—Each contract with a Medicaid managed care organization under section [1903\(m\)](#) and each contract with a primary care case manager under section [1905\(t\)\(3\)](#) shall require the organization or manager—

(i) to provide coverage for emergency services (as defined in subparagraph (B)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization or manager,¹

Federal law also provides the following definitions:

¹ See Section 1932(b)(2) of the Social Security Act [42 USC 1396u-2(b)(2)].

(B) Emergency services defined. In subparagraph (A)(i), the term “emergency services” means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

(i) are furnished by a provider that is qualified to furnish such services under this title, and

(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (C)).

(C) Emergency medical condition defined. In subparagraph (B)(ii), the term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a *prudent layperson*, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part.²

Consequently, federal law creates the *prudent layperson* standard and mandates that it be used by states in their contracts with Medicaid managed care organizations (referred to as “CMOs” in this report) to determine whether a provider’s claim for emergency services is reimbursable as an emergency service or as a triage fee.

Since this law was enacted in the Balance Budget Act of 1997 (“BBA”), several sources of federal guidance have been published regarding how a CMO is to determine whether a particular service is an emergency service under the prudent layperson standard. These sources include State Medicaid Director Letters from the Centers for Medicare and Medicaid Services (“CMS”) and federal regulations. These sources are discussed in chronological order.

² *Id.* (Emphasis added).

(B) State Medicaid Director Letters.

1. February 20, 1998

The CMS February 20, 1998 letter expands on requirements found in the BBA which requires each State contract with an CMO to stipulate that the CMO will pay for emergency services rendered to Medicaid enrollees without regard to prior authorization or the emergency services provider's contractual relationship with the CMO. The letter summarizes this requirement as allowing Medicaid enrollees to obtain emergency services from the nearest provider when and where the need arises. The letter also defines emergency services in accordance with the BBA (see above) and explains, "Emergency services are defined broadly by the BBA to mean covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard."

This standard requires CMOs to cover the cost of examinations when the symptoms *with which the patient presents* are severe enough to constitute an emergency medical condition according to the judgment of a prudent layperson. The letter also prohibits CMOs from retroactively denying a claim for an emergency screening examination when the condition, which appeared to be emergent under the prudent layperson standard, later is determined to be non-emergent.

The letter also sets forth the requirements with respect to certain situations involving emergency screenings under the Emergency Medical Treatment and Active Labor Act ("EMTALA"). Specifically:

- If there is determined to be an actual emergency medical condition, CMOs must pay for both the services involved in the screening and the services required to stabilize the patient.
- CMOs are required to pay for all medically necessary emergency services until the clinical emergency is stabilized, including all treatment that may be necessary to assure, within reasonable medical probability that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility.
- If it is determined that an actual emergency medical condition does not exist, then the determining factor for payment liability is whether the beneficiary had acute symptoms of sufficient severity *at the time of presentation*.
- When a beneficiary's primary care physician or other plan representative instructs the beneficiary to seek emergency care in-network or out-of-network, the plan is responsible for payment for the medical screening and other medically necessary emergency services, without regard to whether the patient meets the prudent layperson standard.

Finally, the February 20, 1998 letter explained that failure to cover emergency screening or stabilization services may result in intermediate sanctions or contract termination.

2. April 5, 2000

The April 5, 2000 State Medicaid Director letter clarifies the February 20, 1998 letter by stating that the BBA does in fact require both CMOs and Primary Care Case Managers (“PCCMs”) to specify in their contracts with States that CMOs and PCCMs are required to pay for emergency services provided according to the prudent lay person standard. Furthermore, prior authorization is not to be required for such services whether the services are furnished inside or outside of the CMO or PCCM. The letter also states that “in a fee-for-service PCCM arrangement in which States pay claims, States are required to cover (i.e., pay for) emergency services that meet the prudent layperson standard in exactly the same manner as are CMOs. States should make this obligation clear in all fee-for-service PCCM contracts.”

The April 5, 2000 letter states that whether the prudent layperson standard is met is a determination that must be made *on a case-by-case basis*; however, there is an exception to this rule.

[P]layers may approve coverage on the basis of an ICD-9 code, and payers may set reasonable claim payment deadlines (taking into account delays resulting from missing documents from the initial claim).

However, *payers cannot deny coverage solely on the basis of ICD-9 codes, nor can they deny coverage on this basis and then require that the claim be resubmitted as part of an appeals process- even if the process is not labeled as an appeal.* When a CMO or a State denies or modifies a claim for payment, the determination of whether the prudent layperson standard was met:

[M]ust be based on *all* pertinent documentation, must be focused on the *presenting* symptoms (and not on the final diagnosis), and must take into account that the decision to seek emergency services was made by a *prudent layperson* (rather than a medical professional).

The letter clarifies that since prior authorization is prohibited for emergency services under the prudent layperson standard, the patient cannot be charged any amount for such services, except for a minimal cost-sharing amount, and a CMO or a State, in a PCCM arrangement, cannot make payment for the services contingent on the patient providing notice to the State or CMO either before or after receiving the service. With regard to CPT codes, the letter states that in the absence of suspicion that a provider is up-coding, codes 99283 through CPT 99285:

[A]re very likely to be appropriately regarded as emergency services for purposes of the BBA and should be approved for coverage regardless of prior authorization. This should not be taken to imply that claims codes as CPT 99281 and CPT 99282 will not also meet the BBA definition; they may, but, as opposed to those claims involving the higher CPT codes, there may be instances in which payers have a reasonable basis to disagree.

3. April 18, 2000

The April 18, 2000 State Medicaid Director letter merely replaces the April 4, 2000 letter as the April 5 letter inadvertently had omitted from it a paragraph regarding notification requirements. The April 4 letter states that payment for services cannot be made contingent on notice from the patient either before or after receiving the services. However, the April 18 letter goes on to state that:

[CMOs] and States may, however, enter into contracts with providers or facilities that require, as a condition of payment, the hospital to provide notification after beneficiaries present at the emergency room, assuming adequate consideration is given for such a provision. In the case of States as payers (e. g., PCCMs), such notification requirements are permissible as long as they do not violate the State Plan (or that part of the State Plan is waivable).³

These three letters provide the following key elements in evaluating the Georgia Families Program policies and procedures:

- (a) Emergency services are to be defined *broadly* to mean covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard.
- (b) This standard requires CMOs to cover the cost of examinations when the symptoms *with which the patient presents* are severe enough to constitute an emergency medical condition according to the judgment of a prudent layperson.
- (c) CMOs are prohibited from retroactively denying a claim for an emergency screening examination when the condition, which appeared to be emergent under the prudent layperson standard, later turned out to be non-emergent.
- (d) If it is determined that an actual emergency medical condition does not exist, then the determining factor for payment liability is whether the beneficiary had acute symptoms of sufficient severity *at the time of presentation*.
- (e) A CMS State Medicaid Director letter explained that failure to cover emergency screening or stabilization services may result in intermediate sanctions or contract termination.
- (f) “[P]ayers may approve coverage on the basis of an ICD-9 code, and payers may set reasonable claim payment deadlines (taking into account delays resulting from missing documents from the initial claim).” However, *payers cannot deny coverage solely on the basis of ICD-9 codes, nor can they deny coverage on this basis and then require that the claim be resubmitted as part of an appeals process-even if the process is not labeled as an appeal*.
- (g) When a CMO or a State denies or modifies a claim for payment, the determination of whether the prudent lay person standard was met, “must be based on *all* pertinent documentation, must be focused on the *presenting* symptoms (and not on the final

³ However, federal regulation, 42 CFR 438.114 requires the notification period to be a minimum of ten days after the patient presents for treatment at the provider’s emergency department.

diagnosis), and must take into account that the decision to seek emergency services was made by a *prudent layperson* (rather than a medical professional).”

Next, we look to the federal regulations for guidance.

(C) Federal regulations.

Federal regulations regarding Medicaid CMO payments for emergency services define emergency services and emergency medical condition the same as in the BBA. The regulations then explain that CMOs are responsible for coverage and payment of emergency services and such entities:

(i) Must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the Managed Care Organization (“MCO”), Prepaid Inpatient Health Plan (“PIHP”), Prepaid Ambulatory Health Plan (“PAHP”), or Primary Care Case Management (“PCCM”); and

(ii) May not deny payment for treatment obtained under either of the following circumstances:

(A) An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2), and (3) of the definition of emergency medical condition in paragraph (a) of this section.

(B) A representative of the MCO, PIHP, PAHP, or PCCM instructs the enrollee to seek emergency services.⁴

Further, the regulation then explains:

(d) Additional rules for emergency services. (1) The entities specified in paragraph (b) of this section may not--

(i) ***Limit what constitutes an emergency medical condition with reference to [the definition of emergency medical condition], on the basis of lists of diagnoses or symptoms;*** and

(ii) ***Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO, PIHP, PAHP or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.***

(2) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

(3) The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized

⁴ See 42 CFR 438.144.

for transfer or discharge, and that determination is binding on the [CMO] of this section as responsible for coverage and payment.⁵

The federal regulations reveal the following important aspects key to the evaluation of the Georgia Families Program policies and procedures for claim determinations of emergency services under the prudent layperson standard:

(1) A CMO may not deny payment for treatment when the enrollee had an emergency medical condition, *including cases in which the absence of immediate medical attention would not have led to placing the health of the individual in (a) serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.*

(2) A CMO *may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.*

(3) A CMO may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO, PIHP, PAHP or applicable State entity of the enrollee's screening and treatment *within 10 calendar days* of presentation for emergency services.

II. Contracts and State Law.

(A) DCH's Model Contract with CMO's.

We reviewed an example of the contract that DCH has with each of the CMOs (the "DCH/CMO contract"), which contains the pertinent requirements regarding emergency medical services and contractual remedies.

1. Emergency Medical Services.

The example DCH/CMO contract contained the following language pertaining to emergency medical services:

4.6.1.1 *An Emergency Medical Condition shall not be defined or limited based on a list of diagnoses or symptoms.* An Emergency Medical Condition is a medical or mental health Condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a *prudent layperson*, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

⁵ *Id.* (Emphasis added).

- 4.6.1.2.1 Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
 - 4.6.1.2.2 Serious impairment to bodily functions;
 - 4.6.1.2.3 Serious dysfunction of any bodily organ or part;
 - 4.6.1.2.4 Serious harm to self or others due to an alcohol or drug abuse emergency;
 - 4.6.1.2.5 Injury to self or bodily harm to others; or
 - 4.6.1.2.6 With respect to a pregnant woman having contractions: (i) that there is adequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.
- 4.6.1.3 ***The Contractor shall provide payment for Emergency Services when furnished by a qualified Provider, regardless of whether that Provider is in the Contractor's network. These services shall not be subject to prior authorization requirements.*** The Contractor shall be required to pay for all Emergency Services that are Medically Necessary until the Member is stabilized. The Contractor shall also pay for any screening examination services conducted to determine whether an Emergency Medical Condition exists.
- 4.6.1.4 ***The Contractor shall base coverage decisions for Emergency Services on the severity of the symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a prudent layperson.***
- 4.6.1.5 (Omitted).
- 4.6.1.6 The Contractor shall not retroactively deny a Claim for an emergency screening examination because the Condition, which appeared to be an Emergency Medical Condition under the prudent layperson standard, turned out to be non-emergency in nature. ***If an emergency screening examination leads to a clinical determination by the examining physician that an actual Emergency Medical Condition does not exist, then the determining factor for payment liability shall be whether the Member had acute symptoms of sufficient severity at the time of presentation.*** In this case, the Contractor shall pay for all screening and care services provided. Payment shall be at either the rate negotiated

under the Provider Contract, or the rate paid by DCH under the Fee for Service Medicaid program.

- 4.6.1.7 ***The Contractor may establish guidelines and timelines for submittal of notification regarding provision of emergency services, but, the Contractor shall not refuse to cover an Emergency Service based on the emergency room Provider, hospital, or fiscal agent's failure to notify the Member's PCP, CMO plan representative, or DCH of the Member's screening and treatment within said timeframes.***

The contract language between DCH and the CMOs reveals the following important aspects for purposes of evaluating the Georgia Families Program policies and procedures for payment of claims for emergency medical services:

- (a) An Emergency Medical Condition ***shall not be defined or limited based on a list of diagnoses or symptoms.***
- (b) The Contractor shall base coverage decisions for Emergency Services on the severity of the symptoms ***at the time of presentation*** and shall cover Emergency Services when the ***presenting symptoms*** are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a prudent layperson.
- (c) The Contractor shall not retroactively deny a Claim for an emergency screening examination because the Condition, which appeared to be an Emergency Medical Condition under the prudent layperson standard, turned out to be non-emergency in nature.
- (d) The Contractor may establish guidelines and timelines for submittal of notification regarding provision of emergency services, but, ***the Contractor shall not refuse to cover an Emergency Service based on the emergency room Provider, hospital, or fiscal agent's failure to notify the Member's PCP, CMO plan representative, or DCH of the Member's screening and treatment within said timeframes.***

2. Contractual Provisions.

Two provisions of the DCH/ CMO contract and its incorporated documents allow DCH to require the CMOs to comply with federal requirements, regulations, and policies currently in place and as may be amended from time to time. First, the DCH/CMO contract states, "DCH has caused Request for Proposals Number 41900-001-0000000027 (hereinafter the "RFP") to be issued through Department of Administrative Service(s) (DOAS), which is expressly incorporated as if completely restated herein." Based on this provision, the RFP is a part of the Contract and its provisions shall be adhered to as such. The RFP states:

The Offeror [the CMOs] shall comply with the most recent versions and future revisions to all applicable Federal and State laws, court orders, regulations, policies, and subsequent amendments. The following Applicable Documents are incorporated into the Contract, as well as any pertinent amendments, by this reference.⁶

Based on this provision of the RFP, which is incorporated as a term of the DCH/CMO contract, in order to be in compliance with the Contract, the CMOs must comply with all current and future versions of federal and State laws, regulations, policies and subsequent amendments. Federal policies include State Medicaid Director's Letter issued by the Centers for Medicare and Medicaid Services ("CMS"). Therefore, the CMOs are required to comply with the State Medicaid director letters described in this report. It also includes state laws, regulations and policies, such that if DCH issues formal policies or if the pending legislation is passed, the CMOs would be required to comply with them.

Secondly, the DCH/CMO contract states:

The Contractor shall agree to conform to such requirements or regulations as the United States Department of Health and Human Services may issue from time to time. Authority to implement federal requirements or regulations will be given to the Contractor by DCH in the form of a Contract amendment.⁷

This provision requires the CMOs to comply with all requirements and regulations issued by the Department of Health and Human Services ("HHS") which has as a sub-agency, CMS. Therefore, this provision also provides the DCH with the authority necessary to amend the DCH/CMO contracts so as to comply with any requirements or regulations of HHS. This provision seems to require the CMOs to agree to amendments to the DCH/CMO contract to comply with HHS requirements.

(B) CMO Contracts with Providers.

We performed a review of a few sample contracts between the CMOs and provider hospitals. A chart showing the relevant provisions of the contracts reviewed for each CMO is provided below.

⁶ Appendix I, RFP 41900-001-0000000027.

⁷ Contract § 27.2.1, page 170.

1. CMO #1.

Contract provision	Provider A	Provider B	Provider C
<p>Definition of Emergency Medical Services</p>	<p>The definition is the same as that in the BBA, but is not the same as the definition in the DCH/CMO contract. The definition in the contract can be found at Section 1.8 and is as follows: “To the extent not otherwise defined in the applicable Benefit Agreement and consistent with the definition set forth in the DCH Contract, “Emergency” or “Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the patient (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. (The definition does not include the following additional reasons as to why the condition would be considered an emergency: (1) Serious harm to self or others due to an alcohol or drug abuse emergency; (2) Injury to self or bodily harm to others; or (3) With respect to a pregnant woman having contractions: (i) that there is adequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child. This definition also does not specify that health is to include both “physical and mental” health.)</p>	<p>The definition is the same as that in the BBA, but is not the same as the definition in the DCH/CMO contract, nor is it the same as in the CMO’s other provider contracts we reviewed. The definition in the contract can be found at Section 1.6 of the Agreement and means as follows: “A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the patient (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. (Note that this agreement does not make reference to any other source for determining the meaning of an emergency medical condition. (The definition also does not include the following additional reasons as to why the condition would be considered an emergency: (1) Serious harm to self or others due to an alcohol or drug abuse emergency; (2) Injury to self or bodily harm to others; or (3) With respect to a pregnant woman having contractions: (i) that there is adequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child. This definition also does not specify that health is to include both “physical and mental” health.)</p>	<p>The definition is the same as the definition in the DCH/CMO contract.</p>

Contract provision	Provider A	Provider B	Provider C
Grievances/ Complaints/ Arbitration and Appeals	<p>Article VIII discusses “Dispute Resolution”. Section 8.1 explains the Joint Operating Committee, or bi-annual joint meeting between CMO #1 and the provider to discuss outstanding issues, including accounts receivable review, payment discrepancies and network opportunities. Section 8.2 explains that the parties are to try to resolve any controversies arising from the Agreement informally. If the matter is not resolved within 30 days, then a party can initiate binding arbitration proceedings. Section 8.3 explains; if informal dispute resolution does not work then the parties agree to submit to binding arbitration. The cost of arbitration is to be born equally between the parties.</p>	<p>Article VIII explains the parties agree to meet to try to resolve any disputes between them. Section 8.2 provides for binding arbitration if the disputes between them are not resolved. Costs are to be born individually by the parties.</p>	<p>Article VIII explains the parties agree to meet to try to resolve any disputes between them. Section 8.2 provides for binding arbitration if the disputes between them are not resolved. Costs are to be born by the opposing party if the party bringing the suit “wins” it.</p>
Reimbursement of Emergency Services.	<p>See Attachment A, Compensation. Emergency Covered Services are to be reimbursed at X% of the Facility’s billed charges multiplied by the Facility-specific cost to charge ratio. Note that Non-Emergency Care appears to be defined so that it can include “non covered Emergency Services”. The contract states, “Non-emergency care means care for conditions that are assumed to indicate the presence of conditions requiring medical attention, but do not appear to require immediate medical attention or otherwise do not meet this Agreement’s definition of Emergency and/ or for a condition not otherwise authorized by Health Plan or its designee for treatment in the Facility’s emergency department.”</p> <p>The language specifically states that the facility may appeal a determination made by the Health Plan regarding the presence or absence of a condition necessitating Emergency Care.</p> <p><i>Section 4.14.3.3 of the DCH/CMO contract states that any notice of “Proposed Action must contain the following: (1) The Action the Contractor has taken or</i></p>	<p>See Attachment A, Compensation. Facility is to be reimbursed for Emergency Covered services at X% of its current hospital specific Medicare APC rate. Services not reimbursable as a DRG are to be reimbursed at X% of its interim outpatient rate as calculated by DCH. Emergency Services that cannot be documented as “true medical emergencies” or “potential medical emergencies” shall be reimbursed at the Georgia Medicaid rate.</p>	<p>See Attachment A, Compensation. When Hospital outpatient Emergency Services meet the definition of Emergency or Emergency Medical Condition as set forth in this Agreement and the Payor contract, Hospital is to be reimbursed at X% of allowable charges for covered services for all Emergency Services provided during the visit, except OP clinical laboratory services and outpatient injectibles.</p> <p>“In determining whether an emergency room service is an Emergency or is for treatment of an Emergency Medical Condition upon initial claims submission by Hospital, Health Plan shall consider all diagnosis appearing in the UB-92 field locators 67 through 75, and the hospital may reposition the Member’s admitting diagnosis for the purposes of claims payment processing from field locator 76</p>

Contract provision	Provider A	Provider B	Provider C
	<p><i>intends to take. (2) The reasons for the Action. (3) The Member's right to file an Appeal through the Contractor's internal Grievance System as described in Section 4.14. (4) The Provider's right to file a Provider Complaint as described in Section 4.9.7; (5) The requirement that a Member exhaust the Contractor's internal Grievance System and a Provider exhaust the Provider Complaint process prior to requesting a State Administrative Law Hearing; (6) The circumstances under which expedited review is available and how to request it; and (7) The Member's right to have Benefits continue pending resolution of the Appeal with the Contractor or with the State Administrative Law Hearing, how to request that Benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services."</i></p>		<p>to field locator 75 to ensure that Health Plan is able to consider whether the visit meets the State of Georgia's prudent layperson standard.</p>

Observations re: CMO #1's contracts with providers:

(1) CMO #1's definition in all but Provider C's agreement varies from the DCH/CMO contract's definition of Emergency Medical Service. We believe that all contracts should reflect the definition of Emergency Medical Service found in the DCH/CMO agreement.

(2) CMO #1 should clearly state the Appeal rights in each of the Provider's contracts and in any notices of Proposed Actions it sends to providers. The only contract in which it is clear that a provider has the right to appeal a determination regarding whether a service is an emergency medical service is in Provider C's agreement. We also looked at other sources to determine CMO #1's appeal processes.

In the response to Myers and Stauffer's questions regarding payment of emergency claims, CMO #1 provided a Powerpoint presentation containing slides regarding an "ER Reconsideration Process". These slides state that through the "ER Reconsideration Process" providers may "submit additional information for consideration in determining if a previously submitted ER claim meets the prudent layperson standard for a true emergency." This process appears to be an informal appeals process for emergency medical services claims initially paid by CMO #1 at the triage rate. If the "Reconsideration" request of the provider is denied by CMO #1, then the provider may use CMO #1's "formal claim appeal process" to appeal the triage decision. The flow chart does not show the availability of an appeal to an ALJ.

It appears from the ER Process –Summary flow chart provided by CMO #1, that CMO #1 pays all Emergency Medical Services claims at either the triage rate or the "Full ER Payment"; consequently, we equate payment at the triage rate as the same as or equivalent to a denial of the emergency medical services claim. We also note that due to the rate of emergency medical services claims paid by CMO #1 at the triage rate, CMO #1 appears to be denying emergency medical services based on a diagnosis list and then requiring providers to submit "reconsideration" requests with full medical records to pay the claims at the emergency services rates.

Next, we looked to CMO #1's provider manual for its appeal processes. CMO #1's provider manual provides for the following Administrative Review and Grievances' Processes:

(a) An *administrative review* is a request for review of an action taken by or on behalf of the Plan. A member, member's representative, or a provider acting on behalf of the member may file an administrative review. Examples of actions that can be administratively reviewed include, but are not limited to, the following: (1) Denial or limited authorization of a requested service, including the type or level of service; (2) The reduction, suspension or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; and (4) The failure to provide services in a timely manner. The first level of administrative review is a *request for reconsideration*. It must be submitted in writing or verbally (which must be supplemented by a written, signed administrative review request) within 30 calendar days, or good cause must be shown for the Plan to accept the late request. There also appears to be a *second level of administrative review* for members if the request for reconsideration is denied. This is

the request for an Administrative Law (Medicaid) or DCH (PeachCare for Kids) hearing only after completing the Plan's administrative review process.

(b) Providers also appear to have a separate process for submitting *provider administrative reviews*. The Provider Manual states, “[p]roviders have 90 days from the original utilization management denial or claim denial to file a *provider administrative review*. Cases reviewed after that time will be denied for untimely filing. A provider may either submit a letter stating it is filing an administrative review or submit an administrative review form with supporting documentation such as medical records. Cases received without the necessary documentation will be denied for lack of information. A provider will be notified of the Plan's decision. However, the provider manual then explains what appears to be a separate provider appeals process called a *Claim Reconsideration*. The Provider Manual states a provider may file a *Claim Reconsideration* by submitting a letter to the Plan with supporting documentation such as medical records within 90 days of the Remittance Advice/Explanation of Benefits issue date. Within the *Claim Reconsideration* language, there is also language stating, “Effective 12/1/07, Administrative Law Hearing requests must be sent to [the CMO's address]”. However, there is no further explanation as to when, why and how a provider may request an administrative law hearing.

(c) A *grievance*, which is “an expression of dissatisfaction about any matter other than an actions that can be administratively reviewed. Specifically, a grievance is an expression of dissatisfaction with any aspect of the managed care Plan or provider's operation, provision of health care services, activities or behaviors. A member or a member's representative acting on behalf of the member and with the member's written consent, may file a grievance within 90 days of the date the member became aware of the issue.

(d) The CMO's *provider complaint system* permits a provider to formally dispute the Plan's policies, procedures or any aspect of the Plan's administrative functions. Providers have 45 days from the date he or she becomes aware of an issue to file a written complaint. A complaint must be submitted by letter with supporting documentation such as medical records. If the provider is not satisfied with the Plan's complaint decision, the provider may request a review at an administrative law hearing. However, provider must exhaust the Plan's provider termination and / or provider complaint process before bringing action by way of arbitration or court actions against CMO #1. A request for an administrative law hearing must include a clear expression by the provider or authorized representative that he/she wishes to present his/her case to an administrative law judge, identification of the adverse action being appealed and the issued that will be addressed at the hearing, a specific statement of why the provider believes the Plan's adverse action is wrong; and a statement of the relief sought. (Note: This ALJ hearing process appears to be for administrative policy issues rather than for appeals of denied or adversely determined claims. It is not clear what the process would be for a provider to appeal a claim issue to an ALJ.)

While it appears that CMO #1 has both an internal and external appeals and complaint process for providers to utilize, the descriptions of the appeals and complaint processes and the various

levels may not be clearly understood by providers. DCH may want to require CMO #1 to clarify these processes in its contracts with providers and its Provider Manual.

(3) CMO #1 should clearly state how the facility is to obtain reimbursement of Emergency Services and how the Health Plan makes a determination of an emergency condition determination. This is specified in Provider C's agreement (i.e. the UB-92 field locators). It is also required to be stated in the provider contracts pursuant to the DCH/CMO contract.

2. CMO #2

Contract Provision	Provider A	Provider B	Provider C
<p>Definition of Emergency Medical Services</p>	<p>Section 1.7 defines “Emergency Care or Emergency Services” to mean “covered inpatient and outpatient services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition.” Section 1.8 states, “Emergency Medical Condition means any medical condition of a recent onset and severity, including but not limited to severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in: (a) placing the patient’s health in serious jeopardy; (b) Serious impairment to bodily functions; or (c) Serious dysfunction of any bodily organ or part.</p> <p>CMO #2’s definition does not include the following additional reasons as to why the condition would be considered an emergency: (1) Serious harm to self or others due to an alcohol or drug abuse emergency; (2) Injury to self or bodily harm to others; or (3) With respect to a pregnant woman having contractions: (i) that there is adequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child. CMO #2’s definition also does not specify that health is to include both “physical and mental” health.)</p> <p>Note: however that CMO #2 then has another definition of Emergency Care Services for</p>	<p>Section 1.9 states, “Emergency Services is defined in Attachment ‘B’.” Attachment B defines Emergency Care or Emergency Services to mean, “inpatient and outpatient Covered Services furnished by a qualified provider of care or practitioner of care that are needed to evaluate or stabilize an Emergency Medical Condition that is found to exist using the prudent layperson standard.” “Emergency Medical Condition means a medical Condition manifesting itself by acute symptoms of severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairments of bodily functions; (iii) serious dysfunctions of any bodily organ or part; (iv) serious harm to self or others due to an alcohol or drug abuse emergency; (v) injury to self or bodily harm to others; or (vi) with respect to a pregnant woman having contractions: (a) that there is adequate time to effect a safe transfer to another Facility before delivery, or (b) that transfer may pose a threat to the health and safety of the woman or the unborn child. An Emergency Medical Condition shall be defined on the basis of diagnosis or symptoms.”</p> <p>CMO #2 pays for “Emergency Care Services” under its “HMO Automated Emergency Department Claims Adjudication Process”. However, it does not separately define “Emergency Care Services”, instead stating, in Notes for Table 2, in Attachment A, that</p>	<p>Section 1.7 states, “Emergency Care has, as to each particular Product, the meaning set forth in the Product Attachment pertaining to each such Product.” Attachment A, Medicaid Product Attachment and State-Mandated Provisions, defines Emergency Care or Emergency Services to mean, “inpatient and outpatient Covered Services furnished by a qualified provider of care or practitioner of care that are needed to evaluate or stabilize an Emergency Medical Condition that is found to exist using the prudent layperson standard.” “Emergency Medical Condition means a medical Condition manifesting itself by acute symptoms of severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairments of bodily functions; (iii) serious dysfunctions of any bodily organ or part; (iv) serious harm to self or others due to an alcohol or drug abuse emergency; (v) injury to self or bodily harm to others; or (vi) with respect to a pregnant woman having contractions: (a) that there is adequate time to effect a safe transfer to another Facility before delivery, or (b) that transfer may pose a threat to the health and safety of the woman or the unborn child. An Emergency Medical Condition shall be defined on the basis of diagnosis or symptoms.”</p> <p>CMO #2 then has another definition of Emergency</p>

Contract Provision	Provider A	Provider B	Provider C
	<p>purposes of reimbursement under its “HMO Automated Emergency Department Claims Adjudication Process. This definition does not contain the “prudent layperson” standard. Note 10 of “Exhibit 2, Compensation Schedule,” states, “Emergency Care Services means conditions that are obvious medical emergencies; or, conditions that represent significant medical problems even if they do not, in and of themselves, indicate the presence of an emergency.”</p> <p>It then defines Non-Emergency Care Services to mean “conditions that are assumed to indicate the presence of conditions requiring medical attention, but that do not appear to require immediate medical attention or for conditions that do not meet the definition of Emergency Care Services.”</p>	<p>“Emergency Care/Emergency Services is a defined term in this Agreement. Emergency Care Services are reimbursed in accordance with the Negotiated Payments set forth herein. Facility agrees to bill for Emergency Services using HCPCS codes.” It also states, “Non-Emergency Care means conditions that are assumed to indicate the presence of conditions requiring medical attention, but that do not appear to require immediate medical attention or for conditions that do not meet the definition of Emergency Care/Emergency Services and/or are not otherwise authorized by HMO or its designee.”</p>	<p>Care Services for purposes of reimbursement under its “HMO Automated Emergency Department Claims Adjudication Process.” This definition does not contain the prudent layperson standard. Note 1 for Table 2 of “Exhibit 2, Compensation Schedule,” states, “Emergency Care Services means conditions that are obvious medical emergencies; or, conditions that represent significant medical problems even if they do not, in and of themselves, indicate the presence of an emergency. Emergency Care Services are reimbursed in accordance with the Negotiated Payments set forth herein. Hospital must bill using the appropriate HCPCS code or payment will be denied.”</p> <p>It then defines Non-Emergency Care Services to mean “conditions that are assumed to indicate the presence of conditions requiring medical attention, but that do not appear to require immediate medical attention or for conditions that do not meet the definition of Emergency Care Services.”</p>
Grievances/ Complaints/ Arbitration And Appeals	<p>Note 1(b) to Table 2, Exhibit A, Compensation Schedule, states, “Unless otherwise set forth in the Participating Health Care Provider Manual, Hospital may appeal a determination made by HMO regarding the presence or absence of a condition necessitating Emergency Care.”</p>	<p>Note 1 (b) to Table (2), Compensation Schedule, states, “Facility may appeal a determination made by HMO regarding the presence or absence of a condition necessitating Emergency Care.”</p>	<p>Note 1(b) to Table 2, Exhibit 2, Compensation Schedule, states, “Unless otherwise set forth in the Participating Health Care Provider Manual, Hospital may not appeal a determination made by the HMO regarding the presence or absence of a condition necessitating Emergency Care.”</p>
Reimbursement of Emergency Services	<p>Exhibit 2, Compensation Schedule, Table 2, states the Hospital is to be paid by the HMO the rates for Medically Necessary Covered Services listed in Table 2. Table 2 provides that Emergency Care Services are those revenue codes 45x, HCPCS and CPT Codes 99281-99285, and that the Negotiated Payment rate is</p>	<p>Exhibit A, Compensation Schedule, Table 2, states the Hospital is to be paid by the HMO the rates for Medically Necessary Covered Services listed in Table 2. Table 2 provides that Emergency Care Services are those revenue codes 45x and the HCPCS & CPT Codes 99281-99285. The Negotiated Payment is X% of the Facility’s billed charges multiplied by the</p>	<p>Exhibit 2, Compensation Schedule, Table 2, states the Hospital is to be paid by the HMO the rates for Medically Necessary Covered Services listed in Table 2. Table 2 provides that Emergency Care Services are those revenue codes 45x, HCPCS and CPT Codes 99281-99285, and that the Negotiated Payment rate is X% of the Hospital’s Allowable</p>

Contract Provision	Provider A	Provider B	Provider C
	<p>X% of the Hospital’s Allowable Charges multiplied by the Hospital-specific cost to charge ratio in effect on the date of the execution of the Agreement.</p> <p>Notes to Table 2 then explain that the Hospital is to be reimbursed in accordance with “HMO’s Automated Emergency Department Claims Adjudication Process.” The contract explains that the determination that a claim reflects Emergency Care Services is based on the primary ICD-9 diagnosis code (first diagnosis code billed on the UB-92). *** CMO #2’s Agreement then states in Note 1(c) the following: “During the first year of this Agreement, HMO shall use the State’s Division of Medical Assistance Emergency Room Policy Diagnosis List (if billed as the primary diagnosis code) as those diagnoses that are eligible for payment as Emergency Care Services. After the first year of the Agreement, HMO will submit to Hospital HMO’s list of ICD-9 codes that are considered eligible for payment as Emergency Care Services. Payment will be based on the diagnosis list in effect on the date the claim is paid, not the date such services are rendered. HMO periodically reviews the appropriateness of the categories to which ICD-9 codes have been assigned and reserves the right to modify the assignments at any time the parties will meet and mutually agree to the new codes.”</p>	<p>Facility-specific cost to charge ratio.</p> <p>The Notes to Table 2 then explain that the Hospital is to be reimbursed in accordance with “HMO’s Automated Emergency Department Claims Adjudication Process.”</p> <p>The contract explains that the determination that a claim reflects Emergency Care Services is based on the primary ICD-9 diagnosis code (first diagnosis code billed on the UB-92). *** CMO #2’s Agreement then states in Note 1(iii) the following: HMO shall use the State’s Division of Medical Assistance Emergency Room Policy Diagnosis List (if billed as the primary diagnosis code) as those diagnoses that are eligible for payment as Emergency Care Services. This list may be amended with the mutual written consent of the parties. Payment will be based on the diagnosis list in effect on the date the services are rendered.</p>	<p>Charges multiplied by the Hospital-specific cost to charge ratio. The Notes to Table 2 then explain that the Hospital is to be reimbursed in accordance with “HMO’s Automated Emergency Department Claims Adjudication Process.”</p> <p>The contract explains that the determination that a claim reflects Emergency Care Services is based on the primary ICD-9 diagnosis code (first diagnosis code billed on the UB-92).</p> <p>*** CMO #2’s Agreement then states in Note 1(c) the following: “During the first year of this Agreement, HMO shall use the State’s Division of Medical Assistance Emergency Room Policy Diagnosis List (if billed as the primary diagnosis code) as those diagnosis that are eligible for payment as Emergency Care Services. After the first year of the Agreement, HMO will convert to HMO’s list of ICD-9 codes that are considered eligible for payment as Emergency Care Services. Payment will be based on the diagnosis list in effect on the date the claim is paid, not the date such services are rendered. HMO periodically reviews the appropriateness of the categories to which ICD-9 codes have been assigned and reserves the right to modify the assignments at any time.”</p>
Required notification of provision of	Section 3.5 of the Agreement states, “ <u>Emergency Care</u> . Hospital shall notify HMO within 48 hours of rendering or learning of the	Section 3.5 of the Agreement states, “ <u>Emergency Care</u> . HMO agrees that Facility is not required to obtain prior verification of eligibility or Prior	Section 3.5 of the Agreement states, “ <u>Emergency Care</u> . In an emergency, Hospital shall use commercially reasonable efforts to obtain prior

Contract Provision	Provider A	Provider B	Provider C
emergency services.	rendering of Emergency Care to a Covered Person. HMO shall not refuse to cover an Emergency Service based on Hospital's failure to notify the Member's PCP, CMO plan representative, or DCH of the Member's screening and treatment within the foregoing timeframe. In notifying HMO of the provision of Emergency Care, Hospital is not required to provide HMO with clinical information about the care.	Authorization of Emergency Care. Facility shall use commercially reasonable efforts to notify HMO within twenty-four (24) hours or by the next business day of rendering or learning of the rendering of Emergency Care to a Covered Person.	verification of eligibility and authorization of Covered Services to be rendered, but such efforts shall not require Hospital to violate federal, State or local laws relating to the provision of Emergency Care. Hospital shall notify HMO within two (2) business days of rendering or learning of the rendering of Emergency Care to a Covered Person. Nothing in this Agreement shall require advance notice or preauthorization of services rendered for Emergency Medical Condition provided in accordance with DCH requirements, applicable law and with [EMTALA].”

Observation re: CMO #2's contracts with providers:

- (a) CMO #2's definition of emergency covered services is not the same as the definition provided in the DCH/CMO contract for emergency medical services. Its definition never mentions the words "prudent layperson". CMO #2 appears to reimburse services based upon the emergency covered services definition rather than the "emergency medical condition" definition. DCH may wish to consider requiring CMO#2 to change these agreements to clarify the definition provided in the DCH/CMO contract is the correct definition of emergency medical services and is to be used by CMO #2 in making determinations of whether emergency medical services are covered services or not.
- (b) CMO #2 is reimbursing Emergency Services claims through its Automated Emergency Department Claims Adjudication Process, which appears to limit reimbursement of Emergency Services to specified ICD-9 codes. This policy may be inconsistent with the DCH/CMO contract. Additionally, in all but one of the agreements, it appears that CMO #2 has its own approved diagnoses list it uses that is different from the State's diagnoses list and that CMO #2 may change the list at any time.
- (c) CMO #2 requires hospitals to notify the CMO (some within 48 hours and some within 24 hours) of providing emergency services to an enrollee, however, two of the contracts state that a claim will not be denied solely for failure of a hospital to provide notification. Federal regulation and the DCH/CMO contract do not permit claims to be denied based upon failure of a provider to notify the CMO of a patient presenting for emergency services, which may be inconsistent with the other contract. The CMO should consider adding language explaining that claims cannot be denied due to failure of a provider to notify the CMO of a patient presenting for emergency services.
- (d) CMO #2 states that emergency care services are revenue codes "45x" and CPT codes of "99281 through 99285". The DCH/CMO contract specifically states that a list of diagnoses cannot be used to limit or deny emergency services.
- (e) CMO #2, in some contracts, appears to modify the Georgia "list of emergency services" to its own listing of approved emergency services after the first year of the contract with the provider. Payments of the claims, in one contract, is based upon the diagnosis list when the claim is paid, and in the other two contracts we reviewed, based upon the diagnoses list used when the services are rendered. CMO #2 reserves the right to modify its diagnosis list ICD-9 codes at anytime and at other times must have provider approval to do so.
- (f) CMO #2, in accordance with the DCH/CMO contract, should provide appeal rights to all Providers to challenge the determination of a denial of an emergency services claim. In the contract with Provider B, there is language explicitly stating the provider cannot appeal the CMO's determination as to an emergency services claim.

CMO #2 explains its appeal and complaint process in its Provider Manual. The appeal and complaint process is described as follows:

1. Resubmitted claims: Providers may resubmit claims, clearly marking them with the word “resubmission” and the claim number, usually to correct simple or basic errors in the original submission and to qualify the claim as a clean claim. Resubmissions usually are received by CMO #2 within the first 45 days following the initial filing of a non-clean claim.
2. Informal Claim payment adjustment: An informal claim payment adjustment typically corrects an error in processing, for example, typographical errors, contractual payment errors, or supported timely filing reconsiderations. Informal adjustment requests normally are filed after the (maximum) 45-day period that follows initial filing of a claim (in other words, after the claim is either paid in part or denied within 45 days following initial filing of the claim).
3. Claim complaint: Providers may file a claim complaint to seek a reconsideration or exception to a plan policy or contract requirement such as benefit limitations, eligibility, failure to obtain authorizations or reconsideration related to CMO #2’s code auditing process or unsupported timely filing. Claim complaints also are filed after the 45 day (maximum) period that follows initial filing of the claim.
4. Administrative review: A request for administrative review is a request for review of a Proposed Action, which includes certain adverse decisions made by the plan Medical Management Department. Providers may request an administrative review on behalf of a member so long as they submit to CMO #2 within 30 days of the date of the Proposed Action with written member consent for the provider to act on the member’s behalf.
5. Provider Complaints: CMO #2’s provider complaint system permits providers to dispute its policies, procedures, or any aspect of its’ administrative functions (including the process by which it handles Proposed Actions and Explanation of Payment), other than the specific claims and administrative review matters described above. While there is an opportunity for a provider to request an ALJ hearing on behalf of a member as stated above, there is no ability of the provider to request an ALJ hearing on its own behalf. This appears to be inconsistent with the DCH/CMO contract.

3. CMO #3

Contract Provision	Provider A	Provider B	Provider C
Definition of Emergency Medical Services	Attachment B, Section 2 (c) defines “Emergency Services” to mean “inpatient and outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition that is found to exist using the prudent layperson standard” Section 2(b) states, “Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.	Attachment B, Section 2 (c) defines “Emergency Services” to mean “inpatient and outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition that is found to exist using the prudent layperson standard” Section 2(b) states, “Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.	Attachment B, Section 2 (c) defines “Emergency Services” to mean “inpatient and outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition that is found to exist using the prudent layperson standard” Section 2(b) states, “Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.
Grievances/ Complaints/ Arbitration and Appeals	Section 2.4 of the Agreement explains that CMO #3’s grievance and appeal procedures are to comply with applicable law and are to be described in the Provider Manual. Any grievance, or appeal process should meet the requirements in the DCH/CMO contract, by providing an internal appeals process with the CMO, and external appeal to the ALJ, and which also provides members (and authorized providers on their behalves) notification of their rights to appeal.	Section 2.4 of the Agreement explains that CMO #3’s grievance and appeal procedures are to comply with applicable law and are to be described in the Provider Manual. Any grievance, or appeal process should meet the requirements in the DCH/CMO contract, by providing an internal appeals process with the CMO, and external appeal to the ALJ, and which also provides members (and authorized providers on their behalves) notification of their rights to appeal.	Section 2.4 of the Agreement explains that CMO #3’s grievance and appeal procedures are to comply with applicable law and are to be described in the Provider Manual. Any grievance, or appeal process should meet the requirements in the DCH/CMO contract, by providing an internal appeals process with the CMO, and external appeal to the ALJ, and which also provides members (and authorized providers on their behalves) notification of their rights to appeal.

Reimbursement of Emergency Services	<p>Attachment A, Section II, Outpatient Facility Services, provides the following reimbursement rates: Revenue Code 45x and CPT 99281= \$X per case; Revenue Code 45x and CPT 99282 through 99285 = the Interim Outpatient Rate of X% X eligible charges.</p>	<p>Attachment A, Section II, Outpatient Facility Services, provides the following reimbursement rates for emergency services: Level I/Revenue Code 45x and CPT Code 99281 = \$X per case; Level II/ Revenue Code 45x and CPT Code 99282 = \$X Per Case; Level III/ Revenue Code 45x and CPT Code 99283 = \$X Per Case; Level IV/ Revenue Code 45x and CPT Code 99284 = \$X Per Case; Level V/ Revenue Code 45x and CPT Code 99285 = \$X.</p>	<p>Attachment A, Section II, Outpatient Facility Services, provides the following reimbursement rates for emergency services: Level I/ Revenue Code 45x and CPT Code 99281 = \$X per case; Revenue Code 45x and CPT Code 99282 = \$X per case; and Revenue Code 45x and one of the following CPT codes 99283 – 99285 = the Interim Outpatient Rate of X% multiplied by X% of charges.</p>
Required notification of provision of emergency services	<p>Section 1(b) of Attachment C, Provisions Applicable to Facility Providers, states, “Provider shall notify CMO #3 . . . , at the time of eligibility verification or by the end of the next business day after admission and identification of a Covered Person as an inpatient, or after rendition of emergency outpatient Covered Services to a Covered Person.” However, Section 1(c) then states, “Notwithstanding any provision contained in this Attachment or in this Agreement, no notification to, coverage verification from, or pre-authorization from CMO #3 is required for emergency room care services provided in accordance with EMTALA prior to Provider’s providing such care to a Covered Person.”</p>	<p>Exhibit A of the Agreement provides for two “notification” standards relating to emergency services: (1) If the person is admitted to the Hospital because of an Emergency Medical Condition, Hospital shall notify CMO #3 within twenty-four hours of the admission or the next business day; (2) If Covered Persons are treated in the emergency room and released, Provider shall provide a fax of the emergency room facesheet the next business day following the Covered Person’s release to allow for follow-up with the Covered Person regarding discharge instructions, assistance in setting up visits with the Primary Care Physician, assistance with obtaining durable medical equipment, prescriptions, and other services or supplies, as needed.</p>	<p>Attachment C of the Agreement explains, “Provider shall notify CMO #3 in accordance with the then current CMO #3 procedures, at the time of eligibility verification or by the end of the next business day after admission and identification of a Covered Person as an inpatient, or after rendition of emergency Covered Services to a Covered person.</p>

Observations re: CMO #3 contracts:

1. The definition of emergency medical services in the CMO #3 contract is not the same as the definition in the DCH/CMO contract. We believe CMO #3's definition of emergency medical services should reflect the definition in the DCH/CMO contract at Section 4.6.1.
2. The grievance/complaints/ appeals and arbitration provisions applicable to emergency services should be specifically added to the CMO #3 provider agreements to ensure all providers are aware of their appeal rights. Currently, the provider contracts refer to CMO #3's provider manual for its appeals processes.

CMO #3's Provider Manual describes its appeal process for providers and members. There is a (a) Medical Administrative Review Procedure; (b) Member Grievance Resolution policy and procedure; (c) Provider Complaint and Grievance Procedure; and (d) Provider Payment Disputes resolution process.

(a) The Medical Administrative Review Procedure entails:

(1) An informal administrative review that may be initiated by a member, a person acting on behalf of a member, the member's primary care physician or the member's healthcare provider within 30 calendar days from the date of the notice of proposed action (defined to be the denial or limited authorized of a requested service, including the type or level of service, the reduction, suspension, or termination of a previously authorized service, the denial in whole or in part of payment for a service, . . .). CMO #3 will notify the party filing the appeal, the member, the member's PCP and any other healthcare provider who recommended the healthcare service involved in the administrative review, of its decision orally followed up by the written notice of determination. The notice of determination will provide the decision made along with a clear and detailed reason for the determination; the medical or clinical criteria for the determination, the procedures for requesting a State Administrative Law Hearing within 30 calendar days of the date of the letter and how to do so (when applicable); the right to continue benefits during the ALJ hearing and how to request continuation of benefits; and information explaining the member may be liable for the cost of any continued benefit if the adverse determination is upheld in a State Administrative Law Hearing;

(2) An Expedited Administrative Review process that is available for certain types of ongoing types of treatments, the denial of which could significantly increase the risk to a member's health/life, or that would jeopardize the member's ability to reach and maintain maximum function; and (3) a State Administrative Law Hearing (also called an appeal), which may be initiated by a member or person acting on behalf of the member. ***Note: The Provider Manual states that a Provider cannot file on behalf of a member.***

(b) The Member Grievance Resolution policy and procedure is described as follows: “Each member or the person acting on behalf of the member, has a right to voice dissatisfaction with any aspect of [the CMO’s] or the provider’s operations. ***Providers cannot file a grievance on behalf of a member unless the member has granted the provider permission to act as their personal representative.*** Member grievances do not related to Medical Management determinations or interpretation of medically necessary benefits. [The CMO] will respond to member grievances in a timely manner and attempt to resolve all member grievances to the member’s satisfaction. Member grievances will be resolved consistent with Plan policies, covered benefits and member rights and responsibilities.” After the CMO makes its determination regarding the member’s grievance, if the member is dissatisfied with the CMO’s determination, he or she may express dissatisfaction with the grievance decision by sending a letter or fact to the CMO within 10 days of receipt of the written grievance resolution. At which point a Level II Grievance Review will be conducted by the CMO’s Quality Management staff and a decision will be made after a meeting with the member. The Provider Manual states, “[t]his is [the CMO’s] final decision. Upon exhausting, [the CMO’s] internal process, the member may then request a review by the Commissioner of Insurance or the Commissioner of Human Resources.”

(c) Provider Complaint and Grievance Procedure. A provider may file a complaint, which is a written expression of dissatisfaction regarding any aspect of the HMO’s healthcare services provided by the CMO and network providers and/or staff. The Provider Manual explains this to include, “complaints concerning quality of care, choice and accessibility of providers, network adequacy, and issued related to contractual and administrative determinations.” Complaints submitted by a provider on behalf of the member, will be considered a member grievance and addressed through the Member Administrative Review Process. There are two levels of Grievance Review. It appears the first Grievance Review is to be directed to the appropriate Plan department head, Medical Director and/ or CEO and then a Level I Grievance Resolution Letter is sent to the member and/ or the provider either within two business days if the grievance is regarding access to Medicaid-covered services, or within 30 days of receipt. There is also a Level II Grievance Review, which is to be reviewed by a committee consisting of the Associate Vice President (“AVP”) of Quality management, the AVP of provider services, the Medical Director and other members of senior staff. Apparently, a meeting with the provider is held, after which a decision is made by the committee within 30 days. ***Note: This process may not be clearly understood by providers as it does not explain the available remedies. Also note there is no ability of the provider to appeal to an ALJ, which appears to be inconsistent with the DCH/CMO contract.***

(d) Provider Payment Disputes. The Provider Manual explains that “[p]roviders may access a timely payment dispute resolution process. A payment dispute is any dispute between healthcare provider and the CMO for reason(s) including but

not limited to: denials for timely filing; contractual issues; lost or incomplete claim forms or electronic submissions; requests for additional explanation as to services or treatment rendered by a provider; inappropriate or unapproved referrals initiated by providers; provider appeals without member's consent; ***emergency room payment dispute***; retrospective review; formerly insufficient information. No action is required by the member. Payment disputes do not include medical appeals." There is a Level I determination, which is researched and determined by the Appeals Specialty Unit which may then send the payment dispute to the Plan Medical Director for further review and resolution. The Level I determination letter is to include the decision and the provider's appeal options (nothing states the reason for the decision is required to be included in the letter). The Provider Manual then explains there is a Level II appeal process, and that the written appeal should be submitted within 30 days of receipt of the Level I determination letter. No other information about the Level II appeal process is provided. ***Note: the provider payment dispute process may not be clearly understood by providers and appears to be for internal appeals only. While CMO #3's response to Myers and Stauffer's questions referenced a Fair Hearing Process, we were not able to confirm that this language is included within the Provider Manual. Consequently, we believe there is no ability of the provider to appeal to an ALJ, which appears to be inconsistent with the DCH/CMO contract.***

3. Each of the reimbursement sections provide a listing of revenue codes and CPT codes considered emergency services and the rate of reimbursement for such emergency services. It also appears from CMO's responses to Myers and Stauffer's questions that CMO #3 limits reimbursement to certain CPT codes, exclusively. While we acknowledge that the State Medicaid Director letter explains that CPT codes 99281 through 99285 are presumptively emergency services, we believe these to be the minimum of services considered as emergency services, with additional services qualifying for payment under the prudent layperson standard, if warranted.
4. CMO #3's requirement of having providers notify the CMO of a covered person utilizing emergency services appears to be in compliance with law as it appears to not base payment decisions on the fact of timely notification.

(C) State Law.

There is currently a proposed state law that is awaiting signature by Governor Perdue that would define the "prudent layperson" standard for purposes of determination of payment of emergency services claims.⁸ This law also would provide mechanisms to solve many of the issues that we have addressed in this report.

⁸ See Georgia House Bill 1234.

Exhibit G

Department of Community Health

**Response to Myers and Stauffer's
Hospital Claims Audit Report #2**

and

CMO Policies & Procedures Audit Report #3

**Side-by-Side Comparison of Implementation Activities for Audit
Findings and HB 1234**

July 8, 2008

Report #2 – Hospital Claims

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
1	<p><i>Contract Loading and Provider Setup</i></p> <p><i>Timeliness and Accuracy Issues</i></p>					
	<p>42% loaded in system prior to contract effective date. Of remaining, average of 52 days between effective date and loading date (1-357 days).</p> <p>Percentage of contracts entered after effective date ranged was 37% PSHP; 47% WC; and 95% AGP.</p>	<p>Contract establish requirement for the maximum time to load contract terms, and establish procedures to verify accuracy of provider setup.</p> <p>Recommend 30 days, with possible extension to 60 during implementation periods.</p> <p>Require CMOs to generate physical report of terms as loaded to be sent to provider for review.</p> <p>DCH monitor adequacy of</p>	Not addressed	Not addressed	See Credentialing Section 4.8.15	<ul style="list-style-type: none"> • Add contractual requirements related to timeliness of provider loading. • Require CMO reports to hospitals and providers on details of loaded information. • Develop reports for monitoring timeliness and accuracy of loading.

Report #2 – Hospital Claims

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
		networks, timeliness of loading and setup.				
2	<i>Credentialing Timeliness Issues</i>					
	<p>The number of days to complete credentialing ranged from 34 (WC) – 108 days (PSHP).</p> <p>WC completed credentialing of 13% of hospital <i>after</i> effective date; for PSHP this was 48%; AGP data could not be evaluated.</p>	<p>Include requirements for timeliness of credentialing. DOI regulations require decision within 90 days of receipt of all information.</p> <p>DCH may want to consider timeframe of 30 days for hospital providers. With extension during implementation phases.</p>	<p>4.8.14.1 At a minimum the Contractor shall require that each Provider be credentialed in accordance with State law. The Contractor may impose more stringent Credentialing criteria than the State requires.</p>	Not addressed	<p>4.8.15.1 At a minimum, the Contractor shall require that each Provider be credentialed in accordance with State law. The Contractor may impose more stringent Credentialing criteria than the State requires. . The Contractor shall Credential all completed applications packets within 120 calendar days of receipt.</p>	<p>Revision to contract gives CMO more time to credential provider than DOI regulations. Revise to be at least equal to DOI (90 days); M&S recommendation is for 30 days.</p>
3	<i>High Claim Denial Rate Related to Prior Authorization Issues</i>					
	The rate of denied	Recommend changes	4.9.2.1	Not addressed	4.9.2.1 –	• Require CMOs

Report #2 – Hospital Claims

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
	<p>claims ranged from 50% during initial implementation to 9-15% ongoing.</p> <p>16% of denials related to PA issues.</p> <ul style="list-style-type: none"> • 72 hr rule for readmissions, merging of claim and PA data • Confusion of services requiring PA • Add on services during procedure • Auth of specific procedure vs. family of codes • Data entry problems <p>Interest payments were confirmed for claims initially denied, but later paid.</p>	<p>to PA policies:</p> <ul style="list-style-type: none"> • Consider use of standard PA form • Provide electronic confirmation of relevant PA info. • Automated process to merge records impacted by 72 hr rule • Require CMOs to produce comprehensive list of all procedures requiring PA • Allow add on procedures with post review. • Require authorization of family of codes • Require acceptance of PA from other CMO when member changes plans 	<p>Requires the CMO to issue a provider handbook which describes:</p> <ul style="list-style-type: none"> • Covered services • Prior Authorization, Pre-Certification, and Referral procedures; • Claims submission protocols and standards, including instructions and • all information necessary for a clean or complete Claim; • Payment policies <p>4.10.1.5.12 and 4.10.1.5.17 also require provide contracts to contain above information regarding covered services and billing and coding requirements.</p> <p>Does not specify level of detail to which this information must be provided.</p>		<p>Unchanged</p> <p>4.11.4.1 – Adds requirement that CMOs honor pre-existing authorizations for treatment or medications given by DCH or another CMO for at least the first 30 days of new eligibility.</p>	<p>to provide detailed information to providers on specific procedures that require PA</p> <ul style="list-style-type: none"> • Require electronic verification of PA details

Report #2 – Hospital Claims

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
			Does not address standard PA form, electronic verification of PA information, allowing add-on procedures, family of codes, or accepting other CMO authorization (this was adopted in policy).			
4	<i>High Claim Denial Rate Related to Coding Policies, Coding Inconsistencies, and Benefit Limits</i>					
	25% of denied claims related to coding policies, coding inconsistencies, or benefit limits.	<ul style="list-style-type: none"> Require CMOs to update and publish lists of covered services, those that require PA, global fee period, benefit limitations, other restrictions, revenue code/proc code combinations. Provide ongoing training for 	<p>4.16.1.13 Requires CMOs to inform providers about the information required for processing of a “clean” claim.</p> <p>CMOs shall make claim coding and processing guidelines available to providers.</p> <p>CMOs shall notify providers of any changes</p>	Not Addressed	Moved to 4.16.1.11 – content unchanged	<ul style="list-style-type: none"> Require CMOs to provide detailed information to providers on specific coding requirements for claim payment

Report #2 – Hospital Claims

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
		providers <ul style="list-style-type: none"> • Collaborative training between CMOs/provider association focused on coding policies • Ongoing, periodic meetings with associations 	to claim processing or coding guidelines 90 days prior to implementation.			
5	<i>Large Suspended Claims Volume that May Result From CMO's Definitions of Clean Claims</i>					
	Number of CHOA suspended claims ranged from 32 (AGP) to 16,000 (WC). <i>Some claims in suspense status since June 2006 (AGP) but most within prior 3 months.</i> Suspension of claims and lack of interest payments may result form non-standard definition of clean	<ul style="list-style-type: none"> • Require CMOs to define criteria for a clean claim. • Flag and report on clean claims. DCH monitor performance • Identify providers with recurrent problems and target for training. 	4.16.1.9 Requires that clams suspended for additional information be either paid or denied within 30 calendar days of suspense. If required information not received by 30 th day, notice must be sent to provider noting reason for denial and additional information needed to adjudicate the claim. 4.16.1.13	33-24-59.5 (f) Requires the CMOs to use the same timeframes as DCH for submission, processing, payment, denial, adjudication, and appeal of Medicaid claims.	4.16.1.9 – removed This requirement no longer directly addressed. However, it likely falls under 4.16.1.1 - which states that the CMO is required to follow the same time frames as DCH for claim submission,	<ul style="list-style-type: none"> • Verify DCH timeframes for claims remaining in suspense status.

Report #2 – Hospital Claims

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
	claim.		The CMO is required to inform providers of information required to submit a clean claim. The CMO must notify providers 90 days prior to implementing any changes to claims coding or processing guidelines.		processing, payment, denial, and adjudication. 4.16.1.13 changed to 4.16.1.11, content the same.	
6	<i>Timely Filing Denials & Confusion</i>					
	<p>Providers report several issues including:</p> <ul style="list-style-type: none"> • Different requirements between FFS and each of CMOs • Some CMOs using admission date to determine timely filing • Retro-active denials that cannot be appealed 	<ul style="list-style-type: none"> • Require CMOs to follow FFS timeframes • Require CMOs to use discharge date as date of service • Suspend timely filing edits during implementation periods. 	<p>4.16.1.12 Allows CMO to deny payment if claim not submitted within 120 days of date of service; require CMO to deny if submitted more than 180 days from date of service. CMO shall override if provider has evidence they erroneously filed with another CMO or the state within 120 days.</p>	<p>33-24-59.5 (f) Requires the CMOs to use the same timeframes as DCH for submission, processing, payment, denial, adjudication, and appeal of Medicaid claims.</p>	<p>4.16.1.12 - removed, replaced by section 4.16.1.1 - which states that the CMO is required to follow the same time frames as DCH for claim submission, processing, payment, denial, and adjudication.</p>	
7	<i>Apparently Improper Claim Denials for Members That Appear to Have Been Eligible</i>					

Report #2 – Hospital Claims

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
	<i>for CMO Coverage</i>					
	<p>Approximately 5% of claim denials relate to member eligibility. In many of these, system indicated member locked-in to CMO on date of service.</p>	<ul style="list-style-type: none"> • Increase frequency of eligibility file transfers – recommend daily file transfer. • Require CMOs to identify discrepancies between their enrollment files and fiscal agent lock-in files. 	<p>Not addressed</p>	<p>33-21-A-6(a) Requires CMOs to pay for care to newborn, born to the mother that is covered under their plan.</p> <p>33-21A-9 (a) Requires payment to provider based on eligibility information, if provider documents that they verified eligibility within 72 hours of service, even if this eligibility later turns out to be incorrect.</p> <p>33-21A-9 (b) Allows provider to re-bill correct payer without</p>	<p>4.16.1.9 Requires CMO to pay for services regardless of eligibility, if provider can document that they verified eligibility with that CMO within 72 hours of service.</p> <p>4.16.1.10 Prohibits CMO for denying claims for timely filing or out-of-network status, when due to incorrect eligibility information.</p>	<ul style="list-style-type: none"> • Determine whether more frequent eligibility file transfers would improve eligibility data • Develop central site for verification of all eligibility data • Investigate scenarios where CMOs denying for eligibility where member is locked-in to their CMO; address any systemic issues.

Report #2 – Hospital Claims

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
				penalty for timely filing, if initial eligibility information is incorrect.		
8	<p><i>Several Claims Payment Components and CMO Performance Indicators May Require Additional Monitoring for Contract Compliance</i></p>					
	<p>Findings suggest additional monitoring may be necessary.</p>	<p>Financial Indicators:</p> <ul style="list-style-type: none"> • Medical loss ratio • Administrative loss ratio • Current ratio • Days cash on hand • Cash to claims payable • Days in claims payable • Medicaid profit margin <p>Claim Indicators</p> <ul style="list-style-type: none"> • Suspended claim 	<p>Provider Network</p> <ul style="list-style-type: none"> • Providers by specialty • Voluntary terminations <p>The above reports are received and monitored monthly by DCH staff.</p> <p>See Section 4.8 Provider Network</p>	Not Addressed		

Report #2 – Hospital Claims

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
		<ul style="list-style-type: none"> volume • Denial claim volume • Interest payments • Claims paid at emergency and triage rates • ER appeal and overturn rates • Adjudication statistics • PA approval/denial rates Provider Network • Providers by specialty • Voluntary terminations • Contract loading timeliness • Credentialing timeliness • Member plan changes 				
9	<i>Emergency Room Coverage and Reimbursement Issues</i>					

Report #2 – Hospital Claims

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
	<p>CMOs utilize different methodologies to define and determine reimbursement of emergency medical conditions.</p> <p>2 of 3 CMOs pay significant number of claims (99283-9985) at triage rate, but one eventually pays emergency rate on reconsideration.</p> <p>2 of 3 CMOs do not consider time of day, day of week, or age of patient in making determination.</p>	<ul style="list-style-type: none"> Require CMOs to use standardized approach for reimbursement. Could base on CPT or diagnosis code. If diagnosis based, DCH should provide minimum list of presumed conditions. Require CMOs to evaluate policies and modify based on reconsideration and overturn rates. DCH evaluate and update list of presumed diagnoses on annual basis. 	<p>4.6.1 States that emergency medical condition cannot be defined by a list of diagnoses or symptoms. Requires coverage based on prudent layperson standard. Must base on symptoms at time of presentation. Cannot deny retroactively deny if condition later determined to not be true emergency. If a representative of the CMO instructs the member to seek emergency services they shall be covered regardless of whether they meet prudent layperson standard.</p>	<p>33-21A-4 In processes claims for emergency services, the CMO shall consider age of patient, time and day of week, severity of presenting symptoms, initial and final diagnosis, any other criteria prescribed by DCH.</p>	<p>No changes</p>	<ul style="list-style-type: none"> Require CMOs to submit specific guidelines for processing claims, review that complaint with HB 1234 requirements. Require monthly reports on percentage of ER claims paying at emergency vs. triage rate Conduct periodic audits on sample of claims paying at triage rate
10	<i>Claim Reprocessing for Known Claim Issues</i>					
	Some CMOs do not routinely reprocess claims after making	Require CMOs to reprocess claims for known issues	(See section 4.16.1.12) The Contractor shall assume all costs associated with	Not addressed	No change made	Implement M& S recommendation.

Report #2 – Hospital Claims

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
	retroactive system changes, such as rate changes.	following system corrections or retroactive rate changes.	Claim processing, including the cost of reprocessing/resubmission, due to processing errors caused by the Contractor or to the design of systems within the Contractor’s span of control.			

Report #3 – Policies & Procedures

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
1	CMO accreditation and notification requirements					
	DCH contract does not mandate retention of accreditation, or notification of DCH in the event of any findings of deficiencies, or loss of accreditation.	<ul style="list-style-type: none"> • Require accreditation with one specific agency (NCQA) • Require notification of loss of accreditation within 15 days • Report any deficiencies found within 30 days • Require corrective action plan to address deficiencies within 60 days. 	Not addressed	Not addressed	Not addressed	Include recommendations in future contract revisions.
2	Comprehensive Managed Care Resources for Providers					
	Virginia DMAS publishes annual Managed Care Resource Guide for providers that has summary of programs,	Publish annual resource guide for providers that includes key staff, PA processes at each plan,	Not Addressed	Not Addressed	Not Addressed	

Report #3 – Policies & Procedures

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
	staff, PA requirements, etc.	and other relevant information.				
3	Emergency Medical Condition Definition Listed in Model Contract Contains an Inaccuracy					
	Section 4.6.1.2.6 has error and states: “With respect to a pregnant woman having contractions: (i) that there is adequate time to effect a safe transfer to another hospital before delivery, or...” Per CFR should state “inadequate”	Change language to be consistent with CFR	Not Addressed	Not Addressed	Not Addressed	Correct language in current contract revision.
4	CMOs Utilize Different Methodologies to Process Emergency Room Claims					
	Same as Recommendation #9, <i>Emergency Room Coverage and Reimbursement Issues</i> , from Report #2.					
5	Lack of Uniformity of Prior Authorization Processes					

Report #3 – Policies & Procedures

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
	<p>Hospitals noted a number of issues related to submission of prior authorization requests. MI uses a standard PA and standard credentialing form across all MCOs; FL is considering the use of a standard PA form. Currently each GA CMO has its own PA process.</p>	<ul style="list-style-type: none"> • Require CMOs to collaboratively develop and utilize common PA form. • Provide electronic confirmation of authorization that includes all relevant information regarding the request. • Maintain comprehensive list of all services that require PA. • CMOs designate specific staff knowledgeable of PA process to communicate with providers • Require CMOs to conduct training for hospitals on PA requirements • Require payment of medically 	<p>4.9.2.1 Requires the CMO to issue a provider handbook which describes:</p> <ul style="list-style-type: none"> • Covered services • Prior Authorization, Pre-Certification, and Referral procedures; • Claims submission protocols and standards, including instructions and • all information necessary for a clean or complete Claim; • Payment policies <p>4.10.1.5.12 and</p>	<p>Not addressed by HB 1234.</p> <p>SB 507 requires DCH to implement consistent requirements, paperwork, and procedures for utilization review and prior approval of therapy services for children.</p> <p>SB 507 also requires that prior approval for services shall be for general areas of treatment or ranges of specific treatments or processing codes.</p>	<p>4.9.2.1 – Unchanged</p> <p>4.11.4.1 – Adds requirement that CMOs honor pre-existing authorizations for treatment or medications given by DCH or another CMO for at least the first 30 days of new eligibility.</p>	<ul style="list-style-type: none"> • Require CMOs to provide detailed information to providers on specific procedures that require PA • Require electronic verification of PA details

Report #3 – Policies & Procedures

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
		<p>necessary add-on procedures. Verification through post payment review.</p> <ul style="list-style-type: none"> • Require authorization of family of codes for similar procedures • Require automated processes to merge records and authorizations when 72 hr rule applied. • Require acceptance of PA from another CMO when eligibility changes. 	<p>4.10.1.5.17 also require provide contracts to contain above information regarding covered services and billing and coding requirements.</p> <p>Does not specify level of detail to which this information must be provided.</p> <p>Does not address standard PA form, electronic verification of PA information, allowing add-on procedures, family of codes, or accepting other CMO authorization (this was adopted in policy).</p>			

Report #3 – Policies & Procedures

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
6	Recoupment Process Not Adequately Addressed in DCH Model Contract					
	Provider feedback indicates that this is an issue. One state requires health plans to notify the state prior to recoupment.	<ul style="list-style-type: none"> • Include time-limit for recoupment • Require that CMO contracts and policies address recoupment process, provider rights, and that notice provides sufficient detail. • Address appeal rights related to recoupments in model contract. 	Not addressed	If a provider has verified member eligibility through web portal CMO cannot recoup payment for members later determined to not be covered, if the service occurred within 72 hours of verification.	Contains same provision as HB 1234	Consider adding requirements to address recoupment process, provider rights, notice, and timeframes in CMO provider contracts.
7	Providers Require Access to Explanation of Payment Disposition Codes					
	Hospital providers indicate that they could not understand payment disposition codes, due to	<ul style="list-style-type: none"> • Require CMOs to provide payment disposition codes on website or 	Not Addressed	Not Addressed	Not Addressed	

Report #3 – Policies & Procedures

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
	insufficient information, or lack of explanation of benefit codes.	<ul style="list-style-type: none"> provider manual Add information to provider resource manual Require that each denied claim include detailed explanation. 				
8	Confusion Regarding the Provider Appeal Process					
	There is considerable variation among CMOs regarding appeal processes.	<ul style="list-style-type: none"> DCH add NCQA definitions regarding appeals to improve standardization Require each CMO to permit appeals in accordance with contract Add requirements to ensure timely and fair outside appeal process, and to consolidate appeals. Require that CMOs provide complaint process 	Current contract has specific requirements (4.14) related to both internal and external appeals that are mandated by CFR	<ul style="list-style-type: none"> Requires CMO to allow provider to consolidate complaints or appeals relating to similar issues Allows providers to select administrative review or binding arbitration. 	Incorporates requirements of HB 1234 – 4.9.7.2 – Allow providers to consolidate complaints or appeals of multiple claims 4.9.7.3 – Allows provider that has exhausted internal appeal process to seek binding arbitration	

Report #3 – Policies & Procedures

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
		with DCH.				
9	DCH Model Contract Does Not Address the Date That Initiates the Start of Filing Time Limit Calculation					
	DCH Contract does not specify whether admission or discharge date shall be used for calculating the claim filing time limit.	<ul style="list-style-type: none"> DCH add requirement to include discharge date as criteria for filing time limit calculations. 	Not addressed	DCH must require CMOs to utilize the same timeframes and deadlines for Medicaid claims as DCH uses for claims it pays directly.	Not addressed	
10	Inconsistent Definition of Emergency Medical Services in CMO Contracts					
	Each CMO is using a different definition of “Emergency Medical Services” in their contracts, which differs from the definition in the DCH CMO contract.	Require each CMO to use the same definition as in the DCH CMO model contract.	Emergency Medical Condition: A medical Condition manifesting itself by acute symptoms of sufficient severity (including severe	In processing claims for emergency care, a CMO must consider the age of the patient, the time and day of the week the patient presented for	No changes	

Report #3 – Policies & Procedures

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
			<p>pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall not be defined</p>	<p>services, the severity and nature of the symptoms, the patient’s initial and final diagnosis, and any other criteria prescribed by DCH.</p>		

Report #3 – Policies & Procedures

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
			on the basis of lists of diagnoses or symptoms.			
11	Lack of Direction as to How to Apply the “72-Hour Rule”					
	DCH model contract does not contain language regarding application of this reimbursement policy.	<ul style="list-style-type: none"> • Modify the model contract to include language regarding utilization of 72-hour rule, consistent with DCH FFS policy • Require CMOs to develop processes to properly merge updated authorization records when 72 hour rule is applied 	Not Addressed	Not Addressed	Not Addressed	Address processes for application of 72 hour rule through DCH CMO policy manual.
12	Model Contract Provides Limited Information Regarding the Handling of Third Party Liability Claims	Consider adding requirements regarding the handling of third party liability claims.	8.4.2.1 - The Contractor shall cost avoid all Claims or services that are subject to payment from a third party health insurance carrier...	Not Addressed	No Changes	

Report #3 – Policies & Procedures

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
			<p>8.4.2.3 - The requirement of Cost Avoidance applies to all Covered Services except Claims for labor and delivery, including inpatient hospital care and postpartum care, prenatal services, preventive pediatric services, and services provided to a dependent covered by health insurance pursuant to a court order. For these services the Contractor shall ensure that services are provided without regard to insurance payment issues and must</p>			

Report #3 – Policies & Procedures

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
			provide the service first.			
13	Innovative Incentive Plan Found in Comparison State					
	Indiana uses 3 tiered approach of state incentive to MCO, who must reinvest at least 50% in physician and/or member incentive	DCH may wish to develop incentive plan for CMO, providers, and members.	7.4 - Allows for payment of performance incentives to CMOs for Health Check screening; blood lead screening; dental visits; newborn enrollment; and EPSDT tracking	Not Addressed	No Changes	

**AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT**

M&S Report #2 – Hospital Claims		
Area of Concern	Action Required	CMO Response
<p>The initial Myers and Stauffer claims analyses appear to indicate that many hospital contracts were entered after the contract effective date.</p>	<p>Clarify whether this problem only related to the implementation process?</p> <p>Describe the steps have been (or were) taken to ensure that new contracts and/or providers are loaded prior to the effective date of the contract.</p> <p>Describe the process for monitoring contract loading to ensure that contracts are loaded prior to their effective date.</p>	<p>The concern regarding loading providers after the go-live date is a valid concern. Some reasons for this included: Providers submitted their contract after the go-live date but we agreed to back-date (for providers satisfaction reasons), providers were not through the credentialing process (i.e. missing data elements) so we held on loading the contract until we had all pertinent information and then backdated the effective date (to process claims), and we because most hospitals responded at go-live time and not prior, we had over 100 hospitals to load at the same time. Providers were given deadlines for the contract at least 30-90 days prior to go-live, but most waited until the week of go-live (or after) to submit their signed contracts.</p> <p>- For provider loading, the AGP process is to accept the credentialing application and contract from the providers. We take 30-45 days to credential/load the hospitals and then place the effective date in our system showing the date the contract was</p>

**AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT**

M&S Report #2 – Hospital Claims		
Area of Concern	Action Required	CMO Response
		signed by the provider, or the date specifically listed as the effective date in the contract. In most cases, this would mean that the effective date will show a date prior to the loading of the contract. We notify providers when their contract is loaded and an orientation is performed. In the future you would see similar results related to contracts being loaded after the effective date since we do not push the effective date out until after the contract is loaded. We use the effective date as the date negotiated in the contract or the date the provider signed. In addition, we cannot finalize the loading process until the provider is through the credentialing process and credentialing committee approval (30-45 day process). Currently, our average turnaround time to load a hospital contract is approximately 30-40 days from receipt.
System corrections do not appear to automatically be applied to previously processed claims.	Describe your policy for handling changes that are made within the system (e.g. system logic updates, provider rate changes/corrections, retro-active policy	Please provide examples as to what is being referenced. For example, if the Interim Outpatient

**AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT**

M&S Report #2 – Hospital Claims		
Area of Concern	Action Required	CMO Response
	<p>changes, eligibility updates or provider contracts loaded after the effective date). Describe your policy for handling changes that are made within the system (e.g. system logic updates, provider rate changes/corrections, retro-active policy changes, eligibility updates or provider contracts loaded after the effective date).</p> <ul style="list-style-type: none"> • What steps are taken to ensure any previously submitted claims are reprocessed/adjusted? • Are all claims affected by the issue reprocessed/adjusted or only those claims submitted by the provider who brought the issue to your attention? • If you only reprocess/adjust the claims for the provider that brought the issue to your attention, please explain the rationale for this policy. 	<p>Rate (IOR) is changed by the state then AGP will make the updates but the changes are made <u>prospectively</u> and do not necessarily drive the requirement for reprocessing of claims. This is in compliance with AGP provider contracts</p> <ul style="list-style-type: none"> • Per contracts with providers AGP will update the fee schedule no more than 90 days from receipt of notice of final changes or on the effective date of such changes, whichever is later. Fee Schedule changes will be applied on a <u>prospective basis</u>. <p>If a contract has approval for a Non Standard Effective date (NSED) and was approved as such, then once the contract is loaded a claims report would be pulled and claims reprocessed to pay at the contracted rate based on the effective date in the NSED. NSED require approval by the COO or CEO of a Health Plan.</p> <p>If claims did not pay according to contract and a root cause issue is discovered then a complete claim report is pulled to determine all claims that would need to be reprocessed. Typically this is a result of a provider supplying a few claims as</p>

**AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT**

M&S Report #2 – Hospital Claims		
Area of Concern	Action Required	CMO Response
		<p>examples, the root cause is discovered, corrected and the above is completed to ensure all impacted claims are reprocessed in a claims project via the AGP CAMP process.</p> <p>If examples can be provided, we will review to determine if the claims were paid according to contract terms or if an error exist.</p>
<p>Interest payments do not appear to be applied to claims that are reprocessed to adjust for system or processing error.</p>	<p>Describe your policy for paying interest when claims are reprocessed/adjusted after a reference file or system update (e.g. corrected authorization, corrected file rate, delayed provider entry, or system logic change).</p> <ul style="list-style-type: none"> • Is interest automatically paid to the provider retroactively to the date of original submission? • If you do not pay interest in these instances, please provide the rationale for not paying interest in these cases. 	<p>Interest Payments can not be seen with in the claims processing screen of a claim. You would have to transfer into the payment detail or pull an EOP to see the interest applied to a claim.</p> <p>If a claim is reprocessed for example waiving Timely Filing as the provider was at fault for the TFO submission then interest would not be applied to the claim if AGP agrees to pay and over ride TFO denials.</p> <p>To validate whether the M&S area of concern is correct, we will need claim examples from M&S to determine if interest was paid appropriately.</p>
<p>The initial Myers and Stauffer claims analyses appear to indicate that a</p>	<p>Please provide your analysis of the reasons/issues that are leading to these</p>	<p>AGP would need examples of claims from M&S to respond accurately and</p>

AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT

M&S Report #2 – Hospital Claims		
Area of Concern	Action Required	CMO Response
significant portion of suspended claims and denied claims are related to authorization issues.	types of denials. Describe the steps or corrective actions that are being taken to address these issues.	completely to this statement. If a provider did not obtain an authorization and it was a service that required an authorization, it would be appropriate to deny or suspend a claim for review. If during the review we are unable to find an authorization in our system, the claim would be denied for no pre-authorization.
The initial Myers and Stauffer claims analyses appear to have identified claims denials that indicate the member was not eligible on the date of service. However, after reviewing the data from the fiscal agent contractor (ACS), it appears that these members were determined by DCH to be eligible on the date of service (i.e., a member included in the ACS lock-in file for which the CMO received a capitation payment).	Describe your policy and process for handling eligibility updates. Specifically indicate your reconciliation process for identifying and updating previously denied claims.	AGP would need examples of claims denied for eligibility reasons to respond accurately and completely to this statement. This information is also needed to identify the applicable policy and procedure.
It appears from the Myers and Stauffer claims analyses and provider input that monies previously paid under the merged member have, at times, been recouped with a notice indicating the member as not active. These claims often appear to have been denied for timely filing when resubmitted under the new member number.	Describe your process for handling merged member records. Is the claim history and authorization history transferred to the new member number? What steps have been taken to alleviate this issue?	AGP would need examples of claims to respond accurately and completely to this statement.

**AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT**

M&S Report #2 – Hospital Claims		
Area of Concern	Action Required	CMO Response
<p>Provider complaints regarding ability to submit prior authorization data on-line, along with inability to obtain confirmation of authorization or status of request.</p>	<p>Please confirm that online access to prior authorization (PA) information is available to all providers and that they are able to receive PA status information and PA confirmation online.</p> <p>If this is not functional, when do you anticipate it will be?</p> <p>If it is functional, when did the functionality begin?</p>	<p>Participating providers with AGP have access to an AGP ASSIST secured website. Through this site they have the ability to submit a request for an authorization and check the status of an authorization. This function has been in place with AGP since June 2006.</p>
<p>AMERIGROUP did not supply Myers and Stauffer with providers' application dates or credentialing dates as requested. AMERIGROUP representatives stated that this information was unavailable. However, DCH routinely receives this information in reports from AMERIGROUP.</p>	<p>Please indicate the method used by AMERIGROUP to track this information and to provide this information to DCH.</p> <p>Please explain why the information was unavailable to Myers and Stauffer.</p> <p>Please submit requested information to Myers and Stauffer as soon as possible.</p>	<p>On 9/25/07, AGP had a conference call with M&S representatives and Marvis Butler and John Upchurch. At that time, we discussed the fact that due to the short implementation timeframes AGP was under during go-live, the application date information would not be widely available for most providers and not at all for any delegated entities. AGP did, however, have the credentialing date available. It was agreed during this conference call that AGP could exclude the application date data element.</p> <p>In our research of the initial query that was</p>

**AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT**

M&S Report #2 – Hospital Claims		
Area of Concern	Action Required	CMO Response
		run to produce this file, the credentialing date appears on AGP’s file. We are unclear as to why it was not available for viewing by M&S except that maybe that element disappeared somehow during the file transfer from AGP’s system to the portal. We have re-run this file and have posted to the portal under the file name “Myers & Stauffer – revised provider file 7-08”.
The suspended claims data provided by AMERIGROUP included 32 hospital claims for CHOA with information indicating that the claims were suspended in June 2006.	Please indicate whether these claims have been resolved, and if so, provide the resolution date and explain why the claims appeared in the July 2007 file of suspended claims.	AGP would need the list of 32 claims to respond accurately and completely to this statement. Unable to validate the concern without this information.
A comparison of the provider rate file supplied to Myers and Stauffer by AMERIGROUP to the provider contracts supplied by AMERIGROUP revealed inconsistencies with 14 of the outpatient rates and 1 inpatient rate. Please see list below. Outpatient <ul style="list-style-type: none"> • Candler Hospital • Chestatee Regional Hospital • Cobb Memorial Hospital 	For each facility, please document the rate that you currently have loaded in your system, along with the rate in the provider contract. For rates that have been corrected, please indicate: <ul style="list-style-type: none"> • The date of correction • Reason for inconsistency 	AGP would need the 14 out-patient rates referenced to respond accurately and completely to this statement. Unable to validate the concern without this information.

**AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT**

M&S Report #2 – Hospital Claims		
Area of Concern	Action Required	CMO Response
<ul style="list-style-type: none"> • East Georgia Regional Medical Center • Mountain Lakes Medical Center • North Georgia Medical Center • Northeast Georgia Medical Center • Satilla Regional Medical Center • St Mary’s Hospital • Tattnall Community Hospital • Walton Regional Medical Center • Wellstar Cobb Hospital • Wellstar Douglas Hospital • Wellstar Paulding Hospital <p>Inpatient</p> <ul style="list-style-type: none"> • Hutcheson Medical Center 	<ul style="list-style-type: none"> • Whether all previously submitted claims have been reprocessed/adjusted for these providers? • If so, was interest paid on the mis-payment amounts? • If no interest was paid or if the claims have not been corrected, please describe when these events will occur. 	
<p>According to the data you provided, it appears that two hospital provider contracts required more than 120 days to load based on the difference between the effective date as a participating provider and the date the hospital was loaded into the system as participating (Redmond Regional Medical Center and Emory Johns Creek Hospital).</p>	<p>Please explain why these providers required this amount of time to load as participating providers.</p> <p>Describe any system improvements that were made to correct any problems identified above.</p>	<p>Emory Johns Creek was contracted via Emory hospital prior to the hospital officially being open by Emory. The delay in loading was due to both the opening of the hospital and the hospital obtaining a Georgia Medicaid ID.</p> <p>Redmond Regional Medical Center was a part of the HCA contract. The Health Plan tested the contract on 12/15/2006. They were made par based on an effective date of 12/06/06.</p>

**AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT**

M&S Report #2 – Hospital Claims		
Area of Concern	Action Required	CMO Response
		<p>AGP provided weekly reports to DCH on hospital contacting loading due to go live and had previously addressed the questions related to these facilities.</p> <p>The health plan since go live has experienced a 30 -45 day contract load on hospital contracts and does not feel this is an issue any longer. The time frame is based on the complexity of the contract.</p>

M&S Report #3 – Policies and Procedures		
Area of Concern	Action Required	CMO Response
<p>For the post stabilization requirements listed in section 4.6.2 of contract, policy and procedure documentation was found for one of the five requirements. One of the requirements, 4.6.2.4, appears to be partially met as language for 4.6.2.4.2 and 4.6.2.4.3 was found, but requirement 4.6.2.4.1 was not found. The other three requirements were not found in the documentation provided by AGP.</p>	<p>Please confirm and submit policies that confirm adherence to the requirements of the following sections of the DCH Model contract:</p> <p>4.6.2.1, 4.6.2.4, 4.6.2.5, and 4.6.2.6.</p>	<p>The following is available in the provider manual:</p> <p>Emergent Admission Notification Requirements</p> <p>AMERIGROUP prefers immediate notification by network hospitals of emergent admissions. Network hospitals must notify AMERIGROUP of emergent admissions within one business day.</p> <p>AMERIGROUP utilizes InterQual® and Milliman criterion for review of emergent</p>

**AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT**

	<p>If policies do not exist, please draft and submit to DCH for approval.</p>	<p>admissions. AMERIGROUP Medical Management staff will verify eligibility and determine benefit coverage. AMERIGROUP is available 24 hours a day, 7 days a week to accept emergent admission notification at the National Contact Center at 1-800-454-3730.</p> <p>Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets criteria, an AMERIGROUP reference number will be issued to the hospital.</p> <p>If the notification documentation provided is incomplete or inadequate, AMERIGROUP will not approve coverage of the request, but will notify the hospital to submit the additional necessary documentation.</p> <p>If the Medical Director denies coverage of the request, the appropriate notice of proposed action will be mailed to the hospital, member's primary care provider and/or attending physician and member.</p>
<p>Contract requirement 4.11.1.1.4 states that all Medical Necessity determinations are made in accordance with DCH's Medical Necessity definition as stated in Section</p>	<p>Please confirm and describe why additional components are present.</p>	<p>Need information as to what they are referencing to respond.</p>

**AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT**

<p>4.5.4 The medical necessity definition used by AGP appears to contain components from the GF CMO model contract definition state in Section 4.5.4, however additional components are present.</p>		
<p>Myers and Stauffer was unable to confirm whether the policies of AGP are consistent with the contractual requirements in 4.14.3.4.1, related to proposed actions.</p>	<p>Please confirm if this contract requirement, including effective date, is in your policies and procedures and provide documentation of this policy.</p> <p>If policies do not exist, please draft and submit to DCH for approval.</p>	<p>If AGP <u>previously authorized services</u>, we would not terminate, reduce or suspend. We do not retroactively change the authorization. For a request for <u>continuation of services</u>, AGP follows NCQA and DCH requirements/timeframes to make a determination within 14 days or 72 hours for expedited requests.</p>
<p>Contract language in 4.6.1.4 requires that a CMO base coverage decisions for Emergency Services on the severity of the symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a prudent layperson. Myers and Stauffer was not able to identify policies and procedures for AGP that states coverage decisions for emergency room services are based on the severity of presenting symptoms.</p>	<p>Please confirm if this contract requirement, including effective date, is in your policies and procedures.</p> <p>Please provide documentation of this policy and procedure.</p> <p>If policies do not exist, please draft and submit to DCH for approval.</p>	<p>AGP pays the ER claim regardless of the severity of the presenting systems.</p> <p>Attached is another copy of the AGP reimbursement policy related to non participating providers that relates to ER services.</p>
<p>Myers and Stauffer asked AGP to describe</p>	<p>Please provide additional explanation</p>	<p>AGP responded not applicable as AGP</p>

**AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT**

<p>how the prudent layperson criteria are applied when adjudicating claims and to describe the staff resources and qualifications used in the process. AGP provided the following response: “Not applicable to AGP”.</p>	<p>regarding this response, including why a federal regulation would not be applicable to AGP.</p> <p>Submit policies that document how AGP applies the prudent layperson standard.</p> <p>If policies do not exist, please draft and submit to DCH for approval.</p>	<p>pays ER claims regardless of the Diagnosis codes that are billed. AGP does not downgrade ER claims based on non emergent DX codes similar to the other CMOs.</p> <p>Attached another copy of the AGP reimbursement policy related to non participating providers that relates to ER services.</p> <p>AGP needs the M&S claim examples to review to determine whether the area of concern is valid. Our processes do not support that area of concern stated by M&S.</p>
<p>For third party liability claims, AGP does not have information listed for pre-certification requirements related to these types of claims in the documentation submitted to Myers and Stauffer.</p>	<p>Please confirm and describe if this process is in your policies and procedures.</p> <p>Please provide documentation to support this policy and procedure.</p> <p>If policies do not exist, please draft and submit to DCH for approval.</p>	<p>Need clarification on the area of concern related to pre-certification requirements??</p>
<p>Regarding recoupment’s, stated in 4.10.4.5, criteria were not found in AGPs policies and procedures to address this requirement.</p>	<p>Please confirm if this contract requirement, including effective date, is in your policies and procedures and please describe how it is applied.</p> <p>If policies do not exist, please draft and</p>	<p>Recoupment information is covered in the base contract for providers under section 4.6 <u>Right of Offset</u> (older contracts 5.7)</p> <p>AGP did submit all P & Ps to DCH recently related to recoupements. The P &</p>

**AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT**

	<p>submit to DCH for approval.</p>	<p>Ps can be found on the AGP portal. The process is as follows:</p> <p>Claim Submission Within 90 Days of Service</p> <p>If the health plan pursues a post payment audit or retroactive denial of a claim that was <u>submitted within 90 days</u> of the last date of service or discharge covered by the claim, the following limitations apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The provider must be provided with a written notice of the health plan’s intent and the specific reason for the audit or claim denial; <input type="checkbox"/> The written notice must be delivered within 12 months of the last date of service or discharge covered by the claim; and <input type="checkbox"/> The audit or retroactive denial of payment must be completed within 18 months of the last date of service or discharged covered by the claim. The provider must also be notified of any payment or refund due prior to the expiration of the 19 month period. <p>Claims Submitted After 90 Days of Service</p> <p>If the health plan pursues a post payment audit or retroactive denial of a claim that</p>
--	------------------------------------	--

**AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT**

		<p>was <u>submitted after 90 days</u> of the last date of service or discharge covered by the claim, the following limitations apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The provider must be provided with a written notice of the health plan’s intent and the specific reason for the audit or claim denial; <input type="checkbox"/> The written notice must be delivered within 12 months of the initial submission of the claim; <input type="checkbox"/> The audit or retroactive denial of payment must be completed the earlier of <ul style="list-style-type: none"> o Within 18 months of the initial submission of the claim; or o Within 24 months of the date of service; and <input type="checkbox"/> The provider must also be notified of any payment or refund due within the same period of time.
<p>Does AGP have a policy and procedure that outlines the “72 hour rule” criteria in regards to claim adjudication?</p>	<p>Please describe the categories of service for which this policy applies, and the specific criteria that are used in the claim adjudication process.</p> <p>Please also describe how providers have been informed of these policies.</p>	<p>AGP is responding to this question under the assumption that this is being referred to as it relates to “any charges for inpatient services associated with the readmission for the same DRG that occurs within 3 days of discharge from the provider for an earlier admission. Attachment A of a hospital contract addresses readmissions within 3 days of a discharge for the same</p>

**AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT**

		<p>DRG. The provider is responsible for combining the bill and submitting one bill to AGP for payment.</p> <p>If the provider submits 2 separate bills for the same DRG for re admission then AGP will recoup the readmission via the recoupment process called Forager. Notifications would be sent to the provider allowing response, etc following recoupment process on notifications prior to recoupment.</p>
<p>Does AGP have a policy or procedure regarding global charge claims adjudication?</p>	<p>Please describe the categories of service for which this policy applies, and the specific criteria that are used in the claim adjudication process.</p> <p>Please also describe how providers have been informed of these policies.</p>	<p>AGP would need more specifics as to what the question is related to so that an accurate response can be supplied.</p>
<p>Myers and Stauffer was unable to find policies or other documentation describing AGPs process for reprocessing claims when system changes are made that would apply retroactively.</p>	<p>Please describe AGP’s policies and procedures when changes are made within the claims processing system for reasons other than provider related causes (e.g. system logic updates, provider rate changes/corrections, or provider contract updates) to ensure any previously submitted claims are reprocessed/adjusted?</p> <p>Is there a process in place to reprocess/adjust the affected claims or</p>	<p>AGP would reprocess claims via the process in place at the Health plan called CAMP.</p> <p>For example, if a provider was placed on an incorrect agreement ID that paid 100% and was corrected to an agreement ID that paid 105%.</p> <p>Then the Provider Data Maintenance Department would notify the CAMP</p>

**AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT**

	<p>does AGP require providers to resubmit claims?</p> <p>If a MMIS correction is made based on provider inquiry, comments, reconsideration, or appeal, is this same change applied to all providers' claims, if applicable. Or, does AGP require other affected providers to resubmit claims?</p>	<p>analyst by placing a note in the CAMP database that a claims report is needed and possible claims need to be reprocessed. The report would outline all applicable claims paid incorrectly (if that is the case) and then AGP would re-process with interest.</p> <p>If identified by the Health Plan then the Health plan would initiate these steps.</p> <p>AGP does not require a provider to resubmit claims for the above issues. Only if the provider incorrectly billed the claim the first time would corrected claims need to be resubmitted. This would be considered a separate issue and not related to payment/system changes.</p>
<p>Myers and Stauffer was unable to confirm functionality of capability for on-line submission of authorization and verification of prior authorization request status.</p>	<p>Please confirm if the following functionality is available to providers on the AGP website: Check status of prior authorization request and submit an authorization request.</p> <p>If this functionality is not available, when do you anticipate it will be?</p> <p>If this functionality is available, when did this begin and please confirm this process is operational and functioning correctly?</p>	<p>Duplicate question. See above.</p> <p>Participating providers with AGP have access to an AGP ASSIST secured website. Through this site they have the ability to submit a request for an authorization and check the status of an authorization. This function has been in place with AGP since June 2006.</p>

**AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT**

<p>Myers and Stauffer did not find policies that address handling of urgent and emergent admissions in the absence of notification.</p>	<p>Is a claim denied if the provider does not provide notification of an emergent or urgent admission in accordance to the said timeframes listed in the provider manual?</p> <p>Is there a comparable notification requirement for emergency services as well? If so, is a claim denied if the provider does not provide notification of emergency services?</p> <p>Please describe AGP's policies and procedures for emergent and urgent care notification.</p> <p>If policies do not exist, please draft and submit to DCH for approval.</p>	<p>If an authorization is not on file for the facility for a given member then the Inpatient Claim will be denied for no authorization.</p> <p>See attached ER policy for non participating providers.</p>
<p>From a review of a sample of contracts between AGP and network providers, it appears that these contracts do not always use the same definition of emergency medical services found in the DCH/CMO contract.</p>	<p>Please explain and provide the rationale for not using the same definition.</p>	<p>Due to negotiations with hospital it may be necessary to negotiate language but in keeping with the same intent. If specific responses are required to the contracts in question please provide the contracts in question and AGP can review to provide any additional clarity if needed.</p>
<p>It appears that for many providers, AGP reimburses providers for emergency medical services based on the CPT billed by the provider. However, for a smaller number of providers, it appears that AGP uses a different methodology, including the</p>	<p>Please explain the rationale for using two different approaches and why the CPT only approach (i.e. reimbursement based on CPT code only) is not used for all providers.</p>	<p>AGP would need examples as previously stated AGP does not downgrade ER billing based on non emergent DX codes.</p> <p>Attached another copy of the AGP</p>

AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT

application of the prudent layperson provision for claims with certain diagnoses codes and CPT codes.	Please provide policies that document handling of emergency services. If policies do not exist, please draft and submit to DCH for approval.	reimbursement policy related to non participating providers that relates to ER services.
---	---	--

Myers & Stauffer Report #2- Hospital Claims Peach State Health Plan

Area of Concern	Action Required	CMO Response
<p>1. The initial Myers and Stauffer claims analyses appear to indicate that many hospital contracts were entered after the contract effective date.</p>	<p>A. Clarify whether this problem only related to the implementation process?</p> <p>B. Describe the steps that have been (or were) taken to ensure that new contracts and/or providers are loaded prior to the effective date of the contract.</p> <p>C. Describe process for monitoring contract loading to ensure that contracts are loaded prior to their effective date.</p>	<p>1A. This problem was isolated to the start up activities of the health plan.</p> <p>1B. PSHP has improved the process so contracts are loaded prior to the effective date. Process improvements include frequent meetings to discuss contract strategies, date of contract renewals, changes in rates and new contracting prospects. Contract loading is coordinated through a Contract Implementation Manager (CIM) who ensures the required information is received in order to meet the effective date. The contracting goal is to ensure that all contracts are implemented within 45 (not to exceed 60) business days.</p> <p>1C. PSHP's Contract Implementation Manager (CIM) and staff monitor the implementation of the contracts through the process described in 1B above and update applicable functional areas of any risks of not meeting the expected timeframe. The CIM is responsible for the testing, validation and approval of contracted rate configuration and provides updates of timeframes, testing results and the possible financial liability if timeframes will are not met. The process is independently audited to validate turnaround time targets are being met.</p>
<p>2. System corrections do not appear to automatically be applied to previously processed claims.</p>	<p>A. Describe your policy for handling changes that are made within the system (e.g. system logic updates, provider rate changes/corrections, retro-active policy changes, eligibility updates, or provider contracts loaded after the effective date).</p> <ol style="list-style-type: none"> 1. What steps are taken to ensure any previously submitted claims are reprocessed/ adjusted? 2. Are all claims affected by the issue reprocessed/ adjusted or only those claims submitted by the provider who brought the issue to your attention? 3. If you only reprocess/adjust the claims for the provider that brought 	<p>2A. Claims are re-adjudicated when they are identified as incorrectly paid. Incorrectly paid claims are identified through provider adjustment requests, appeals and Joint Operating Committee meetings. Timely filing requirements are routinely waived and interest is applied to the reprocessed claims. Adjustments are paid back to the date the error occurred. This has been done regardless of whether the root cause of the payment error was PSHP's or the providers'. PSHP is experiencing fewer payment error complaints after completing an initiative to correct provider data files and improve the provider contract loading turn around time.</p> <p>If a trend attributed to a specific error is discovered, it is investigated and corrective action is taken to adjust impacted claims. Beginning July 1, 2008, PHSP will comply with HB 1234, which establishes a 90 day limit for providers to submit batch payment reconsiderations to PSHP. If PSHP identifies payment errors, corrections are made to our systems to appropriately pay the specific claim type going forward. If the provider submits claims for reconsideration within the time limits established by HB 1234, PSHP will review the claims, render a decision and take appropriate action to correct</p>

Myers & Stauffer Report #2- Hospital Claims Peach State Health Plan

Area of Concern	Action Required	CMO Response
	the issue to your attention, please explain the rationale for this policy.	the root cause. If the reconsideration is approved, we will issue correct payment adjustments for the claims submitted within the time limits established by HB 1234 and pay the mandated 20 percent interest rate.
3. Interest payments do not appear to be applied to claims that are reprocessed to adjust for system or processing errors.	<p>A. Describe your policy for paying interest when claims are reprocessed/ adjusted after a reference file or system update (e.g. corrected authorization, corrected rate file, delayed provider entry, or system logic change).</p> <ol style="list-style-type: none"> 1. Is interest automatically paid to the provider retroactively to the date of the original submission? 2. If you do not pay interest in these instances, please provide the rationale for not paying interest in these cases. 	<p>3A. Interest is paid on claims that are adjusted or rekeyed when it is determined that the initial payment or non-payment is a PSHP error.</p> <ol style="list-style-type: none"> 1. Interest is calculated from the original received date of the claim to the check run date of the adjustment. 2. Interest is not paid when a provider submitted a claim that does not meet clean claim criteria.
4. The initial Myers and Stauffer claims analyses appear to indicate that a significant portion of suspended claims and denied claims are related to authorization issues.	<p>A. Provide your analysis of the reasons/ issues that are leading to these types of denials.</p> <p>B. Describe the steps or corrective actions that are being taken to address these issues.</p>	<p>4A. PSHP's root cause analysis indicated these types of denials are mainly caused by user errors and configuration issues. PSHP strives to correct these errors immediately when identified. A complete re-training of all PSHP UM staff occurred at the end of March that resulted in a sharp decline of the error rate. Root cause analysis of error reports and issue remediation continues on a daily basis.</p> <p>4B. As of June 23, 2008, we are manually reviewing any system denial for no authorization on file if there is an authorization indicated on the claim. If an authorization is found during the manual review process, the denial is overturned and paid.</p>
5. The initial Myers and Stauffer claims analyses appear to indicate the member was not eligible on the date of service. However, after reviewing the data from the fiscal agent contractor (ACS), it appears that some of these members were	A. Describe your policy and process for handling eligibility updates. Specifically indicate your reconciliation process for identifying and updating previously denied claims.	5A. Eligibility files are received daily and monthly from ACS. Eligibility updates are automated and uploaded into Amysis within hours of receiving of the file. In cases where the member record is incomplete or cannot be loaded automatically, the record is manually updated by an Eligibility Specialist. Errors and issue remediation of eligibility spans are not included in the manual updates unless instructed by DCH. At the time the claim is submitted, if the member record does not reflect an active

Myers & Stauffer Report #2- Hospital Claims Peach State Health Plan

Area of Concern	Action Required	CMO Response
determined by DCH to eligible on the date of service (i.e. a member included in the ACS lock-in file for which the CMO received a capitation payment.		eligibility span for the date of service, the claim will be denied. Providers are instructed to utilize the appeals process for reprocessing previously denied claims. Once a provider submits a formal appeal for the denied claim, analysis is performed to validate the eligibility spans (using both the data received via the 834 file from ACS and the GHP portal). If the member is deemed eligible during dates of service provided, the claim is adjudicated accordingly.
6. It appears from the Myers and Stauffer claims analyses and provider input that monies previously paid under the merged member have, at times, been recouped with a notice indicating the member was not active. These claims often appear to have been denied for timely filing when resubmitted under the new member number.	<p>A. Describe your process for handling merged member records.</p> <p>B. Is the claim history and authorization history transferred to the new member number?</p> <p>C. What steps have been taken to alleviate this issue?</p>	<p>6A. If a claim is paid under the incorrect member record, it is recouped, rekeyed and processed under the correct member record.</p> <p>6B. Yes, the claims history and authorization history are transferred to the new member number.</p> <p>6C. When provided the necessary documentation to identify the members as merged, we recoup payments from the deleted file and reissue payments to the valid member file upon receipt of amended claims. The original submission time frames will be used to release payment of the valid member file</p>
7. Provider complaints regarding ability to submit prior authorization data on-line, along with inability to obtain confirmation of authorization or status of request.	<p>A. Please confirm that online access to prior authorization (PA) information is available to all providers and that they are able to receive PA status information and PA confirmation online.</p> <p>B. If this is not functional, when do you anticipate it will be?</p> <p>C. If it is functional, when did the functionality begin?</p>	<p>7A. PSHP's secure web portal allows registered users to submit authorization requests online and obtain the status of the authorization. This feature is available through the reporting function on the secure portal (See attachment of screen shots). Please note providers are not able to see or obtain a status report for authorizations that are phoned or faxed into the plan. See the notations on the bottom of the instructions web page that inform the provider of this fact.</p> <p>7B. N/A</p> <p>7C. This website functionality has been available since August 2006.</p>
8. The suspended claims data provided by Peach State indicated that approximately 75% of the suspended claim volume was related to provider set-up issues.	<p>A. Describe the steps that have been taken to resolve these issues.</p> <p>B. How long does it take, on average to resolve provider set-up issues (from date of</p>	<p>8A. PSHP has completed an audit of executed contracts to ensure that all participating providers are properly loaded into the claims payment system. This contract file review was completed in April 2008. Quality metrics are in place to monitor all contracts loaded to ensure that providers are loaded timely and accurately according to the information provided.</p>

Myers & Stauffer Report #2- Hospital Claims Peach State Health Plan

Area of Concern	Action Required	CMO Response
	<p>initial notification, to date provider is notified of change and claims pay correctly)?</p> <p>C. In the case of a claim that is suspended due to a provider set-up issue, does Peach State pay interest to the provider?</p>	<p>PSHP has also restructured its provider data department to better coordinate with the contracting department. This reorganization ensures that the process is efficient and that all parties are aware of any opportunities for process improvements. It also identifies any roadblocks in timeliness or accuracy of data loads.</p> <p>In addition, PSHP has assigned a provider representative to work with each hospital and conduct joint operating meetings to resolve identified issues.</p> <p>8B. The average turnaround time for correcting provider set-ups varies depending on the type of change/correction required. Demographic corrections/changes are completed within 2 business days of notification (24 hours for urgent requests). Rate/configuration corrections/changes range from one to 30 business days depending on the complexity. Turnaround time is based on the time it takes to configure, test and approve the configuration change. After the change is made, a claims project is developed for claim adjustments which should occur within 30 days of the approved change. As of June 30, 2008, PSHP has 13 open claim projects with an average project age of 6 days.</p> <p>8C. Yes, PSHP pays interest on all claims that are suspended due to provider set-up issues.</p>
<p>9. A comparison of the provider rate file supplied to Myers and Stauffer by PSHP to the provider contracts supplied by PSHP revealed inconsistencies with 5 of the outpatient and inpatient rates. Please see list, below:</p> <p>Inpatient and Outpatient:</p> <ul style="list-style-type: none"> • Archbold Medical Center • Calhoun Memorial Hospital • Donaldsonville Hospital • Early Memorial Hospital (Archbold) <p>Inpatient only:</p>	<p>A For each facility, please document the rate that you currently have loaded in your system, along with the rate in the provider contract.</p> <p>B. For rates that have been corrected, please indicate:</p> <ol style="list-style-type: none"> 1. The date of correction 2. Reason for the inconsistency 3. Whether all previously submitted claims have been reprocessed/adjusted for these providers 4. If so, was interest paid on the 	<p>9A and B. Please see attached workbook with rates of all hospitals listed, dates of any corrections made, explanation of change, reprocessed claims, and interest paid. PSHP pays interest on all claims that require adjustment for under or non-payments.</p>

Myers & Stauffer Report #2- Hospital Claims Peach State Health Plan

Area of Concern	Action Required	CMO Response
<ul style="list-style-type: none"> • Grady General Hospital (Archbold) <p>Outpatient only:</p> <ul style="list-style-type: none"> • Berrien County Hospital 	<p>mispayment amounts?</p> <p>5. If no interest was paid or if the claims have not been corrected, please describe when these events will occur.</p>	
<p>10. According to the data you provided, it appears that two hospital provider contracts required more than 120 days to load based upon the difference between the effective date as a participating provider and the date the hospital was loaded into the system as participating. The providers are:</p> <ul style="list-style-type: none"> • Tift General Medical Center • Taylor Telfair Regional Hospital • Effingham Hosp & Care Center • Gordon Hospital 	<p>A. Please explain why these providers required this amount of time to load as participating providers.</p> <p>B. Describe any system improvements that were made to correct any problems identified above.</p>	<p>10A. PSHP has improved the process so contracts are loaded prior to the effective date. According to the provider database the following provider contracts were loaded on or prior to the effective date with the exception of Gordon hospital: Tift General Medical Center was entered into the system as par on 9/1/06 Taylor Telfair Regional Hospital was entered into the system as par on 5/4/06 Effingham Hospital & Care Center was entered into the system as par on 5/5/06 Gordon Hospital was entered into the system as par on 3/9/07.</p> <p>10B. PSHP has in place a process to monitor and ensure that all contracts are loaded prior to the effective date. Please see process in question 1B.</p>

POLICIES AND PROCEDURES- PEACH STATE

<p>11. The DCH Model Contract states in 4.3.3.2.19, the contractor must include a description for utilization policies and procedures in the member handbook. Myers and Stauffer were not able to confirm that PSHP had this description in the member handbook.</p>	<p>A. Please provide documentation, including effective date, showing the inclusion of this material in the member handbook.</p> <p>B. If this material is not in the handbook, please describe reasons for not including and submit a plan with timeframes for inclusion in member handbook.</p>	<p>11A and B. The Member Handbook has been revised. [See attached utilization verbiage that will appear in the enhanced Member Handbook which was just recently approved by DCH.] This revised document will be printed the week of July 7 and be distributed in August 2008.</p>
<p>12. For the post-stabilization requirements listed in section 4.6.2 of contract (including 4.6.2.1-4.6.2.4), Myers and Stauffer was unable to locate policy and procedure</p>	<p>A. Please confirm and submit policies that confirm adherence to the section 4.6.2 (in its entirety) of the DCH Model contract.</p>	<p>12A. Policies are in place. [See attached GA.UM.05 Timeliness of UM decisions.]</p> <p>12B. N/A</p>

Myers & Stauffer Report #2- Hospital Claims Peach State Health Plan

Area of Concern	Action Required	CMO Response
documentation for any of the required elements.	B. If policies do not exist, please draft and submit to DCH for approval, along with a plan for implementation.	
13. PSHP's policy for their contracted providers requires the provider to waive their rights to an administrative law hearing while participating with the plan. This appears to be contrary to the requirements set forth in the Georgia Model contract in 4.9.7.6.	A. Please confirm and describe why this approach is used and why it is in compliance with the DCH contract.	13A. The PSHP policies and procedures changes were made and PSHP began advising providers they may request an administrative law hearing when an outcome of a provider complaint is adverse to the provider. [See attached the version of policies sent on July 1, 2008 to DCH for approval and provider complaint outcome letter.]
14. PSHP has timelines for submittal of notification of emergency services, but Myers and Stauffer was unable to locate language that the contractor shall not refuse to cover an emergency service based on the failure of the provider to notify the contractor, PCP, or DCH of member's screening and treatment within said timeframes, as stated in 4.6.1.7.	A. Please confirm if this contract requirement, including effective date, is listed in your internal policies and procedures. B. Please provide documentation for this policy and procedure, along with description of how your system assures payment in this scenario.	14A. Yes, the contract requirement and effective date is in our internal policies. 14B. The Emergency Services Policy, GA.UM.12, provides documentation of this. [See attached.] There is system configuration to accommodate payment of emergency services as the benefits require.
15. Notification of emergent or urgent inpatient admissions in PSHP provider documentation was not consistent. The provider manual states notification is required within 2 business days while the prior authorization list states within 24 hours or next business day.	A. Please confirm the correct timeframe for notification of an emergent inpatient authorization. B. Submit corrected policies and provider manual to reflect the correct time frames.	15A. The correct timeframe is next business day. 15B. All UM policies are consistent with next business day. [See attached GA.UM.05 Timeliness of UM Decisions-revised.] The PSHP Provider Manual revision was submitted July 1, 2008 to DCH for approval. [See attached revised page 26 of PSHP Provider Manual which was submitted.]
16. Is there information in policies and procedures not provided to Myers and Stauffer that outline "72 hour rule" criteria in regards to claims adjudication?	A. Please describe the categories of service for which this policy applies, and the specific criteria that are used in the claim adjudication process.	16A. The 72 hour rule applies to outpatient and diagnostic services, as well as admissions that occur within 72 hours of discharge from an inpatient admission. The claims system is configured to global (deny) the service being billed when there are subsequent dates of service submitted that are within 72 hours of the discharge date of an inpatient claim.

Myers & Stauffer Report #2- Hospital Claims Peach State Health Plan

Area of Concern	Action Required	CMO Response
	B. Please also describe how providers have been informed of these policies.	16B. Our standard hospital contract language lists the 72 hour verbiage. This is how providers have been informed of this policy.
17. Myers and Stauffer was unable to find any policies regarding global charge claim adjudication.	<p>A. Please indicate whether there are policies and procedures not provided to Myers and Stauffer regarding global charge claims adjudication?</p> <p>B. Please describe the categories of service for which this policy applies, and the specific criteria that are used in the claim adjudication process.</p> <p>C. Please also describe how providers have been informed of these policies.</p>	<p>17A. All relevant policies and procedures were provided based on Myers and Stauffer's requests.</p> <p>17B. The categories of service include surgeries and emergency department services. There is system configuration to accommodate this requirement</p> <p>17C. The Provider Manual, pages 58, 59, 62 and 72 describe global periods as they apply to surgeries and emergency department services.</p>
18. Myers and Stauffer was unable to find policies or other documentation describing PSHP's process for reprocessing claims when system changes are made that would apply retroactively.	<p>A. Please describe PSHP's policies and procedure when changes are made within the claims processing system for reasons other than provider related causes (e.g. system logic updates, provider rate changes/ corrections, or provider contract updates) to ensure any previously submitted claims are reprocessed/ adjusted?</p> <p>B. Is there a process in place to reprocess/ adjust the affected claims or does PSHP require providers to resubmit claims?</p> <p>C. If a MMIS correction is made based upon a provider inquiry, comments, reconsideration, or appeal, is this same change applied to all other providers'</p>	<p>18A. Claims are re-adjudicated when they are identified as incorrectly paid. Incorrectly paid claims are identified through provider adjustment requests, appeals and Joint Operating Committee meetings. Timely filing requirements are routinely waived and interest is applied to the reprocessed claims. Adjustments are paid back to the date the error occurred. This has been done regardless of whether the root cause of the payment error was PSHP's or the providers'. PSHP is experiencing fewer payment error complaints after completing an initiative to correct provider data files and improve the provider contract loading turn around time.</p> <p>If a trend attributed to a specific error is discovered, it is investigated and corrective action is taken to adjust impacted claims. Beginning July 1, 2008, PSHP will comply with HB 1234, which establishes a 90 day limit for providers to submit batch payment reconsiderations to PSHP. If PSHP identifies payment errors corrections are made to our systems to appropriately pay the specific claim type going forward. If the provider submits claims for reconsideration within the time limits established by HB 1234, PSHP will review the claims, render a decision and take appropriate action to correct the root cause. If the reconsideration is approved, we will issue correct payment adjustments for the claims submitted within the time limits established by HB 1234</p>

Myers & Stauffer Report #2- Hospital Claims Peach State Health Plan

Area of Concern	Action Required	CMO Response
	claims, if applicable, or does PSHP require other affected providers to resubmit claims?	and pay the mandated 20 percent interest rate.
19. Myers and Stauffer were unable to confirm website functionality to either submit or check the status of an authorization request.	<p>A. Please confirm if the following functionality is available to providers on the Peach State Health Plan website: check status of prior authorization request and submit an authorization request.</p> <p>B. If this functionality is not available, when do you anticipate it will be?</p> <p>C. If this functionality is available, when did this begin and please confirm this process is operational and functioning correctly?</p>	<p>19A. Peach State’s secure web portal allows registered users to submit authorization requests online and obtain the status of the authorization. This feature is available through the reporting function on the secure portal [See attachment of screen shots.] Please note providers are not able to see or obtain a status report for authorizations that are phoned or faxed into the plan. See the notations on the bottom of the instructions web page that inform the provider of this fact.</p> <p>19B. N/A</p> <p>19C. This website functionality has been available since August 2006.</p>
20. Myers and Stauffer did not find policies that address handling of urgent and emergent admissions in the absence of notification.	<p>A. Is a claim denied if the provider does not provide notification of an emergent or urgent admission in accordance to the said timeframes listed in the provider manual?</p> <p>B. Is there a comparable notification requirement for emergency services as well? If so, is a claim denied if the provider does not provide notification of emergency services?</p> <p>C. Please describe PSHP’s policies and procedures for emergent and urgent care notification.</p> <p>D. If policies do not exist, please draft and submit for DCH approval.</p>	<p>20A. The claim is denied for no authorization if the provider does not provide the notification for an inpatient admission in accordance to the said timeframes listed in the provider manual.</p> <p>20B. Emergency services do not require notification/authorization. The claim will pay.</p> <p>20C. PSHP does not require notification/authorization for emergent /urgent care.</p> <p>20D. Policies are in place and have been approved by DCH.</p>

Myers & Stauffer Report #2- Hospital Claims Peach State Health Plan

Area of Concern	Action Required	CMO Response
<p>21. From a review of a sample of contracts between PSHP and network providers, it appears that these contracts do not always use the same definition for emergency medical services found in the DCH/CMO contract. Furthermore, many of these contracts do not use the term “prudent layperson”.</p>	<p>A. Please explain and provide the rationale for not using the same definition.</p>	<p>21A. All contracts have the Medicaid product attachment which contains the "prudent layperson" and “emergency services” definitions that are found in the DCH/CMO contract. [See attached PSHP Medicaid Product Attachments for contracts reviewed.]</p>
<p>22. In some contracts between PSHP and network providers, PSHP uses its own listing of approved emergency services after the first year of the contract with the provider. Furthermore, it appears that payment of the claims are sometimes based upon the diagnosis list when the claim is paid, and at times based upon the diagnosis list used when the services are rendered. It appears that PSHP reserves the right to modify its diagnosis list ICD-9 codes at anytime and at other times must have provider approval to do so.</p>	<p>A. Please explain and provide the rationale for using different lists of presumptive emergency diagnoses between the first and second year of the contract and the criteria for modification. In addition, please explain and provide the rationale for using the payment date instead of the service date to determine which presumptive list is used and why this appears to vary among providers.</p>	<p>22A. PSHP has not modified the ICD-9 list. We are using the same list that was originally provided by DCH.</p>

**Myers & Stauffer Report #2 – Hospital Claims - WellCare
Area of Concern**

I. The initial Myers and Stauffer claims analyses appear to indicate that many hospital contracts were entered after the contract effective date.

Action Required

Clarify whether this problem only related to the implementation process?

Describe the steps have been (or were) taken to ensure that new contracts and/or providers are loaded prior to the effective date of the contract.

Describe process for monitoring contract loading to ensure that contracts are loaded prior to their effective date.

CMO Response

In some cases noted, providers contracted with WellCare on a retroactive basis and requested retroactive effective dates. WellCare accommodated most of these provider requests and adjudicated claims as appropriate. As a result, contracts were loaded after the agreed upon effective date. As a matter of policy, WellCare conducts an extensive credentialing process for contracting hospitals to ensure that each facility meets NCQA requirements, federal and state regulations for services delivery, quality (i.e. JCAHO) and licensing. During the Go-Live process, many hospitals delayed execution of contracts until several days prior or after the Go-Live effective date. In these cases, providers were advised they would receive 100% of the Medicaid payment rate and were provisionally credentialed (based on instruction and approval from the Department of Community Health) until such time all credentialing information was received and processed. In order to assure provider

**Myers & Stauffer Report #2 – Hospital Claims - WellCare
Area of Concern**

Action Required

CMO Response

<p>2. System corrections do not appear to automatically be applied to previously processed claims.</p>	<p>Describe your policy for handling changes that are made within the system (e.g. system logic updates, provider rate changes/corrections, retro-active policy changes, eligibility updates, or provider contracts loaded after the effective date).</p> <ul style="list-style-type: none"> • What steps are taken to ensure any previously submitted claims are reprocessed/adjusted? • Are all claims affected by the issue reprocessed/adjusted or only those claims submitted by the provider who brought the issue to your attention? • If you only reprocess/adjust the claims for the provider that brought the issue to your attention, please explain the rationale for this policy. 	<p>participation, WellCare added the provider per their instruction. WellCare’s policy is to load provider contracts with effective dates of coverage the first of the following month after the provider has been approved by the Credentialing Committee to ensure accurate payment.</p> <p>Systems updates due to policy modifications are applied prospectively with appropriate notice to participating providers. Please note that our provider agreements allow a 45-day timeframe after receipt of notice to implement any rate/modifications stipulated by DCH. If an adjustment is identified for claims submitted, WellCare adjusts all claims impacted for the adjustment. If a provider advises of a adjustment requirement, WellCare will adjust all claims identified.</p>
--	---	---

**Myers & Stauffer Report #2 – Hospital Claims - WellCare
Area of Concern**

3. Interest payments do not appear to be applied to claims that are reprocessed to adjust for system or processing error.

Action Required

Describe your policy for paying interest when claims are reprocessed/adjusted after a reference file or system update (e.g. corrected authorization, corrected rate file, delayed provider entry, or system logic change).

- Is interest automatically paid to the provider retroactively to the date of original submission?
- If you do not pay interest in these instances, please provide the rationale for not paying interest in these cases.

CMO Response

WellCare adheres to the requirements stipulated in its agreement with DCH as well as Georgia law regarding payment of interest. Interest payments of 18% apply in the event the CMO fails to adjudicate (i.e. process) a clean claim within the claims process deadlines [i.e. 15 days]. This penalty by law applies to the speed of payment of a clean claim and does not apply in instances where system updates are applied; authorizations are waived to accommodate provider requests, etc.

WellCare's agreement with DCH provides further clarity on this point:

Section 4.16.1.8 states, "Not later than the fifteenth (15th) business day after the receipt of a Provider Claim that does not meet Clean Claim requirements, the Contractor shall suspend the Claim and request in writing (notification via e-mail, the CMO plan Web Site/Provider Portal or an interim Explanation of Benefits satisfies this requirement) all outstanding information such that the

Myers & Stauffer Report #2 – Hospital Claims - WellCare Area of Concern	Action Required	CMO Response
		<p>Claim can be deemed clean. Upon receipt of all the requested information from the Provider, the CMO plan shall complete processing of the Claim within fifteen (15) Business Days.</p> <p>Section 4.16.1.14 states further, “The Contractor shall assume all costs associated with Claim processing, including the cost of reprocessing/resubmission, due to processing errors caused by the Contractor or to the design of systems within the Contractor’s span of control.</p> <p>23.4.1.3 Failure to comply with the Claims processing standards as follows:</p> <p>23.4.1.3.1 Failure to process and finalize to a paid or denied status ninety-seven percent (97%) of all Clean Claims within fifteen (15) Business Days during a fiscal year;</p> <p>23.4.1.3.2 Failure to process</p>

Myers & Stauffer Report #2 – Hospital Claims - WellCare Area of Concern	Action Required	CMO Response
<p>4. The initial Myers and Stauffer claims analyses appear to indicate that a significant portion of suspended claims and denied claims are related to authorization issues.</p>	<p>Provide your analysis of the reasons/issues that are leading to these types of denials. Describe the steps or corrective</p>	<p>and finalize to a paid or denied status ninety-nine percent (99%) of all Clean Claims within thirty (30) Business Days of receipt during a fiscal year; and</p> <p>23.4.1.3.3 Failure to pay Providers interest at an eighteen percent (18%) annual rate, calculated daily for the full period during which a clean, unduplicated Claim is not adjudicated within the claims processing deadlines.</p> <p>Based on the provisions within our agreement and Georgia statute, our interest payment methodology is compliant in that interest payments are not required provided the claim is adjudicated within the 15-day timeframe.</p> <p>Although WellCare provided significant training, information and materials early on, certain providers failed to obtain authorizations for required services. We believe these</p>

Myers & Stauffer Report #2 – Hospital Claims - WellCare Area of Concern	Action Required	CMO Response
	<p>actions that are being taken to address these issues.</p>	<p>provider failures were due in part to a lack of knowledge of WellCare's policy and the fact providers willingly provided services without obtaining proper approvals, i.e. Health Departments, non-par facilities, etc. WellCare has and continues to educate providers regarding authorization requirements for services rendered to members and has seen a significant reduction in the number of claims denied due to lack of authorization.</p> <p>During September thru October 2006 WellCare held Provider Summit meetings across all regions of Georgia. Providers were sent invitations to the summits and RSVP to the meetings. The materials for the summits, including all the questions presented in the meetings, were published and sent via fax, to providers. These activities were in addition to making provider handbooks and other communications available on our website. We also participated in the Hometown Health conference calls to educate rural</p>

Myers & Stauffer Report #2 – Hospital Claims - WellCare		
Area of Concern	Action Required	CMO Response
<p>5. The initial Myers and Stauffer claims analyses appear to have identified claim denials that indicate the member was not eligible on the date of service. However, after reviewing the data from the fiscal agent contractor (ACS), it appears that some of these members were determined by DCH to be eligible on the date of service (i.e., a member included in the ACS lock-in file for which the CMO received a capitation payment).</p>	<p>Describe your policy and process for handling eligibility updates. Specifically indicate your reconciliation process for identifying and updating previously denied claims.</p>	<p>We believe these issues are related to the member merge and audit process conducted by DCH and the CMO's. Member retro-activity is a common process in managed care, particularly with new programs. WellCare's policy is to reimburse providers for services rendered to eligible members based on coverage guidelines stipulated by DCH, WellCare medical management policies and operational procedures. As part of the reconciliation process, WellCare processes member additions and deletions during the end-of-month process and weekly as eligibility data is provided to the plan. Eligibility updates are provided to all delegated vendors on a daily and weekly basis.</p>

**Myers & Stauffer Report #2 – Hospital Claims - WellCare
Area of Concern**

Action Required

CMO Response

<p>6. It appears from the Myers and Stauffer claims analyses and provider input that monies previously paid under the merged member have, at times, been recouped with a notice indicating the member was not active. These claims often appear to have been denied for timely filing when resubmitted under the new member number.</p>	<p>Describe your process for handling merged member records. Is the claim history and authorization history transferred to the new member number? What steps have been taken to alleviate this issue?</p>	<p>As a matter of routine, WellCare does not reprocess individual claims denied due to eligibility changes unless requested by the provider. It should be noted that during the identified audit period, there were a significant volume of membership changes due to an on-going eligibility audit conducted jointly by the Plans and DCH. As a result, WellCare paid and denied a significant volume of claims where eligibility was retroactively assigned to the plan after submitted claims were denied.</p> <p>WellCare initially recouped payments during the clean up process on duplicate members as it was unclear the retro terminations were actually duplicate member clean up IDs. As identified, WellCare coordinated payments with providers in instances where recoupments were made, but eligibility indicated that providers could/should be reimbursed for services. In many instances, WellCare over-rode timely filing requirements with providers to ensure payment due to member merge and eligibility changes.</p>
---	---	---

**Myers & Stauffer Report #2 – Hospital Claims - WellCare
Area of Concern**

Area of Concern	Action Required	CMO Response
<p>7. Provider complaints regarding ability to submit prior authorization data on-line, along with inability to obtain confirmation of authorization or status of request.</p>	<p>Please confirm that online access to prior authorization (PA) information is available to all providers and that they are able to receive PA status information and PA confirmation online.</p> <p>If this is not functional, when do you anticipate it will be?</p> <p>If it is functional, when did the functionality begin?</p>	<p>Physicians can submit and check the status of authorizations via the web. This functionality was made available in October, 2007 and is fully functional. It should be noted that only ordering physicians may submit and validate status of authorizations for their patients.</p>
<p>8. The claims data provided to Myers and Stauffer by WellCare appears to indicate that no interest payments have been made by WellCare to Georgia Medicaid hospital providers.</p>	<p>Please confirm whether WellCare has made interest payments to Georgia Medicaid hospital providers.</p> <p>If interest was paid, please provide interest data and explain why the data was not provided as requested.</p> <p>If interest has not been paid, please explain why claims that appear to be clean were not paid interest when the claims were adjudicated more than 15 days after submission (e.g. claim numbers: 237942840, 243374438, and 238717964).</p>	<p>Interest payments have been made by WellCare for hospital services. A summary of the interest payments made to facilities is provided in the attached schedule.</p> <p>Interest checks are sent monthly to providers along with an EOB that provides every claim number for which interest was paid.</p>
<p>9. The suspended claims data provided to Myers and Stauffer by WellCare appears to indicate that over</p>	<p>Please provide an updated status of the suspended claims provided in the</p>	<p>The data supplied represents our efforts to pull all claims in the system</p>

Myers & Stauffer Report #2 – Hospital Claims - WellCare
Area of Concern

150,000 claims with billed charges in excess of \$600 million remained in suspense status as of November 2007. The suspend dates range between June 2006 and November 2007.

Action Required

data you sent to Myers and Stauffer, explain why the volume of claims is so high for that period, and describe in detail how WellCare will ensure that the volume of suspended claims does not reach this level in the future and that claims in the file will be properly and promptly adjudicated.

Provide a plan of action to adjudicate any of these claims that remain in a suspense status.

Please also describe how, and provide assurances that if all the claims in the file were to be adjudicated and paid WellCare would financially cover that volume of claims.

CMO Response

as of June 30, 2007. While the snapshot does accurately represent claims in the system not in a finalized status, it also includes subsequent updates to those claims as the data was not pulled until November 2007. The only way to have obtained a true picture of the system on June 30, 2007 would be to take a snapshot on June 30, 2007. In reviewing these claims, we can see that the subsequent posting dates after June 30, 2007 had to do with audits, overpayment recoupments or adjustments that transpired in the following few months.

10. According to the data you provided, it appears that two hospital provider contracts required more than 120 days to load based on the difference between the effective date as a participating provider and the date the hospital was loaded into the system as participating. The providers are:

- DOUGLAS HOSPITAL
- KENNESTONE HOSPITAL
- PAULDING HOSPITAL
- WELLSTAR COBB HOSPITAL
- WINDY HILL HOSPITAL

Please explain why these providers required this amount of time to load as participating providers.
 Describe any system improvements that were made to correct any problems identified above.

As a matter of policy, WellCare conducts an extensive credentialing process for contracting hospitals to ensure that each facility meets NCCQA requirements, federal and state regulations for services delivery, quality (i.e. JCAHO) and licensing. During the Go-Live process, many hospitals delayed execution of contracts until several days prior to or after the Go-Live effective date. For

Myers & Stauffer Report #2 – Hospital Claims - WellCare

Area of Concern	Action Required	CMO Response
<ul style="list-style-type: none"> • AUGUSTA HOSPITAL • MEMORIAL HOSPITAL • MEMORIAL NORTH PARK HOSPITAL • WEST GEORGIA MEDICAL CENTER 	<p>11. According to the data you provided, it appears that two hospital providers required more than 100 days to credential based on the difference between the application date and the credentialing date you</p>	<p>Please explain why these providers required this amount of time to credential.</p> <p>example, WellStar Medicaid contract was not executed by both parties until 5/30/06, yet the effective date was 6/1/06. WellCare's policy is to load provider contracts with effective dates of coverage the first of the following month after the provider has been approved by the Credentialing Committee to ensure accurate payment.</p> <p>We adopted a process whereby contractors use a more prospective effective date that allows for credentialing and loading of contracts prior to the actual contract effective date.</p> <p>Finally, if a hospital, like WellStar is a delegated credentialled entity, we must complete a Delegated Credentialing review/approval before the contract would be finalized and providers assigned to the facility could be loaded.</p> <p>This question appears to be a duplicate of #10. Please refer to #10 response.</p>

Myers & Stauffer Report #2 – Hospital Claims - WellCare		
Area of Concern	Action Required	CMO Response
provided. The providers are AUGUSTA HOSPITAL and MEMORIAL NORTH PARK HOSPITAL.	Describe any system improvements that were made to correct any problems identified above.	

Myers & Stauffer Report #3 – Policies & Procedures – WellCare		
Area of Concern	Action Required	CMO Response
<p>12. Contract requirement 4.3.3.2.24, in Member Handbook Requirements section of the DCH Model contract, which contains several requirements related to emergency room services, it does not appear that WellCare expressly states in their member handbook that prior authorization is not required for emergency services.</p>	<p>Please confirm and provide documentation that WellCare has met this requirement.</p>	<p>WellCare's policy stipulates that ER services don't require prior authorization. In fact, our handbook instructs members to go directly to the emergency room in case of an emergency. The WellCare member handbooks were reviewed and approved by DCH prior to distribution to members. WellCare can update the member handbook to expressly indicate prior authorization is not required for ER.</p>
<p>13. It does not appear that WellCare included hours of operation for a prior authorization and pre-certification telephone hotline in the documentation supplied to Myers and Stauffer. The contract between DCH and WellCare requires that the hours of operation must be included in the policies and procedure, as stated in 4.9.5.5 of the DCH Model contract.</p>	<p>Please confirm and provide documentation that WellCare has met this requirement.</p>	<p>WellCare does include hours of operation for prior authorization and pre-certification telephone hotline in its policy and procedures. Please refer to Customer Service Requirements Policy and Procedure.</p>
<p>14. Myers and Stauffer was unable to confirm</p>	<p>Please confirm if these contract</p>	<p>WellCare policies are consistent with</p>

Myers & Stauffer Report #3 – Policies & Procedures – WellCare

Area of Concern	Action Required	CMO Response
<p>whether the policies of WellCare are consistent with the contractual requirements in 4.14.3.4.1 and 4.14.3.4.5, which are related to proposed actions.</p>	<p>requirements, including effective date, are listed in your internal policies and procedures.</p> <p>Please provide documentation regarding these policies and procedures.</p>	<p>contractual requirements. Please refer to the Adverse Determinations/Proposed Action P&P.</p>
<p>15. Contract language in 4.6.1.4 requires that a CMO base coverage decisions for Emergency Services on the severity of the symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a prudent layperson. Myers and Stauffer was not able to identify policies and procedures for WellCare that states coverage decisions for emergency room services are based on the severity of presenting symptoms.</p>	<p>Please confirm if this contract requirement, including effective date, are listed in your internal policies and procedures.</p> <p>Please provide documentation of this policy and procedure.</p> <p>If policy does not exist, please submit plan for completing and implementing policy that addresses these requirements.</p>	<p>WellCare conforms with section 4.6.1.4 of the contract regarding emergency room services. Please refer to our Emergency Services - Institutional P&P provided for your reference</p>
<p>16. WellCare has timelines for submittal of notification of emergency services, but Myers and Stauffer was unable to locate language that the contractor shall not refuse to cover an emergency service based on the failure of the provider to notify the contractor, PCP, or DCH of member's screening and treatment within said timeframes, as stated in 4.6.1.7.</p>	<p>Please confirm if this contract requirement, including effective date, is listed in your internal policies and procedures.</p> <p>Please provide documentation for this policy and procedure, along with description of how your system assures payment in this scenario.</p>	<p>Please refer to Emergency Services - Institutional P&P. This policy outlines those scenarios when a claim is denied. Emergency room services do not require notification. Services provided in an ER setting are paid based upon prudent layperson criteria, as stipulated in the CMO agreement.</p>

Myers & Stauffer Report #3 – Policies & Procedures – WellCare Area of Concern	Action Required	CMO Response
		<p>As noted above, notification is <u>not</u> required for emergent or urgent care services performed in an emergent or urgent care setting. Emergent or urgent <u>admissions</u> require the submission of a written plan of care within 24 hours of the admission for payment. The plan of care should include:</p> <ul style="list-style-type: none"> • Diagnosis, symptoms and complaints for the admission • A description of the functional level of the individual • Medication or treatment orders • Diet and activity levels • Plans for hospital course • Plans for discharge <p>The plan of treatment should be multi-disciplinary and include the attending physician as well as nursing staff.</p> <p>Section 8, of our hospital manual (Utilization Management) describes our policies and procedures regarding</p>

Myers & Stauffer Report #3 – Policies & Procedures – WellCare		
Area of Concern	Action Required	CMO Response
<p>17. WellCare emergency services policy states that the company provides payment for any screening examination to determine if an emergency medical condition exists, however, language or similar language to that in 4.6.1.8 was not found in this or other available policies.</p>	<p>Please confirm if this contract requirement, including effective date, is listed in your internal policies and procedures and provide documentation of this policy.</p>	<p>As a matter of policy, WellCare provides payment for any screening examination to determine if an emergency medical condition exists. This is provided in our triage payment or included in the claim payment if the claim is determined to meet emergency criteria. Our current Policy and Procedure for ER services is silent on this contract language; as a result, we will modify our policies to expressly state this requirement. It should be noted, in most cases, a claim does not contain information specifying the member was sent to the ER by their physician. As such, these cases are handled during the reconsideration process when the hospital sends medical records with documentation indicating member sent to ER by a physician for ER services.</p>
<p>18. For third party liability claims WellCare does not have information listed for pre-certification requirements related to these types of claims in the documentation submitted to Myers and Stauffer.</p>	<p>Please confirm and describe if this process is in your policies and procedures. Please provide documentation to</p>	<p>WellCare does acknowledge other carrier authorizations/pre-certifications when considering a TPL claim for payment. However, since the auto-adjudication process</p>

Myers & Stauffer Report #3 – Policies & Procedures – WellCare Area of Concern	Action Required	CMO Response
<p>19. Does WellCare have a policy or procedure that outlines the “72-hour rule” criteria in regards to claim adjudication?</p>	<p>Please describe the categories of service for which this policy applies, and the specific criteria that are used in the claim adjudication process.</p> <p>Please also describe how providers have been informed of these policies.</p>	<p>does not review other carrier policies, if a provider received a denial for services, they would need to file an appeal with the appropriate documentation from the Primary Insurance plan. Current Coordination of Benefits Policy states WellCare does acknowledge the member’s benefit coverage (which takes into consideration prior authorization/pre-certification rules).</p> <p>Yes, WellCare has a policy that outlines the “72-hour rule. Please refer to Inpatient Hospital Services P&P.</p>
<p>20. Myers and Stauffer was unable to find any policies regarding global charge claim adjudication.</p>	<p>Please indicate whether there are policies or procedures not provided to Myers and Stauffer regarding global charge claims adjudication?</p> <p>Please describe the categories of service for which this policy applies, and the specific criteria that are used in the claim adjudication process.</p> <p>Please also describe how providers</p>	<p>WellCare does have a policy regarding global charge claim adjudication. Please refer to Maternity Services P&P. Our policy on global OB payment was reviewed with our Provider Relations staff who shared with the Providers during orientation meetings. Providers are made aware of these policies through our provider relations staff and training.</p>

Myers & Stauffer Report #3 – Policies & Procedures – WellCare		
Area of Concern	Action Required	CMO Response
<p>21. Myers & Stauffer was unable to find policies or other documentation describing Wellcare's process for reprocessing claims when system changes are made that would apply retroactively.</p>	<p>Please describe Wellcare's policies and procedures when changes are made within the claim processing system for reasons other than provider related causes (e.g. system logic updates, provider rate changes/corrections, or provider contract updates) to ensure any previously submitted claims are reprocessed/adjusted?</p> <p>Is there a process in place to reprocess/adjust the affected claims or does WellCare require providers to resubmit claims?</p> <p>If a MMIS correction is made based on a provider inquiry, comments, reconsideration, or appeal, is this same change applied to all providers' claims, if applicable, or does WellCare require other affected providers to resubmit claims?</p>	<p>WellCare instituted an internal process within 60 days of implementation involving corporate and market team members reviewing claims/configuration issues on a weekly basis. During the process, the team identifies and corrects any errors and pulls reports to assess scope of impact and determine course of actions to reprocess claims. In certain cases, the issues presented are provider specific, and therefore, all claims for all providers are not necessarily reprocessed.</p>
<p>22. Myers & Stauffer were unable to confirm website functionality to either submit or check the status of an authorization request.</p>	<p>Please confirm if the following functionality is available to providers on the WellCare website: check status of prior authorization request and</p>	<p>WellCare provides on-line authorization functionality. Physicians may submit and check the status of authorizations via the web.</p>

**Myers & Stauffer Report #3 – Policies & Procedures – WellCare
Area of Concern**

	Action Required	CMO Response
<p>23. Myers & Stauffer did not find policies that address handling of urgent and emergent admissions in the absence of notification.</p>	<p>submit an authorization request. If this functionality is not available, when do you anticipate it will be? If this functionality is available, when did this begin and please confirm this process is operational and functioning correctly?</p>	<p>This functionality was made available in October, 2007 and is fully functional. It should be noted that only ordering physicians may submit and validate status of authorizations for their patients.</p>
	<p>Is a claim denied if the provider does not provide notification of an emergent or urgent admission in accordance to the said timeframes listed in the provider manual? Is there a comparable notification requirement for emergency services as well? If so, is a claim denied if the provider does not provide notification of emergency services? Please describe Wellcare's policies and procedures for emergent and urgent care notification, including whether claims are denied if notification is not received.</p>	<p>WellCare does provide policies for handling of urgent and emergent admissions. WellCare requires a written plan of care for all emergent or urgent admissions within 24 hours of the admission for payment. Notification is not required for emergency services performed in the emergency room. Services are processed and paid based on WellCare ER services payment criteria. The written plan of care must be submitted in order to receive payment. As noted above, notification is not required for emergent or urgent care services performed in an emergent or urgent care setting. Emergent or urgent admissions require the</p>
	<p>If policies do not exist, please draft and submit to DCH for approval.</p>	

Myers & Stauffer Report #3 – Policies & Procedures – WellCare Area of Concern	Action Required	CMO Response
<p>24. From a review of a sample of contracts between Wellcare and network providers, it appears that these contracts do not always use the same definition for emergency medical services found in the DCH/CMO contract.</p>	<p>Please explain and provide the rationale for not using the same definition.</p>	<p>submission of a written plan of care within 24 hours of the admission for payment. The plan of care should include:</p> <ul style="list-style-type: none"> • Diagnosis, symptoms and complaints for the admission • A description of the functional level of the individual • Medication or treatment orders • Diet and activity levels • Plans for hospital course • Plans for discharge <p>The plan of treatment should be multi-disciplinary and include the attending physician as well as nursing staff.</p> <p>Section 8, of our hospital manual (Utilization Management) describes our policies and procedures regarding emergent admissions</p> <p>WellCare's contracts should contain the same/consistent language regarding emergency medical services definition. There are instances where payment for</p>

Myers & Stauffer Report #3 – Policies & Procedures – WellCare		
Area of Concern	Action Required	CMO Response
		<p>emergency room services may differ (PLP criteria versus case rates or fee schedule payments). However, the definition for emergency care services should be consistent. If possible, please provide specific examples of variance.</p>