GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Contract Oversight for CareSource

Independent Accountant's Report on Applying Agreed-Upon Procedures

Report Issue Date: 12/13/2023

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Independent Accountant's Report

Georgia Department of Community Health
Medical Assistance Plans Division
2 Martin Luther King, Jr. Dr. SE
East Tower, 19th Floor
Atlanta, GA 30334

We have performed the procedures enumerated in *Appendix B: Agreed-Upon Procedures* on the documentation and information provided by CareSource (CS) for September 21, 2022 through December 15, 2022. We were asked to apply these procedures in order to evaluate CS's contract compliance, program integrity (PI) oversight, subcontractor oversight, and encounter submissions. CS's management is responsible for the documentation and information provided, which was submitted to the Georgia Department of Community Health (DCH or the Department) for purposes of compliance with the Department's policies and procedures for encounter submissions.

The Department has agreed to and acknowledged that the procedures performed are appropriate to meet the intended purpose compliance with Medicaid program requirements. This report may not be suitable for any other purpose. The procedures performed may neither address all the items of interest to a user of this report, nor meet the needs of all users of this report and, as such, users are responsible for determining whether the procedures performed are appropriate for their purposes.

Our procedures are contained within *Appendix B: Agreed-Upon Procedures*, and our findings are contained in the *Findings and Recommendations* section beginning on page 57 of this report.

We were engaged by the Department to perform this agreed-upon procedures (AUPs) engagement and conducted our engagement in accordance with attestation standards established by the American Institute of Certified Public Accountants. We were not engaged to and did not conduct an examination or review engagement, the objective of which would be the expression of an opinion or conclusion, respectively, on CS's contract compliance, PI oversight, subcontractor oversight, and encounter submissions. Accordingly, we do not express such an opinion or conclusion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

We are required to be independent of the provider and to meet our other ethical responsibilities in accordance with the relevant ethical requirements related to our AUPs engagement.

This report is intended solely for the information and use of the Department as administrative agent for the Medicaid program, and is not intended to be, and should not be, used by anyone other than this specified party.

Myers and Stauffer LC
Atlanta, Georgia
12/13/2023

Project Background

CareSource is one of three care management organizations (CMOs) providing care management services to Georgia Families®, Medicaid, and PeachCare for Kids members, in addition to Planning for Healthy Babies (P4HB) participants under the Georgia Families® program. Georgia Families® is a risk-based managed care program designed to unite private health plans, health care providers, and patients for the purpose of improving the health status of this population.

Myers and Stauffer has been engaged to assist the Department in its efforts in assessing the policies and procedures of the Georgia Families® program. Our assessments include researching and reporting on specific issues presented to DCH by providers, certain claims paid or denied by the CMOs, and selected Georgia Families® policies and procedures. The Department has also engaged Myers and Stauffer to perform AUPs at each of the CMOs and their subcontractors in order to assess the effectiveness of contractually-mandated monitoring and operational requirements.

As part of this initiative, the Department requested that Myers and Stauffer perform a review of the monitoring activities being performed by CS to ensure contract compliance by each of its subcontractors; a review of corrective action procedures administered, if any, to CS's subcontractors as a result of contract non-compliance; and a review of CS's PI procedures.

Methodology

Pre-Virtual Interviews

On September 21, 2022, we submitted a data and documentation request to CS prior to initiating the virtual interviews. The materials requested for our analysis were designed to provide us with detailed background information specific to the objectives of this engagement. We reviewed the contracts, policies, procedures, and other documentation related to the engagement's procedures to validate the CS and its subcontractor's compliance. This review was performed October 14, 2022 through October 25 2022.

Upon receipt of the data and information requested, we performed a review of the following items:

- *The requirements included in the contract (and amendments) between DCH and CS.*
- *The requirements included in the contracts between CS and its subcontractors.*
- *The existing policies and procedures relative to contract compliance, PI, and subcontractor oversight for CS and each subcontractor.*
- *The encounter workflows and processes within CS, within the subcontracted vendors, and between the subcontractors and CS.*
- *The policies and procedures utilized to ensure timely and accurate reporting of encounters.*

We developed a general template of procedures for the virtual interview activities and identified the specific focal areas based on the results of the preliminary analysis. Utilizing the data and documentation provided, we also performed the following:

- *Identified the staff responsible for the following functional areas:*
  - *Contract compliance.*
  - *PI.*
  - *Subcontractor oversight.*
  - *Encounter submissions.*
- *Performed a risk assessment to identify the subcontractors to be included in this engagement.*
- *Obtained DCH approval of the list of subcontractors to be included in this engagement.*
- *Prepared and submitted schedules of CS and its subcontractor's staff to be interviewed.*
- *CS scheduled all virtual interviews by sending meeting requests to selected participants via Microsoft Teams.*

Virtual Interviews

Virtual interviews of designated CS staff members were conducted by Myers and Stauffer utilizing Microsoft Teams. General and ad-hoc questions were asked of CS staff to ensure our thorough understanding of the item(s) being discussed. In the same manner, virtual interviews were also conducted with the subcontractors Express Scripts, Inc. (ESI), SKYGEN, and Versant. Myers and Stauffer identified additional CS staff to interview when further clarification or additional information was needed.

The virtual and face-to-face interviews were conducted on October 25, 2022 through December 16, 2022. *Table 1* outlines the health plan, dates, and the Myers and Stauffer engagement team members.

Table 1: Virtual Interview Schedule and Details

Virtual Interview Schedule and Details		
Health Plan	**Date**	**Myers and Stauffer Engagement Team**
CS (Local)	10/25/2022 – 10/26/2022	**Myers and Stauffer:** Savombi Fields Stephen Fader Mitchell Keister Nickie Turner Hailey Plemons
CS (Corporate)	11/01/2022 – 11/02/2022	**Myers and Stauffer:** Savombi Fields Stephen Fader Mitchell Keister Nickie Turner Hailey Plemons
SKYGEN	11/07/2022	**Myers and Stauffer:** Savombi Fields Stephen Fader Mitchell Keister Nickie Turner Hailey Plemons
Versant	11/11/2022 – 11/12/2022	**Myers and Stauffer:** Savombi Fields Stephen Fader Mitchell Keister Nickie Turner Hailey Plemons
ESI	12/15/2022 – 12/16/2022	**Myers and Stauffer:** Savombi Fields Stephen Fader Mitchell Keister Nickie Turner Hailey Plemons

Myers and Stauffer concluded the virtual interviews by compiling the interview notes, reviewing additional data and documentation received, and preparing any necessary follow-up questions for CS.

Post-Virtual Interviews

Upon completion of the virtual interviews, Myers and Stauffer identified and documented key findings from the interviews. We concluded the interview activities, compiled interview notes, and prepared necessary follow-up questions including requests for additional supporting documentation.

Assumptions and Limitations

1. The existence of a policy or procedure document does not provide assurance that the policy was being adhered to by those to whom the policy was addressed.
2. The findings and recommendations included in this report were limited to the information gathered from interviews and documents provided to Myers and Stauffer by CS and its subcontractors.
3. Interviews were conducted with members of management and subject matter experts within each organization. We accepted the information that these individuals provided without additional verification.
4. We assumed information received was truthful and correct. Unless information was presented to the contrary, we accepted the information as accurate.
5. The findings and recommendations included in this engagement were limited to the policies and procedures, information system descriptions, data, and other documents provided to Myers and Stauffer by CS, Express Scripts Inc., SKYGEN, and Versant.
6. We assumed data from CS's information systems operated as described in the documentation supplied by CS.
7. We assumed that claims data and claims payment information received was correct. Unless conflicting information was presented to the contrary, we accepted the claims data and claims payment information as accurate.

Contract Compliance

This section of the report provides an overview of CS's contract compliance. We performed an assessment of the operational areas of internal grievance/appeal system, member and provider call center operations, member services including ombudsman, provider network, provider services, quality management and performance improvement, and utilization management (UM). We identified the key contractual requirements, then determined whether CS's policies and procedures were in compliance with the DCH contract outlined in *Appendix C: Contract Compliance*.

Internal Grievance/Appeal System

Overview of Internal Grievance/Appeal System

Section 4.14.1 of the contract requires CS to have a grievance and appeal system available to its Medicaid members. The system must include a process for receiving, tracking, resolving, and reporting member grievances and appeals.

CS policy acknowledges the right of the member or their authorized representative to voice dissatisfaction with administration, operations, or provision of health care services. CS gives members reasonable assistance at no cost, to access the grievance system through a toll-free number with text telephone yoke, as well as provider interpreter capabilities to submit their grievance/appeal. CS also provides an explanation of their process to be followed in submitting and resolving their grievance or appeal, completion of forms and taking other procedural steps as outlined in this policy, and assistance for non-English speaking members and individuals with disabilities, including, but not limited to the visually and hearing impaired. The process for members to follow in order to file a grievance or appeal is outlined in the CS Member Handbook. The Member Handbook includes resources, such as the CS toll-free Member Services phone number, mailing address, and a copy of the forms necessary for members to submit a grievance or appeal with CS.

Per CS policy, a member or their authorized representative can initiate a grievance/appeal orally or in writing. A provider cannot file a grievance to CS on behalf of the member. The grievances/appeals are documented, tracked, and monitored in a centralized database by the quality management department. Members receive a written acknowledgement letter within 10 days of receiving the grievance/appeal. Expedited grievances or appeals must be responded to within 72 hours of receipt. The grievance/appeal is investigated, and upon the completion of the resolution by an approved health care professional under the supervision of the CS Medical Director, a resolution letter is mailed to the member within 90 calendar days of the receipt of the grievance, and 30 calendar days of the receipt of the appeal, indicating the resolution and the basis for the resolution. If the grievance resolution disposition requires action on the part of the CMO, a proposed action will be filed by CS. The member will be sent a notice, 10 calendar days before the start date of the proposed action, which should including a description of

the intended actions and various other details of the proposed action. The resolution letter also notifies the member of their right to appeal the decision which a member must submit within 60 days of receipt of the resolution letter. If a member requires assistance with requesting an appeal to the proposed action and resolution letter, CS associates are available to assist the member with that request. If necessary, the members are able to appeal the proposed action and grievance resolution provided by CS through an administrative review process, which, if unsuccessful in resolving the grievance and appeal, can be moved to the administrative law hearing process, which gives the member an opportunity for their grievance to be reviewed by an impartial administrative law judge in order to address the grievance.

Observations: Internal Grievance/Appeal System

- *CS members may express any type of dissatisfaction when submitting a grievance.*
- *CS receives approximately 50 grievances per month.*
- *The timeframe for acknowledging a new grievance or appeal is 10 business days from receipt in GuideCare (system used by CS to receive, track, and process appeals, grievances, and state fair hearings).*
- *The timeframe for completion of grievances is within 90 days from the date it is received in GuideCare.*
- *CS members may express dissatisfaction with an adverse decision when submitting an appeal.*
- *CS receives approximately 1,500 claims related appeals and 60 to 70 clinical-related appeals per month.*
- *The timeframe for completion of appeals by the provider is within 30 days from the date it is received in GuideCare.*

Assessment: Internal Grievance/Appeal System

Upon review of CS's policies and procedures for their internal grievance/appeal system, Myers and Stauffer determined that CS's policies and procedures for grievance/appeals were in compliance with the DCH contract.

Member and Provider Call Center Operations

Overview of Call Center Operations

Section 4.3.7.1 of the contract requires CS to operate a toll-free telephone line to respond to member calls, comments, and questions. Policies and procedures must be developed to address staffing and personnel, operational hours, access and response standards (performance), monitoring of calls, and compliance with contract standards.

CS policy indicates that the plan operates a call center from 7:00 a.m. to 7:00 p.m. with the exception of certain state of Georgia holidays. Per CS policy, after normal business hours, members have access to an automated member inquiry line that is available 24 hours a day, seven days a week (24/7). The automated system has the capability of providing information such as operating hours information and instructions on verifying enrollment. In addition, the automated system allows callers to leave a message. The member will receive a call back within 24 hours of leaving the message.

- *CS's Member Call Center organizational structure begins with the director, followed by four managers and 10 teammates.*
  - *The Provider Call Center has 32 specialists trained on Georgia.*
- *An interactive voice response system is utilized to document calls, and a repository documentation system enables CS to access accounts on calls.*
- *Both Member and Provider Call Centers utilize Streamline as the call intake system.*
- *Five monthly quality evaluations are completed by the vendor, the Northridge Group. These are housed in CS' Quality Central tool for Member Call Center. Two evaluations are completed for Provider Call Center.*
  - *The specialists can dispute results of assessment within six business days and their requests are processed within five to seven days once received.*
- *Customer issues are prioritized by grades of high, medium, and low, with high priority items being regulatory in nature. CS aims to resolve provider tickets within 72 hours.*
  - *There is no service-level agreement (SLA) around e-manual requests, but alerts are responded to within the hour, and lower prioritized events receive responses within seven days.*
- *CS maintains dashboards that monitor turnaround times for the Issue Resolution (IR) team. The team lead for IR will do five ticket audits every month on their specialists.*
- *The IR teams meets monthly with the claims team to discuss issues and trends.*
- *The average number of calls for the Provider Call Center is between 300 and 400 calls daily.*

Assessment: Call Center Operations

Upon review of CS's policies and procedures for their call center operations, Myers and Stauffer determined that CS was in compliance with the DCH contract.

Member Services including Ombudsman

Overview of Member Services

Section 4.3 of the contract requires CS to ensure its members are aware of the following:

- *Member rights and responsibilities.*
- *The role of primary care providers (PCPs) and dental homes.*
- *The role of the family planning providers and PCPs.*
- *How to obtain care.*
- *What to do in an emergency or urgent medical situation (for P4HB participants, information must address what to do in an emergency or urgent medical situation arising from the receipt of demonstration-related services).*
- *How to request a grievance, appeal, or administrative law hearing.*
- *How to report suspected fraud and abuse.*
- *Providers who have been terminated from the CS network.*

The contract mandates that CS must utilize all forms of communication to reach and receive responses from the largest number of members. Acceptable forms of communication include, but are not limited to, telephone, hard copy documents via mail, email, social media, and texting. The email system must allow members to submit questions and receive responses in a secure manner that protects the confidentiality and protected health information of the member. Upon request, CS must provide Medicaid materials and resources, including the Member Handbook, the member website information, various member written materials, the Provider Directory, and access to the call center in the format preferred by the member. CS must also provide these materials based on the member's needs including for those who require interpretation and/or translations services. The contract requires all member information and materials to be written at a fifth grade reading level and be culturally competent based on a DCH approved Cultural Competency Plan.

CS has a Member Engagement team and Ombudsman Liaison who work with the Office of the Ombudsman as the initial point of contact for members. The Member Engagement team and the Ombudsman Liaison work together to identify, investigate, track, and resolve member issues and grievances regarding all services and activities performed by CS. They are responsible for educating members about their rights and responsibilities. They respond to questions regarding benefit coverage, finding a doctor, obtaining a new identification (ID) card, requesting transportation, and any other member-related questions. They also respond to requests for member materials and provide them to the member in the member's preferred format.

Ombudsman staff are responsible for collaborating with DCH's designated staff to identify and attempt to resolve member issues. The Ombudsman staff will work collaboratively with DCH staff on member issues, such as access to health care services and communication and education members and providers.

Observations: Member Services including Ombudsman

- *CS has a 24/7 call center staffed with six customer care representatives, one lead, and one manager.*
- *Calls are transferred to the after-hours line at the end of normal business hours.*
- *CS utilizes Variant, a software that captures audio and video of the incoming calls.*
- *At the time of the interviews, CS stated they are meeting the performance metrics' mandated service rates with a 90 percent answer rate, less than one minute hold time, less than 30 seconds to answer, and less than five percent abandonment.*
- *CS has both English and Spanish-speaking associates, and for members who speak other languages, there is an oral interpreter service available.*
- *CS has begun implementing initiatives to address members' lack of knowledge on the benefits and rewards CS offers for activities, such as completing doctors' visits.*
- *The CS Life Services team has also begun to implement a $3 million housing initiative that is attempting to assist members suspected of being homeless with finding housing.*

Assessment: Member Services including Ombudsman

Upon review of CS's policies and procedures for member services, Myers and Stauffer did not identify policies or standard operating procedures (SOPs) for contract Section 4.3.2.1. We recommend that CS, in accordance with their contract with DCH, create policies and/or policy references to address the contract requirement outlined in this area.

Provider Network

Overview of Provider Network

Section 4.8.1 of the contract requires CS to develop and maintain a network of providers and facilities that is robust enough to deliver covered Medicaid services to its members. The network must ensure adequate coverage exists for both urban and rural areas, in addition, telemedicine is also an option when appropriate for the member's health care needs. The network should contain physicians, pharmacies, hospitals, physical therapists, occupational therapists, speech therapists, border providers, and other health care providers. Network providers must be appropriately credentialed by DCH or its agent, maintain current license(s), and have appropriate locations to provide covered Medicaid services.

Per policy, CS uses a targeted and innovative approach to provider recruitment to develop and maintain an adequate network of providers that reflects the diversity of cultural and ethnic backgrounds of their membership. CS's providers and facilities will be credentialed by DCH's Credentialing Verification Organization where appropriate. They will ensure licenses are current and that locations are appropriate and adequate to deliver covered services to members. In rural areas, and when otherwise appropriate, the use of telemedicine may be an option for providing care to members in deficient areas. The provider network contains physicians, specialists, behavioral health providers, pharmacies, hospitals, physical therapists, occupational therapists, speech therapists, border providers, and other health care professionals. The network will not include any providers that have been excluded form participation by the U.S. Department of Health and Human Services, Office of the Inspector General, or are on the list of excluded providers in Georgia. CS will perform monthly checks of the exclusions list to identify and immediately terminate any participating provider found on the list.

Observations: Provider Network

- *CS is in compliance with network standards besides a few counties with deficiencies in terms of non-available providers.*
  - *Waivers allow CS to not have to register and report a non-available provider type as a deficiency.*
  - *CS has no formal waiver approvals from DCH with respect to its network deficiencies noted in their Access and Availability regulatory reporting.*
- *CS performs monthly, if not weekly, outreach through documented phone calls and messages to find potential providers.*
- *CS provides a standard base agreement for all providers which is used as an initial template in the event that a provider would like to negotiate for non-standard rates.*
- *Claims that CS receives for providers that are not in their network can only be reimbursed if the provider submits a form and get prior authorization to see members.*
  - *Retrospective authorizations are situationally based.*
- *Secret shopper calls are done monthly by SPH Analytics after a review of the GeoAccess and Network Adequacy reports to determine which providers are not meeting the performance standards.*

Assessment: Provider Network

Upon review of CS's policies and procedures for their provider network operations, Myers and Stauffer determined that CS was in compliance with the DCH contract.

Provider Services

Overview of Provider Services

Section 4.9.1 of the contract requires CS to provide information about Georgia Families® to all providers in order to operate in full compliance with the contract and all applicable federal and state regulations. CS is responsible for monitoring provider knowledge and understanding of provider requirements and taking corrective actions to ensure compliance with the requirements. The contract requires CS to provide all providers with a copy of the provider handbook and to provide a hard copy upon provider request. For the providers, the provider handbook serves as a source of information regarding covered services, policies and procedures, statutes, regulations, telephone access, and special requirements to help ensure all contract requirements are being met.

CS, per policy, maintains a provider services department that utilizes CS Health Partners who provide information about Georgia Families® to both participating and non-participating providers. A toll-free provider service line is dedicated to provider service calls. Providers can call to get assistance with member information such as benefits and enrollment status. Additionally, providers can obtain information regarding providers' rights and responsibilities, claims and payment, prior authorizations, provider information, the policies and procedures outlined in the provider manual, complaints and assistance filing, appeals and assistance filing, web portal functionality, and assistance with obtaining forms.

CS, per policy and procedures, also conducts monthly, quarterly, and annual provider visits to gain an understanding of the provider experience and address any issues providers may have. Providers are placed in tiers based on the number of CS members they serve. For providers serving 100 or more CS members, Health Partners conduct monthly site visits. For providers serving 50 to 100 CS members, Health Partners conduct quarterly site visits. For providers serving less than 50 CS members, Health Partners conduct annual site visits. Health Partners are assigned a territory where they visit providers based on the schedule listed above.

Observations: Provider Services

- *The Provider Services Call Center is staffed and available to providers 24/7 for calls regarding prior authorization and pre-certification requests.*
- *The Provider Services call center is staffed to respond to provider questions between the hours of 7:00 a.m. and 7:00 p.m. Eastern Standard Time Monday through Friday, excluding state holidays. After regular business hours, the line is answered by an automated system with the capability to provide callers with operating hours information and instructions on how to verify enrollment for a member with an emergency or urgent medical condition.*

- *CS has established a provider complaint system that allows a provider to submit complaints and disputes of CS policies, procedures, function, or decision.*
- *CS resumed performing on-site visits with providers; however, providers still have the option to conduct virtual visits with CS Health Partners.*
- *The minimum number of provider visits being completed monthly is approximately 100, and the maximum number of provider visits being completed monthly is approximately 400.*
- *CS Health Partners do not have a required number of provider visits to be completed each month, quarter, or year.*
- *Provider contacts and the information and details related to the visit are documented in the Microsoft Dynamics System.*

Assessment: Provider Services

Upon review of CS's policies and procedures for provider services, Myers and Stauffer did not identify policies or SOPs for contract Section 4.9.2.2. We recommend that CS, in accordance with their contract with DCH, create policies and/or policy references to address the contract requirement outlined in this area.

Quality Management and Performance Improvement

Overview of Quality Management

Section 4.12.1 of the contract requires CS to provide for the delivery of quality care with the primary goal of improving or maintaining the health status of its members. This includes the implementation of interventions and designation of adequate resources to support the intervention(s) necessary for members identified by CS as being at risk of developing serious conditions. CS is required to partner with members, providers, community resources, and agencies to actively improve the quality of care provided to members.

CS has policy and procedures in place to manage the quality of care provided to its members, as mandated by the contract. The primary goal of these policies is to ensure the provision of quality care resulting in the improvement of member health. In situations where the member's health status cannot be improved, measures are implemented to prevent further decline and/or deterioration of the member's condition or health. Cost containment and directing members' care are direct results of quality management.

CS policies and procedures for quality management include strategies for identifying members at risk of developing health conditions and intervening to prevent decline or deterioration of those health conditions. Improving and/or maintaining the member's health condition is a joint effort involving the

member, providers, community resources, and other health agencies who all strive for the primary goal of improving members' overall quality of care.

Observations: Quality Management

- *CS' Director of Quality Management leads the department with approximately 28 supporting staff.*
- *The Quality Management team is split into four sub teams:*
  - *Appeals and Grievances department which also handles DCH disenrollment requests.*
  - *Clinical Compliance department which is responsible for oversight.*
  - *Outreach Staff who are tasked with contacting at least 100 members daily in order to schedule doctor appointments.*
    - *CS is creating a smaller team to specifically focus on Early and Periodic Screening, Diagnostic, and Treatment outreach.*
    - *Averages 30 to 40 percent in 'unable to contact.'*
  - *Health Promotions team that consists of seven field staff, five non-clinical staff, and two clinical staff who focus on promotional projects.*
- *Transportation for appointments is offered to members utilizing non-emergency transportation (NET) via coordination with Logisticare.*
  - *Less than one percent of the population utilizes NET, which CS believes is due to a lack of convenience for most members.*
- *CS's other initiatives for quality management include preventative care for kids, women's health, and a local disease management program.*
- *In the state of Georgia, CS's membership population consists mostly of individuals diagnosed with diabetes, asthma, and hypertension.*

Assessment: Quality Management

Upon review of CS's policies and procedures for quality management, Myers and Stauffer did not identify policies or SOPs for contract Sections 4.12.1.4.1.1 - 4.12.1.4.1.5, 4.12.1.4.2.1 - 4.12.1.4.2.2, 4.12.2.1, 4.12.2.2.1 - 4.12.2.2.8, 4.12.7.2 - 4.12.7.9, 4.12.8.1.1 - 4.12.8.1.5, 4.12.8.2, 4.12.9.5 - 4.12.9.6, 4.12.9.1.1 - 4.12.9.1.7, 4.12.9.2, 4.12.11.1, and 4.12.16.1 - 4.12.16.5. We recommend that CS, in accordance with their contract with DCH, create policies and/or policy references to address the contract requirements outlined in these areas.

Regulatory Reporting and Monitoring

Overview of Regulatory Reporting Monitoring

Section 4.18.1 of the contract requires CS to prepare and submit ongoing dashboards and ad-hoc reports. The reporting assists DCH with monitoring program performance and analysis. CS is responsible for collecting, validating, and reporting required program data to DCH in an accurate and timely manner. Reporting should be compliant with the reporting requirements established by the contract and using the formats, including electronic formats, instructions, and timetables specified by DCH.

CS policy acknowledges the requirement to support DCH in its program monitoring and reporting efforts for overall program performance and trending analysis. In response to this requirement, CS produces ongoing and ad-hoc reporting for the activities mandated in the contract. Each regulatory report is assigned to a primary and secondary owner, and while most of the reporting is automated, functional areas will manipulate that report based on specific needs of the state. Their compliance analyst reviews and signs attestations for the reports before sending to the executive team for further review prior to submission. CS follows the timelines outlined in the contract, therefore, report submissions are weekly, monthly, quarterly, bi-annually, and annually.

Observations: Monitoring and Reporting

- *Ad-hoc report submissions and report resubmission requests from DCH or Myers and Stauffer are the responsibility of Compliance Analyst. These requests are tracked through Outlook personal and GA Regulatory Reporting email boxes.*
- *Most of the reports submitted are encounter reports.*
- *Extensions are typically granted upon request where there is a need for a particular area.*
- *There are no standing meetings related to regulatory reporting with DCH; however, standing meetings are occurring related to encounter data and the compliance committee.*

Assessment: Regulatory Reporting and Monitoring

Upon review of CS's policies and procedures for regulatory reporting and monitoring, Myers and Stauffer did not identify policies or SOPs for contract Sections 4.18.1.2, 4.18.2.2.3, and 4.18.3.1. We recommend that CS, in accordance with their contract with DCH, create policies and/or policy references to address the contract requirements outlined in these areas.

Utilization Management

Overview of Utilization Management

Section 4.11.1 of the contract requires CS to implement effective UM processes and procedures to ensure a high-quality, clinically-appropriate, highly-efficient, and cost-effective health care delivery

system. CS is required to provide ongoing evaluation of the cost and quality of medical services provided by providers and to identify potential over- and under-utilization of clinical services. Additionally, CS must apply objective and evidence-based criteria that take the individual member's circumstances and the local delivery system into account when determining the medical appropriateness of health care services.

CS UM policy outlines the means by which quality and the appropriate use of health care-related services is determined. UM also ensures CS members are treated in the most appropriate, least restrictive, cost-effective setting based on the severity of the illness and/or the intensity of the services needed in order to result in an improved health status relative to the specific condition. Prior authorizations and pre-certifications are used to manage the utilization of certain Medicaid services, ensure high quality and appropriateness of services, and manage costs.

Observations: Utilization Management

- *CS' UM department is separated into a clinical, non-clinical, and operations team. There are designated nurses within each team that focus on Georgia.*
  - *The clinical team is sectioned out by inpatient, outpatient, and behavioral health. The inpatient and behavioral health teams work very closely.*
  - *The medical director team is tasked with secondary reviews.*
- *The GuidingCare platform is used to document authorizations, notes, and houses resources used for determinations.*
- *CS's UM is only delegated to process physical and behavioral health authorizations.*
- *A quarterly inter rater reliability (IRR), regular audits, and spot auditing are used to ensure the teams are reviewing, approving, and denying requests properly.*
- *The last National Committee for Quality Assurance (NCQA) audit was completed and passed within the last two years.*
- *CS's SharePoint website houses policies, initial SOPs, and monitoring for keeping up with employee training for UM.*
- *To ensure parity between physical and mental health authorizations, CS has a Director of Behavioral Health who works with the compliance team on an enterprise level to review parity levels.*

Assessment: Utilization Management

Upon review of CS's policies and procedures for UM, Myers and Stauffer did not identify policies or SOPs for contract Section 4.11.1.4. We recommend that CS, in accordance with their contract with DCH, create policies and/or policy references to address the contract requirement outlined in this area.

Program Integrity Oversight

Myers and Stauffer performed an assessment of CS's policies and procedures for PI oversight and this section of the report provides an overview of that oversight. We identified the key contractual requirements, then determined whether CS's policies and procedures were in compliance with the DCH contract outlined in *Appendix C: Contract Compliance*.

Contract Requirements and Consistency of CS Policies and Procedures for Program Integrity Oversight

Overview of Program Integrity Oversight

Section 4.13.1 of the contract requires CS to implement and maintain a PI program that includes a mandatory compliance plan designed to safeguard against fraud, waste, and abuse (FWA). The PI program must include policies, procedures, and standards of conduct allowing for the prevention, detection, reporting, and corrective action for suspected and confirmed cases of FWA relating to the administration and delivery of Medicaid services under this contract.

The contract also requires the designation of a compliance officer who is accountable to CS's senior management and is responsible for ensuring policies to establish effective lines of communication between CS and DCH staff exist and are being adhered to.

CS maintains a PI program to address how they detect, report, prevent, and apply corrective action(s) to suspected cases of FWA in the provision of Medicaid services. CS's PI policies, procedures, and standards of conduct are documented and include corrective action of suspected cases of fraud and abuse as a means to ensure the integrity of their program. As a part of PI policy and procedures, CS maintains a mandatory compliance program and pharmacy lock-in program as required under the contract. CS has also established a Program Integrity and Investigations Committee, chaired by the Vice President, who annually reviews PI requirements and provides oversight of all PI functions along with FWA Special Investigations Unit (SIU) effectiveness.

Observations: Program Integrity

- *CS' PI department consists of four pillars which include the SIU, compliance-related and insurance risk functions, data reporting and analytics, and medical record audits.*
  - *Within the SIU, cases are investigated after being validated through their triage process.*
  - *For data reporting and analytics, investigators will look for outliers and trends, perform individual data mining, and report suspicions.*
- *The PI department is specific to Georgia and only works on PI cases in Georgia.*

- *The team conducts weekly meetings to discuss cases and corrective action plans (CAPs).*
- *CS utilizes Customer Expressions for tracking and monitoring cases.*
- *For Georgia, any amount under $500 is not pursued as an overpayment. In these cases, CS may conduct provider training to mitigate the overpayment. However, if a concerning pattern is discovered in the provider's records, CS may perform a pre-payment review.*
- *An approved annual risk assessment is utilized to develop a risk plan that is reviewed quarterly.*
- *CS has two payment integrity departments, pre-pay and post-pay.*
- *CS' Pharmacy Lock-in Program consists of three registered nurses and four pharmacy technicians.*
    - *Lock-ins sit within the pharmacy department.*
    - *CS members must meet nine criteria to qualify for the pharmacy lock-in program.*

Assessment: Program Integrity

Upon review of CS's policies and procedures for their provider network operations, Myers and Stauffer determined that CS's was in compliance with the DCH contract.

Fraud, Waste, and Abuse Reporting

CS is contractually required to submit a quarterly FWA report to DCH. The contract specified that the reports must contain suspected cases of FWA identified in the administration and delivery of Medicaid services. FWA case reporting is required to include, at a minimum, the:

- *Source of complaint.*
- *Alleged persons or entities involved.*
- *Nature of the complaint.*
- *Approximate dollars involved.*
- *Date of the complaint.*
- *Disciplinary action imposed.*
- *Administrative disposition of the case.*
- *Investigative activities, corrective actions, prevention efforts, and results.*
- *Trending and analysis as it applies to UM, claims management, post-processing review of claims, and provider profiling.*

Myers and Stauffer reviewed six quarterly FWA reports submitted by CS for the third quarter of calendar year (CY) 2021 through the fourth quarter of CY 2022. These reports comprised 86 FWA cases. We reviewed the history of these cases in terms of the CMO's SIU productivity, case mix, case outcomes, completeness, and consistency of reporting.

SIU Productivity

During the study period (July 2021 through December 2022), CS started with a backlog of 34 FWA cases, opened 52 additional cases, closed 31 cases, and ended with a backlog of 55 FWA cases. It appears the FWA case backlog increased steadily during the 18 months of the study period. The typical turnaround time (from open to close) for all cases closed during the study period was approximately 14 months.

Refer to *Figure 1* and *Figure 2* for a visual depiction of SIU productivity during the study period.

Figure 1: Number of FWA Cases Opened and Closed During Each Month

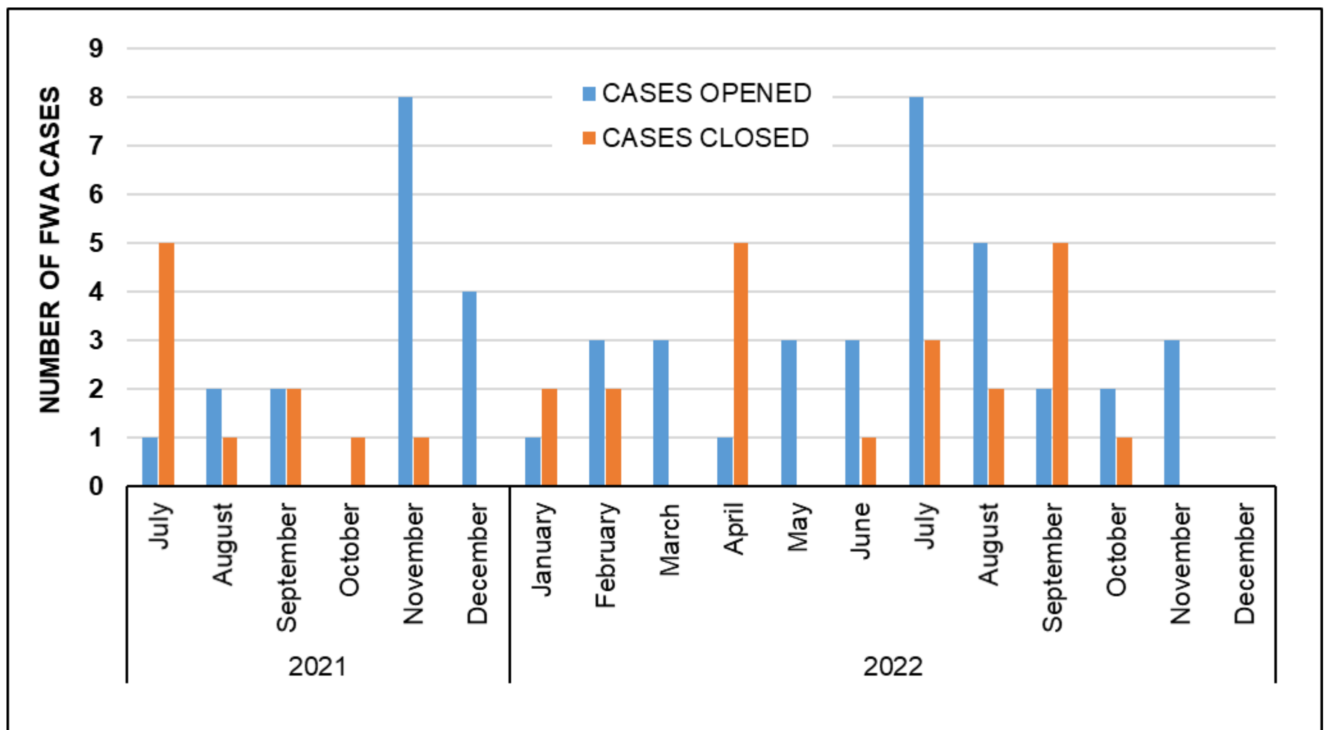
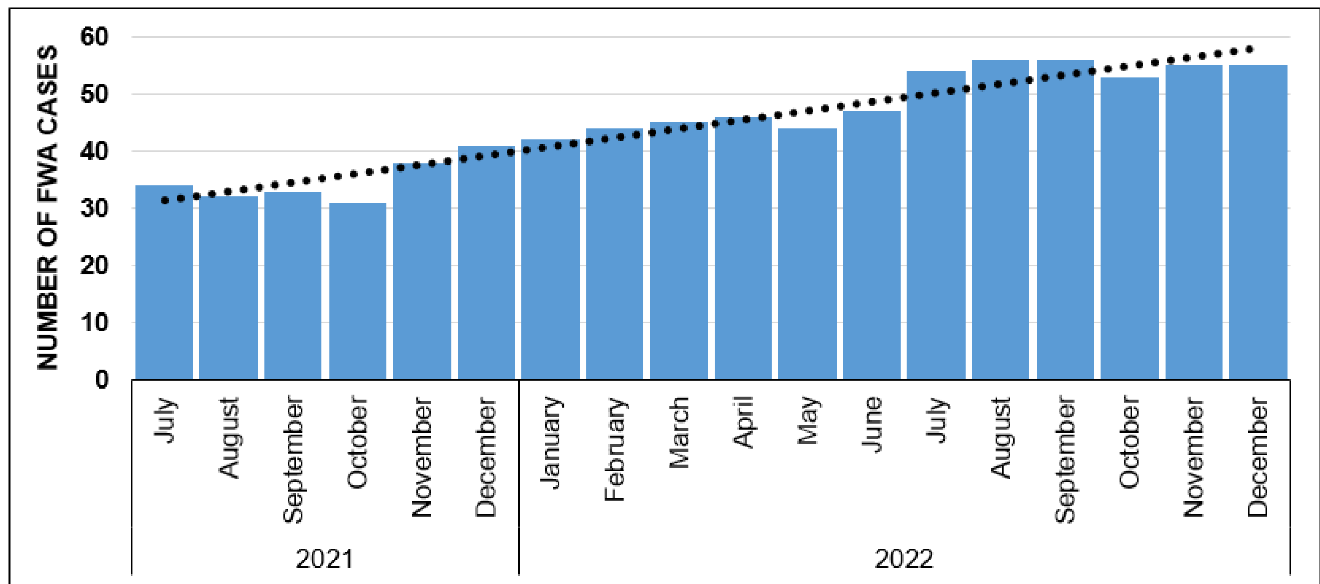


Figure 2: Number of Backlogged FWA Cases by Month



Legend Monthly backlog case count Case backlog trend line

Additionally, it appeared that there was a delay in reporting new cases, as they did not appear until after the report period of the case's date of complaint. Of the 52 new cases during the study period, 23 cases were not reported until after the report period in which the date of complaint occurred. We could not verify when investigation of these cases actually began, so we are unable to determine if these reporting delays indicate a delay in the start of investigation of the case. *Table 2* indicates the reporting delay appeared to increase during the study period.

Table 2: FWA Case Reporting Delays

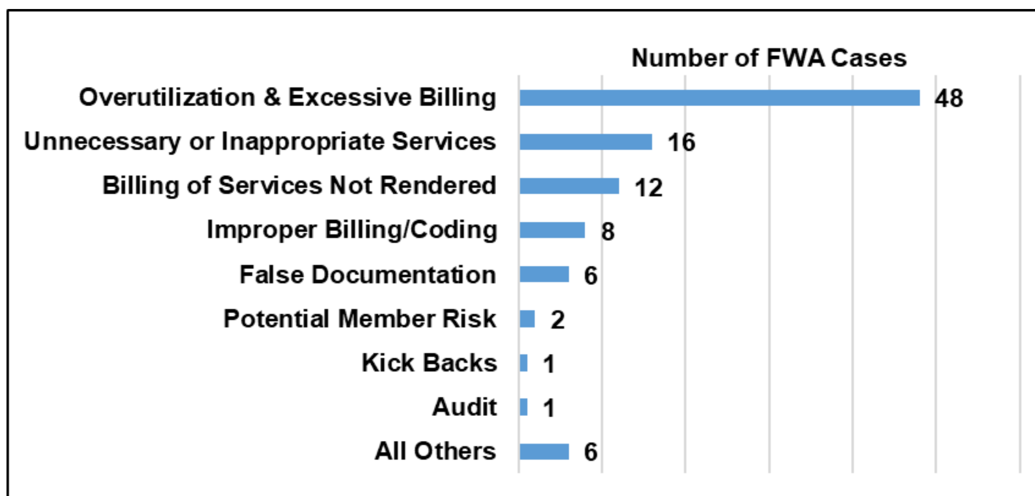
Number of FWA Cases with Reporting Delays					
Report Period	< 31 Days	31 – 60 Days	61 – 90 days	> 90 Days	Total
CY 2021 Q3			1		1
CY 2021 Q4		1			1
CY 2022 Q1	2	1		2	5
CY 2022 Q2	1			1	2
CY 2022 Q3	1	2	1	2	6
CY 2022 Q4	2	4		2	8
Total	**6**	**8**	**2**	**7**	**23**

The time gap was calculated based on the first date of the quarter during which the case was first reported.

FWA Case Mix

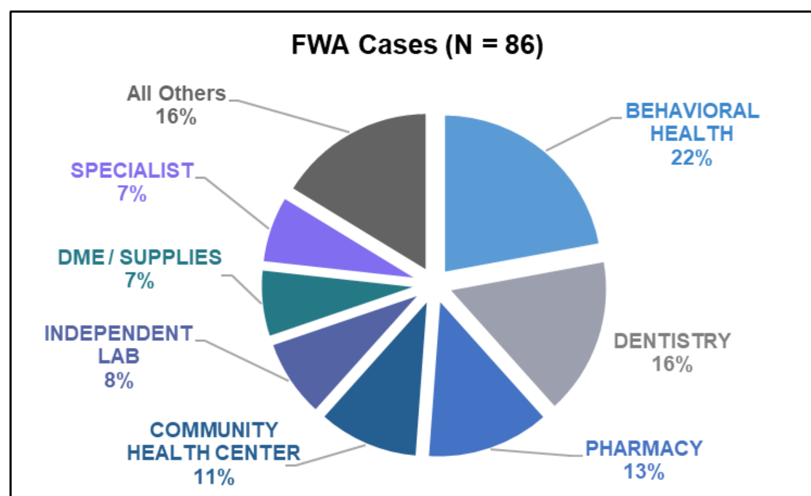
Myers and Stauffer reviewed the FWA case mix within the 86 active cases during the study period in terms of the alleged FWA schemes and the types of providers, individuals, and entities involved. Based on the nature of the complaint stated in the FWA quarterly reports, and ranked by the most to least frequent, the top three identified schemes were overutilization and excessive billing, unnecessary or inappropriate services, and billing of services not rendered.

Figure 3: Nature of Complaints Documented for FWA Cases



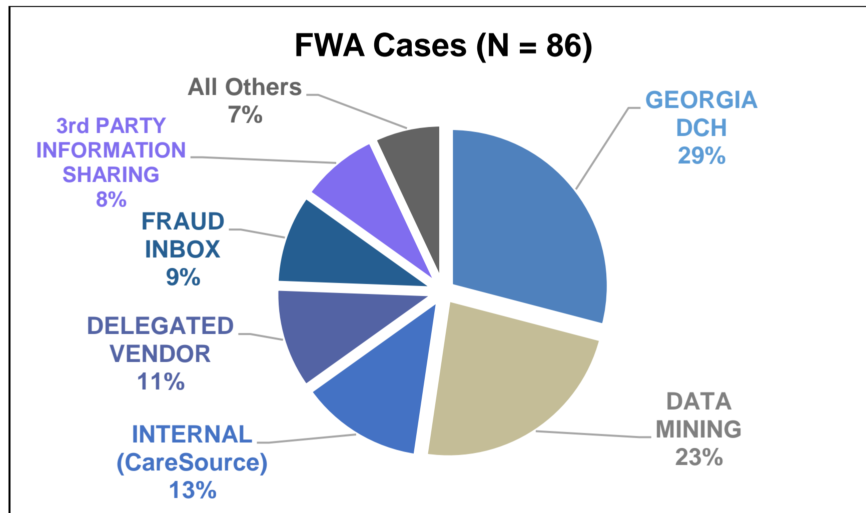
No member fraud cases appeared in FWA reports during the study period. Of the alleged parties in the 86 FWA cases active during the study period, the most prominent types of providers were behavioral health, dentistry, and pharmacy, as shown in *Figure 4*.

Figure 4: Provider Types Involved in FWA Cases



The FWA cases during this 18-month period arose from multiple sources—the primary sources being the DCH and data mining, as shown in *Figure 5*. Nearly half (48 percent) of the cases were sourced from outside of CS (Georgia DCH, CS's delegated vendor for pharmacy, and third party information sharing.)

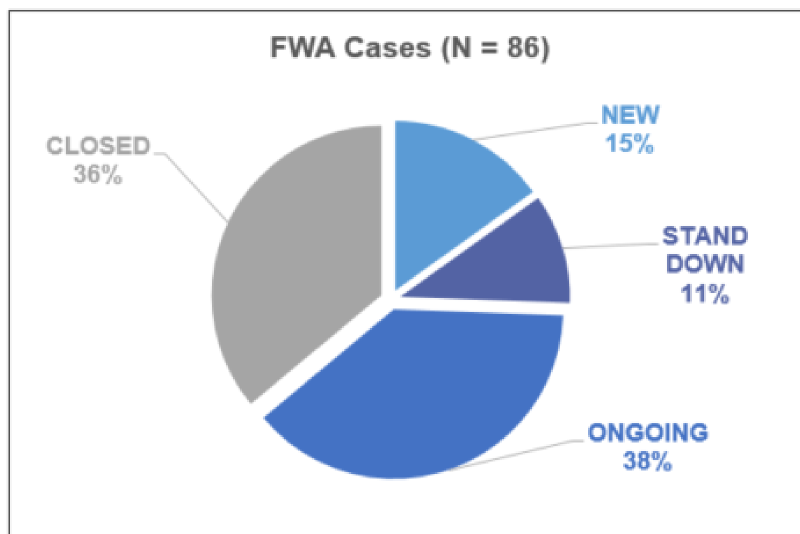
Figure 5: FWA Source of Complaint



FWA Case Outcomes

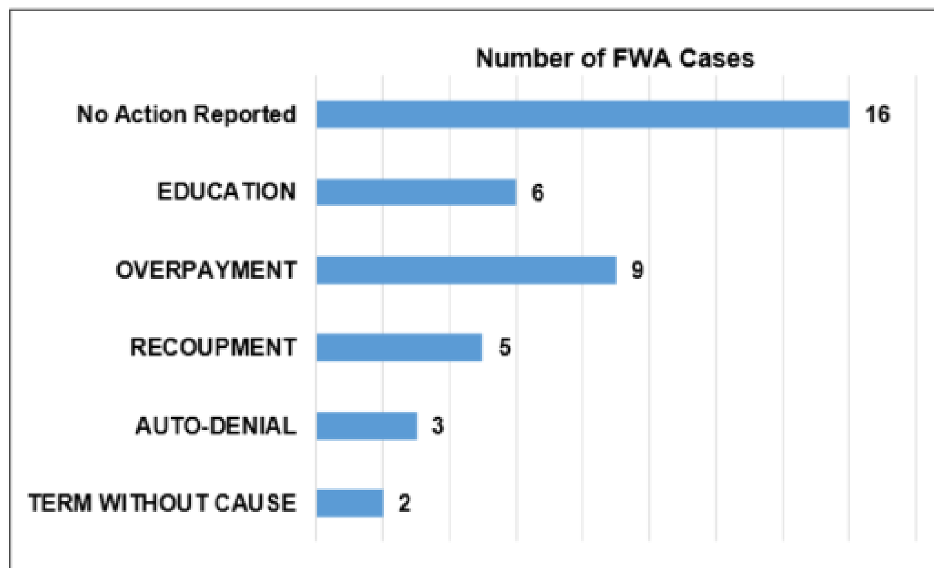
Myers and Stauffer reviewed the actions and outcomes CS reported for the 86 FWA cases active during the study period. We categorized each case's final status as new, stand down, ongoing or closed, as shown in *Figure 6*.

Figure 6: Final Status of FWA Cases



Actions taken by CS SIU as observed in the case records submitted included education, prepay review, overpayment determination, recoupment, auto-denial of provider claims, suspension, and notification to the provider of termination without cause. Of the 31 FWA cases closed during the study period (July 2021 through December 2022), 16 cases had no reports of disciplinary actions, which is assumed to indicate the investigations revealed no findings. Roughly half of the remaining 15 closed cases had multiple actions reported per case during the study period. The most common combination was overpayment determination, followed by recoupment, auto-denial, and/or termination without cause.

Figure 7: Actions Taken by CS SIU



CS SIU recorded an estimate of the dollars involved for all 86 cases, but was not consistent in reporting the dollar amounts for overpayment and recoupment. The overpayment amounts were recorded for 12 cases, and amounts actually recouped were recorded for five cases. The total amount recorded in the reports as recouped during the 18-month period was $58,756.81.

Table 3: FWA Financial Outcomes

FWA Financial Outcomes – Specific Dollar Amounts Documented in Quarterly Reports						
Final Case Status	**Estimate of Dollar Amounts**		**Overpayment Determination**		**Recoupment**	
New	13 cases	$4,069,612.08	0 cases	n/a	0 cases	n/a
Stand Down	9 cases	$2,140,517.77	0 cases	n/a	0 cases	n/a
Ongoing	33 cases	$11,797,109.47	6 cases	$140,684.60	1 case	$9,003.60
Closed	31 cases	$3,937,807.40	6 cases	$65,834.06	4 cases	$49,753.21
Totals	**86 cases**	**$21,945,046.72**	**12 cases**	**$206,518.66**	**5 cases**	**$58,756.81**

Completeness and Consistency of FWA Reporting

During our review of CS's six quarterly FWA reports, we encountered case histories that were inconsistent from one report to the next. Six cases were not reported as closed, but failed to appear in the final report. Additionally, it appeared clerical errors occurred via copy-paste operations, overwriting FWA case IDs, date of complaint, source of complaint, nature of complaint, provider type, or approximate dollars involved. This occurred on 54 (21 percent) of the 258 case records submitted on the six quarterly reports. Although these clerical errors were observed on all six reports, the most occurred on the report for the third quarter of CY 2022, on which 23 (48 percent) of the records were impacted by such errors. Most of these clerical errors continued through to the report for the fourth quarter of CY 2022, impacting 19 (37 percent) of its records.

Table 4: Number of FWA Case Records Impacted by Clerical Errors

Number of FWA Case Records Impacted by Clerical Errors			
Report Period	Number of Case Records Submitted	Number of Case Records with Errors	Percent of Case Records with Errors
CY 2021 Q3	36	1	3%
CY 2021 Q4	37	3	8%
CY 2022 Q1	44	4	9%
CY 2022 Q2	42	4	10%
CY 2022 Q3	48	23	48%
CY 2022 Q4	51	19	37%

Recommendations

Myers and Stauffer has the following recommendations for CS SIU:

- *Increase SIU resources to decrease FWA case backlog and potential delays in initiating investigations.*
- *Review FWA quarterly reports issued for CY 2023, and correct any records reporting erroneous information, with special emphasis on FWA case ID, date of complaint, source of complaint, nature of complaint, provider type, or approximate dollars involved.*
- *Place greater emphasis on the accuracy of quarterly FWA reports to DCH.*

Subcontractor Oversight

This section of the report provides an overview of CS's subcontractor oversight. We performed an assessment of CS's policies and procedures for subcontractor oversight. We identified the key contractual requirements, then determined whether CS's policies and procedures were in compliance with the DCH contract outlined in *Appendix C*: *Contract Compliance*.

In the contract between DCH and the CMO, Sections 18.1.1 and 18.1.3 through 18.1.6 outline the use of subcontractors in the Georgia Families® program. The CMO is required to conduct ongoing monitoring of each subcontractor's performance and perform scheduled periodic reviews. CS's subcontractors with delegated function are represented in *Table 5* below.

Table 5: CS Subcontractors and Functions

CS Subcontractors and Functions			
Delegated Function	**Express Scripts Inc.**	**SKYGEN**	**Versant**
Claims Adjudication	X	X	X
Call Center Operations	X		X
Credentialing/Recredentialing	X		X
Explanation of Benefits (EOB) Generation and Mailing		X	
Pharmacy Benefit Management	X		
Provider Network Management	X		X
Specialty Pharmacy	X		
UM	X		X

Assessment: Subcontractor Oversight

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We identified the following potential issue:

- *Virtual interview responses indicated that CS is not auditing or validating the data found in the oversight reports that they receive from subcontractors.*

Express Scripts, Inc.

Overview of Express Scripts, Inc.

Section 4.6.6.2 of the contract requires CS to provide pharmacy services either directly or through a pharmacy benefit manager (PBM) to its members. A preferred drug list, utilization limits, and conditions for coverage for prior authorization drugs must be available through its website.

ESI is contracted by CS to provide pharmacy services to its members. Further, CS handles their own prior authorizations and coverage reviews through a third-party vendor, MHK (formerly MedHOK). ESI has a real-time connection with MHK, allowing them to view updates as they are made in MHK's system.

Observations: Express Scripts, Inc.

- *ESI provides UM, claims adjudication, member/provider call center, network management, credentialing/recredentialing and specialty pharmacy services for CS.*
- *ESI uses a "three lines of defense" model for compliance monitoring with CIGNA.*
  - *Line 1 is the business level.*
  - *Line 2 is compliance.*
  - *Line 3 is their internal audit.*
- *A risk assessment is done bi-annually from ESI's compliance team to create a compliance work plan.*
- *ESI receives and adjudicates electronic and paper claims for CS.*
- *Statistical reports for call center tracking are not sent out by ESI to CS or any external party.*
- *ESI receives maintenance files for CS on a daily basis.*
- *The PI team uses Statistical Analysis System models to review pharmacy network.*
- *CS receives weekly and monthly reports on new cases and current case status from ESI.*
- *There is a team within ESI that is dedicated to maximum allowable cost, and the list is utilized for pharmacy reimbursement calculation.*

Assessment: Express Scripts, Inc.

Myers and Stauffer evaluated ESI using the submitted policies and procedures, documentation, and interviews. We identified the following potential issues:

- *Myers and Stauffer found that ESI claims that they are not required to submit POS (Point of Sale) denials into encounters, therefore, denials are not submitted.*

- *Myers and Stauffer found that there is no file currently provided to allow ESI to ensure total enrollment matches with CS system.*

SKYGEN

Overview of SKYGEN

Section 4.7.4.5 of the DCH contract requires CS to provide diagnostic care and treatment services to its members. SKYGEN is contracted by CS to provide dental services to its members. At a minimum, these services include relief of pain and infections, restoration of teeth, and maintenance of dental health. Emergency dental services also are provided, as needed, to control bleeding, relieve pain, eliminate acute infections, and more. The specific activities and responsibilities delegated to SKYGEN are outlined in the contract with CS.

Observations: SKYGEN

- *SKYGEN provides claims adjudication, EOB generation and EOB mailing services for CS.*
- *All claims have been processed within the service agreements, and no CAP has been imposed in regards to processing SLAs.*
- *SKYGEN's full delegation is claim adjudication, but they also have a semi-delegation for UM where they send approval and denial letters for determined authorizations.*
- *SKYGEN utilizes a ticketing system to track and manage inquiries of issues received from CS. There was no further elaboration on the ticketing system by CS.*
- *Account management is responsible for the regulatory reporting process and ensures accurate and timely report submissions.*
- *SKYGEN's Client Experiences team collaborates with all of the delegated services' departments to meet the contractual requirement set forth by CS.*
- *SKYGEN's claims processors must meet a 98 percent threshold to pass the claims audit each month.*
- *There are three ways of receiving inbound claims:*
    - *Paper (received via Exela).*
    - *Online (submitted directly from the provider).*
    - *EDI (Electronic Data Interchange) an automated adjudication process involving a data warehouse.*
- *SKYGEN uses an enterprise system as their claims management system to process and report the files on a weekly basis.*

- *An encounter tracking system is being used to track claims that are rejected, pending, or need rework. There was no further elaboration on the encounter tracking system by CS.*
- *SKYGEN creates monthly invoices that detail their revenue stream using data pulled from their enterprise system.*
- *Because the pandemic has affected dental care overall, SKYGEN's analysis has shown an increased need in restorative work and more paradental care.*
- *There are no questionnaires being performed for CS members at the moment.*

Assessment: SKYGEN

Myers and Stauffer evaluated SKYGEN utilizing the submitted policies and procedures, documentation, and interviews. We identified the following potential risk areas:

- *SKYGEN is sending voids as adjustments in its 837 for encounter submissions. CS is then interpreting voids from the information provided.*
- *SKYGEN is not performing any additional quality review of the encounter files or the claims proprietary formats prior to sending it to CS.*
- *During the monthly claims audits, SKYGEN identified a limited number of errors due to human intervention.*

Versant

Overview of Versant

Section 4.7.4.5.1 of the contract requires CS to provide medical and routine vision services to its members. Versant is contracted by CS to provide vision services to its members. The specific activities and responsibilities delegated to Versant are outlined in the contract with CS.

Observations: Versant

- *Versant provides a claims, member, and provider service call center; UM; claims adjudication; provider network; and credentialing/re-credentialing services for CS.*
- *Versant maintains a compliance plan each year and performs an annual risk assessment among each of the operational areas.*
- *Versant handles complaints, appeals, and grievances within the same department. Versant is not delegated for appeals or grievances on the member side for CS.*
- *Versant does not designate call center representatives specifically for CS inquiries.*
- *Versant has NCQA accreditation within UM department which is specific to CS.*

- *Versant does not bill for claim payments to CS; CS is capitated.*

Assessment: Versant

Myers and Stauffer evaluated Versant utilizing the submitted policies and procedures, documentation, and interviews. We identified the following potential issues:

- *The provider master file is utilized as a data point along with other sources for member and enrollment information. This causes a risk for the source of truth for member information.*
- *Some claim sequences may not be submitted into the encounters in instances of adjustments occurring in the same week as original claims (only final state claims are submitted), as well as in cases where the original encounter is rejected and not corrected prior to an adjustment claim being finalized.*
- *There does not appear to be quality control and/or a reconciliation of the cash disbursement journal (CDJ) against source financial documentation to confirm completeness of the file.*

Encounter Submissions and Payment Systems

Approach and Methodology

Overview

Myers and Stauffer's review of CS's claims and encounters management included analyzing the consistency and completeness of data across the claim/encounter life cycle.

One of the primary responsibilities of CMOs and their subcontractors is to accept and adjudicate claims payments for beneficiaries participating in the Georgia Families® program. In order for the State to effectively manage the overall Medicaid program and to conform to regulatory requirements, it must have a complete and accurate record of all the adjudications under its purview, regardless of their outcome. Encounters are records of these adjudications, and each CMO and its subcontractors are contractually required to submit complete, accurate, and timely encounters to the Medicaid Management Information System (MMIS), and to address curing encounters that have been rejected by the MMIS. Failure to do so impacts the State's analysis, decision making, rate setting, and regulatory reporting.

As part of the engagement, Myers and Stauffer reviewed the organizational teams and systems responsible for handling the claims life cycle. This review started with the receipt of provider billings, their adjudication, and their eventual submission to the State as encounters. Our objective was to identify any gaps that had the potential for impacting claims or encounters processing, information, completeness, timeliness, or accuracy. Our review was performed via interviews of responsible personnel, and by analysis of sample claims and encounters.

The analysis was limited to claims and encounters for member populations covered by CS having a service date during April 2022 or a paid date in May 2022. The CMO and its subcontractors were requested to provide all claims satisfying this criteria regardless of outcome (paid, denied, rejected) or version (original, adjusted, voided, replaced, final.)

Myers and Stauffer receives encounter data on a weekly basis from DCH's fiscal agent contractor (FAC), Gainwell. This data extract contains paid and denied CMO institutional, medical, dental, vision, and pharmacy encounters that are submitted by the CMO to the FAC and are subsequently loaded into the MMIS. Unless conflicting information is presented to the contrary, we accept the encounter data as complete and accurate.

Myers and Stauffer mapped the claim/encounter data flow from the subcontractor to the CMO and into the MMIS by linking related claim lines at the different processing points in the claim life cycle. Claim

lines were linked using a combination of unique data fields, where available, and populated. Care was taken to differentiate between multiple versions and adjustments of each claim.

The following diagram depicts the claim/encounter life cycle through the subcontractors' and the CMO's information systems.

Figure 8: Claims and Encounters Data Flow Diagram

INSTITUTIONAL PROVIDERS — CLAIMS — PAPER / PORTAL / Clearing House — CLAIMS

PROFESSIONAL PROVIDERS — CLAIMS — PAPER / PORTAL / Clearing House — CLAIMS

DENTAL PROVIDERS — CLAIMS — PAPER / PORTAL / Clearing House — SKYGEN — DENTAL ENCOUNTERS / DENTAL REJECTIONS

VISION PROVIDERS — CLAIMS — PAPER / PORTAL / Clearing House — VERSANT — VISION ENCOUNTERS

PHARMACIES — CLAIMS — POS — EXPRESS SCRIPTS — RX ENCOUNTERS

CareSource

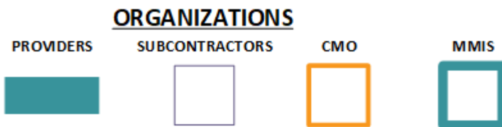
INSTITUTIONAL ENCOUNTERS / INSTITUTIONAL REJECTIONS

PROFESSIONAL ENCOUNTERS / PROFESSIONAL REJECTIONS

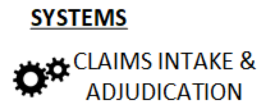
DENTAL ENCOUNTERS / DENTAL REJECTIONS

VISION REJECTIONS

RX REJECTIONS



GAMMIS



LEGEND

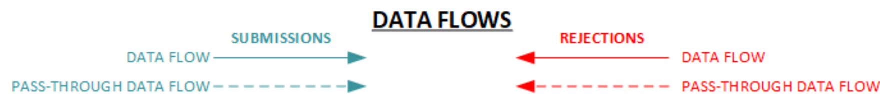
ORGANIZATIONS

PROVIDERS | SUBCONTRACTORS | CMO | MMIS

SYSTEMS

CLAIMS INTAKE & ADJUDICATION

DATA FLOWS



Claims/Encounters Completeness

DCH relies on MMIS encounter claims data to perform many important functions, including, but not limited to:

- *CMO capitation rate setting.*
- *Managed care oversight.*
- *Medicaid PI initiatives.*

CMOs are contractually required to submit complete, accurate, and timely encounter data to the MMIS. To estimate the completeness of member encounter data in the MMIS, Myers and Stauffer reviewed a sample of claims from the CMO and each of their subcontractors' claims processing systems. We compared individual claim lines from these claims to the individual claim lines in a sample of the State's MMIS encounters for the same sample criteria.

Encounter submission completeness analysis is presented in each section below devoted to our observations and recommendations for specific subcontractors. Claims existence is expressed as a percentage of the sampled claims appearing at multiple points in the claim/encounter life cycle.

- *Percentage of sampled lines appearing only in the CMO and subcontractor claims.*
- *Percentage of sampled lines appearing only in the State's MMIS encounters.*
- *Percentage of sampled lines appearing both in the CMO and subcontractor claims, and in the State's MMIS encounters.*

The expected outcome is that all fully adjudicated sampled claims would appear both in the CMO and subcontractor claims, and in the State's MMIS encounters. This would imply the State's MMIS encounters are a complete record of all claims processed by the CMO and its subcontractors. However, there can be multiple explanations for the existence of records in only one data source, including, but not limited to:

- ***Missing MMIS Encounters.*** *CMO and subcontractor claims were not submitted to the MMIS encounters or were rejected by the MMIS. Typically, these instances can be further broken down into the following:*
    - ***Missing Claims.*** *Claims with no representation in the MMIS encounters. These instances may understate payments and services reported in the MMIS.*
    - ***Missing Claim Adjustments.*** *Claims having one or more adjustments or versions reported in the MMIS encounters, and one or more adjustments or versions missing from the MMIS encounters. These instances may impact the accuracy of payments and services reported in the MMIS.*

- ***Missing Claim Voids.*** *Replaced or voided claims which appear to be reported in the MMIS encounters, but do not appear to be voided in the MMIS encounters. These instances may overstate payments and services reported in the MMIS.*
- ***Missing Claims in the CMO and Subcontractor Extracts.*** *The CMO or its subcontractors did not provide all data records from their systems for the requested sample criteria.*
- ***Encounter Data Field Errors.*** *Potential discrepancies in claim data element values reported in the MMIS encounters may impact which MMIS encounters are reviewed for the specified sample criteria. For example, if the service date is reported incorrectly in the MMIS encounters, some claims might not be included in the reviewed sample of MMIS encounters.*
- ***Analysis Limitations.*** *Myers and Stauffer has developed detailed logic to match and compare data records between the CMO and subcontractor's claims and MMIS encounters. In some instances, this logic may fail to match records or mismatch records between the data sources. Myers and Stauffer performs random sampling and manual review of records that do not appear to exist in both the CMO and subcontractor's claims and MMIS encounters to ensure this issue is minimized.*

Myers and Stauffer further reviewed sampled claims appearing only in the CMO and subcontractor claims, and those appearing only in the MMIS encounters. We attempted to further classify these claims and provide additional details to better understand potential deficiencies in the MMIS encounters.

Encounter Submission Accuracy

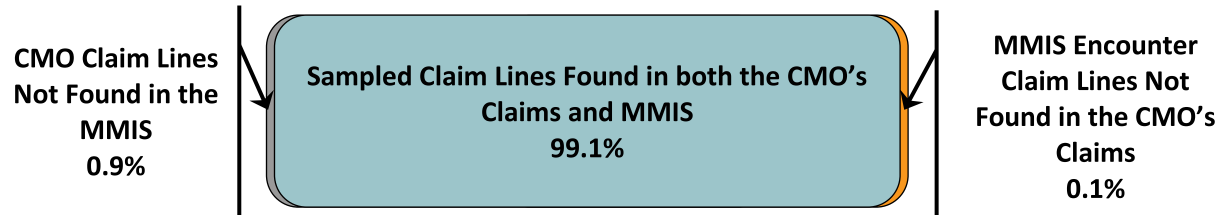
Myers and Stauffer compared data elements in the CMO and subcontractor claims to related encounter data within the claim/encounter life cycle to determine if the information in the originating system ultimately matched the information reported in the MMIS. We evaluated and documented differences in claim element values, including missing values. Results were tallied for percent of matching values, broken out by vendor, claim type, and data element. Our observations and recommendations concerning potential encounter accuracy issues for specific subcontractors are addressed in each section below. Additional detail is available in *Exhibit II: Supporting Detail for Encounter Submissions and Payment Systems*.

Fee-for-Service Claims, Institutional and Professional – CareSource

Encounter Submission Completeness

Myers and Stauffer reviewed approximately 1.8 million claim lines adjudicated by CS for institutional and professional fee-for-service (FFS) claims. Encounter submission completeness is expressed as a percentage of the sampled claim lines appearing at multiple points in the claim/encounter life cycle. Sampled CMO claim lines were compared to MMIS encounters and the percentage of lines appearing in both data sources or appearing in only one data source is outlined in the table below. The percentage of

sampled lines appearing only in the CMO claims, and the percentage of sampled lines appearing only in the MMIS encounters are further broken out in the bullets below each percentage. Additional observations are provided in the following section for percentages greater than 0.2 percent.



Encounter Submission Completeness	
99.1%†	**Percentage of sampled lines appearing in both the CMO's claims and the State's MMIS encounters.**
0.9%	**Percentage of sampled lines appearing only in the CMO's claims.**
	• ***Other (0.8%)*** *– A claim line with insufficient information available to explain their absence as an encounter.* • ***Alternative Found (0.1%)*** *– Claim lines that did not appear to exist as encounters for which a different version or adjustment was found.* • ***Denied (0.1%)*** *– A claim line denied for payment by the CMO during their claim adjudication process due to authorization, eligibility, limits issues, or other reasons.*
0.1%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**

†Note, percentages greater than 0% but less than 0.1% are rounded up to 0.1%. Percentages greater than 99.9% but less than 100% are rounded down to 99.9%. Due to rounding, percentages may not always add to 100%.

CMO's Claims not Found in the MMIS Encounters

- ***Other.*** *Approximately 14,700 (0.8 percent) CS FFS claim lines in the CMO's claims did not appear to exist as encounter claim lines in the MMIS. A portion of these claim lines (approximately 1,400 or 0.1 percent) were flagged as rejected by the MMIS, implying encounter submission was attempted but unsuccessful. There is no additional information present to explain the absence of these claim lines from the MMIS.*

Encounter Submission Accuracy

Myers and Stauffer reviewed claim lines which appeared to exist in both the CMO's claims and MMIS encounters. We compared data values reported in each data source for a series of claim data elements and calculated the percentage of lines with matching data values for each data element.

Myers and Stauffer observed the following CS data elements whose inaccuracy could have concerning impact on the use of encounters for program management, PI, and regulatory reporting.

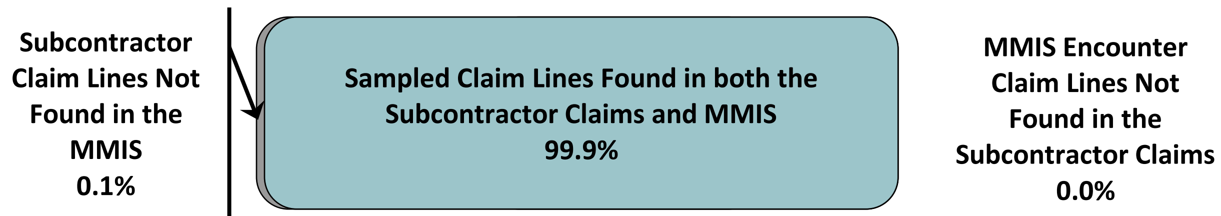
- ***Date Claim Submitted to CS by the Provider (Institutional and Professional Encounters).*** *The claim receipt date in the MMIS encounters appeared to have been consistently misreported to be the same as the claim's paid date.*
- ***Date Paid (Institutional and Professional Encounters).*** *For approximately 3.1 percent of the detail lines in the MMIS encounters, the claim paid date did not match the value found in the claims extracts submitted by CS. For most of these cases, the paid date in the MMIS encounters appeared to have been reported one to three days after the paid date in the CS extracts.*
- ***Amount Paid, Claim Detail Lines (Institutional Encounters Only).*** *Approximately 1.6 percent of institutional claim lines in the CS encounters had detail line paid amounts that did not match the value in CS's claims extracts. These discrepancies took a number of forms, among them, the inclusion/exclusion of Georgia hospital add-on payments in the claims but not encounters, the amount paid at the header level not equaling the sum of the detail lines, and the inclusion/exclusion of interest payments in claims but not encounters.*
- ***Denial Indicator (Institutional Encounters Only).*** *For approximately 1.5 percent of institutional claim lines in the MMIS encounters, the denial indicator did not match the value found in the claims extracts submitted by CS. The majority of these claim lines were identified as $0 paid in the claims extracts, but identified as denied in the MMIS encounters.*
- ***International Classification of Diseases (ICD) Diagnosis Codes (Institutional and Professional Encounters).*** *The majority of diagnosis codes billed on the CS extracts appeared to be reported in the detail lines in the MMIS encounters; however, the ordering of diagnosis codes in the MMIS encounters may not always match the ordering of diagnosis codes as reported in the CS extracts.*
- ***Payee Provider Tax ID (Professional Encounters Only).*** *Approximately 8.1 percent of professional claim lines in the CS encounters appeared to have payee provider tax IDs that were derived from the claim's rendering provider. They may not accurately reflect the claim payee/billing provider submitted on the claim itself.*
- ***Rendering Provider National Provider Identifier (NPI) (Institutional and Professional Encounters).*** *For approximately 45.4 percent of the detail lines in the MMIS encounters for CS, the rendering provider's NPI did not match the value found in the claims extracts submitted by CS. For the majority of these claim lines, the rendering provider NPI did not appear to be reported in the CS claims extracts.*
- ***Operating Provider NPI (Institutional Encounters Only).*** *For approximately 31.3 percent of institutional claim lines in the MMIS encounters for CS, the operating provider NPI appeared to be reported in the CS claims extracts, but missing in the MMIS encounters.*

Exhibit II: Supporting Detail for Encounter Submissions and Payment Systems comprises additional detail concerning the accuracy of all data elements reviewed for institutional encounters (*Table 17*) and professional encounters (*Table 18*).

Dental Claims – SKYGEN

Encounter Submission Completeness

Myers and Stauffer reviewed approximately 280,500 claim lines adjudicated by SKYGEN for dental claims. Encounter submission completeness is expressed as a percentage of the sampled claim lines appearing at multiple points in the claim/encounter life cycle. Sampled subcontractor claim lines were compared to MMIS encounters, and the percentage of lines appearing in both data sources or appearing in only one data source is outlined in the table below.



Encounter Submission Completeness	
99.9%†	**Percentage of sampled lines appearing in both the subcontractor's claims and the State's MMIS encounters.**
0.1%	**Percentage of sampled lines appearing only in the subcontractor's claims.**
0.0%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**
	All claim lines were found in the claims extracts, or in the claims extracts and the MMIS encounters.

†Note, percentages greater than 0% but less than 0.1% are rounded up to 0.1%. Percentages greater than 99.9% but less than 100% are rounded down to 99.9%. Due to rounding, percentages may not always add to 100%.

Encounter Submission Accuracy

Myers and Stauffer reviewed claim lines which appeared to exist in both the subcontractor's claims and MMIS encounters. We compared data values reported in each data source for a series of claim data elements and calculated the percentage of lines with matching data values for each data element.

Myers and Stauffer observed the following SKYGEN data elements whose inaccuracy could have concerning impact on the use of encounters for program management, PI, and regulatory reporting.

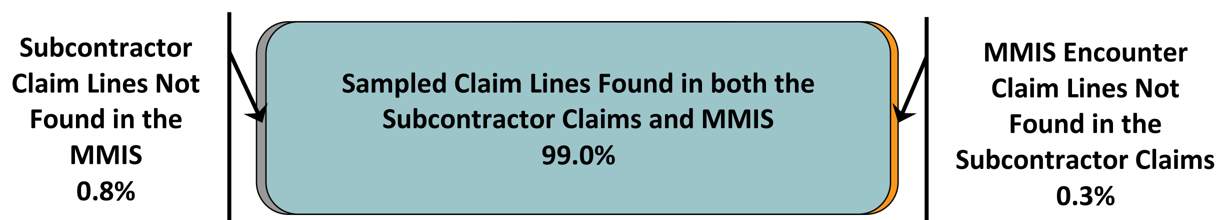
- ***Date Claim Submitted to SKYGEN by the Provider.*** *The claim receipt date in the MMIS encounters appeared to have been consistently misreported as the same as the claim's paid date.*
- ***Interest Paid.*** *We normally expect interest paid amounts to be identified with an adjustment reason code. No identifiable interest amounts were observed to exist in the MMIS dental encounters for SKYGEN.*
- ***Payee Provider Tax ID.*** *Approximately 6.8 percent of the detail lines in the SKYGEN encounters appeared to have payee provider tax IDs that were derived from the claim's rendering provider. They may not accurately reflect the claim payee/billing provider submitted on the claim itself.*
- ***Rendering Provider NPI.*** *For approximately 6.5 percent of the detail lines in the SKYGEN encounters the rendering provider's NPI did not match the value found in the claims extracts submitted by SKYGEN. For the majority of these cases, it appears the rendering provider NPIs share a common payee/billing Medicaid provider ID.*
- ***Tooth Number.*** *For approximately 5.9 percent of the detail lines in the MMIS encounters for SKYGEN, the tooth number appeared to be reported in the claims extracts, but missing in the MMIS encounters.*

Exhibit II: Supporting Detail for Encounter Submissions and Payment Systems, Table 19 comprises additional detail concerning the accuracy all dental data elements reviewed.

Vision Claims – Versant Vision

Encounter Submission Completeness

Myers and Stauffer reviewed approximately 23,200 claim lines adjudicated by Versant Vision for vision claims. Encounter submission completeness is expressed as a percentage of the sampled claim lines appearing at multiple points in the claim/encounter life cycle. Sampled subcontractor claim lines were compared to MMIS encounters and the percentage of lines appearing in both data sources or in only one data source is outlined in the table below. The percentage of sampled lines appearing only in the subcontractor claims and the percentage of sampled lines appearing only in the MMIS encounters are further broken out in the bullets below each percentage. Additional observations are provided in the following section for percentages greater than 0.2 percent.



Encounter Submission Completeness	
99.0%†	**Percentage of sampled lines appearing in both the subcontractor's claims and the State's MMIS encounters.**
0.8%	**Percentage of sampled lines appearing only in the subcontractor's claims.**
	• ***Other (0.5%)*** *– A claim line with insufficient information available to explain its absence as an encounter.* • ***Alternative Version Found (0.2%)*** *– Claim lines that did not appear to exist as encounters for which a different version or adjustment was found.* • ***Denied (0.1%)*** *– A claim line denied for payment by the subcontractor during their claim adjudication process due to authorization, eligibility, limits issues, or other reasons.*
0.3%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**
	• ***Other (0.2%)*** *– An encounter line with insufficient information available to explain its absence from the subcontractor's claims.* • ***Alternative Found (0.1%)*** *– Encounter lines that did not appear to exist as claim lines for which a different version or adjustment was found.*

†Note, percentages greater than 0% but less than 0.1% are rounded up to 0.1%. Percentages greater than 99.9% but less than 100% are rounded down to 99.9%. Due to rounding, percentages may not always add to 100%.

Versant Vision Claims Not Found in the MMIS Encounters

- ***Other.*** *Approximately 120 (0.5 percent) Versant Vision claim lines in the subcontractor's claims did not appear to exist as encounter claim lines in the MMIS. There is no additional information present to explain the absence of these claim lines from the MMIS.*
- ***Alternative Found.*** *Approximately 50 (0.2 percent) Versant Vision claim lines in the subcontractor's claims did not appear to exist in the MMIS; however, an alternate version or adjustment of the claim line was found in the MMIS. Approximately 45 (0.2 percent) of these claim lines appear to have alternate versions with matching line payment amounts and paid date when compared to the associated version identified in the MMIS.*

MMIS Encounters Not Found in the Versant Vision Claims

- ***Other.*** *Approximately 50 (0.2 percent) Versant Vision encounter claim lines in the MMIS did not appear to exist in the subcontractor's claims. There is no additional information present to explain the absence of these claim lines from the subcontractor's claims.*

Encounter Submission Accuracy

Myers and Stauffer reviewed claim lines which appeared to exist in both the subcontractor's claims and MMIS encounters. We compared data values reported in each data source for a series of claim data elements and calculated the percentage of lines with matching data values for each data element.

Myers and Stauffer observed the following Versant Vision data elements whose inaccuracy could have concerning impact on the use of encounters for program management, PI, and regulatory reporting.

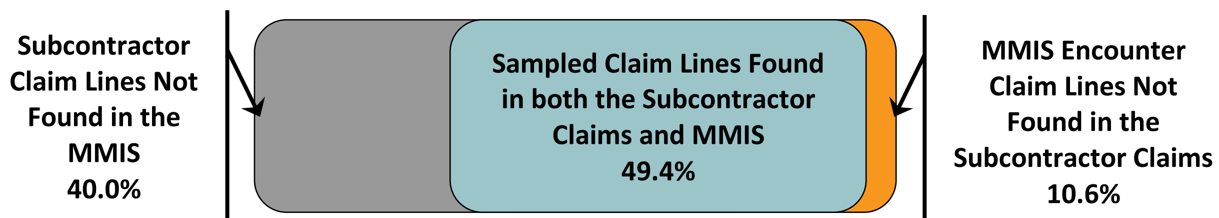
- ***Date Claim Submitted to Versant Vision by the Provider.*** *The claim receipt date in the MMIS encounters appeared to have been consistently misreported to be the same as the claim's paid date.*
- ***Interest Paid.*** *We normally expect interest paid amounts to be identified with an adjustment reason code. No identifiable interest amounts were observed to exist in the MMIS vision encounters for Versant Vision.*
- ***Denial Indicator.*** *For approximately 1.5 percent of the detail lines in the MMIS vision encounters, the denial indicator did not match the value found in the claims extracts submitted by Versant Vision. The majority of these claim lines were identified as $0 paid in the claims extracts, but identified as denied in the MMIS encounters.*
- ***Payee Provider Tax ID.*** *Approximately 22.1 percent of the detail lines in the Versant Vision encounters appeared to have payee provider tax IDs that were derived from the claim's rendering provider. They may not accurately reflect the claim payee/billing provider submitted on the claim itself.*

Exhibit II: Supporting Detail for Encounter Submissions and Payment Systems, Table 20 comprises additional detail concerning the accuracy of all vision data elements reviewed.

Pharmaceutical Claims – Express Scripts, Inc.

Encounter Submission Completeness

Myers and Stauffer reviewed approximately 908,500 claim lines adjudicated by ESI for pharmaceutical claims. Encounter submission completeness is expressed as a percentage of the sampled claim lines appearing at multiple points in the claim/encounter life cycle. Sampled subcontractor claim lines were compared to MMIS encounters and the percentage of lines appearing in both data sources or appearing in only one data source is outlined in the table below. The percentage of sampled lines appearing only in the subcontractor claims and the percentage of sampled lines appearing only in the MMIS encounters are further broken out in the bullets below each percentage. Additional observations are provided in the following section for percentages greater than 0.2 percent.



Encounter Submission Completeness	
49.4%†	**Percentage of sampled lines appearing in both the subcontractor's claims and the State's MMIS encounters.**
40.0%	**Percentage of sampled lines appearing only in the subcontractor's claims.**
	• ***Rejected or Denied (27.9%)*** *– A claim line rejected or denied for payment by the subcontractor during their claim adjudication process due to authorization, eligibility, limits issues, or other reasons.* • ***Alternative Version Found (11.7%)*** *– Claim lines that did not appear to exist as encounters for which a different version or adjustment was found.* • ***Other (0.4%)*** *– A claim line with insufficient information available to explain its absence as an encounter.*
10.6%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**
	• ***Other (7.9%)*** *– An encounter line with insufficient information available to explain its absence from the subcontractor's claims.* • ***Alternative Found (1.9%)*** *– Encounter lines that did not appear to exist as claim lines for which a different version or adjustment was found.* • ***Rejected or Denied (0.8%)*** *– An encounter line rejected or denied for payment by the subcontractor during their claim adjudication process due to authorization, eligibility, limits issues, or other reasons.*

†Note, percentages greater than 0% but less than 0.1% are rounded up to 0.1%. Percentages greater than 99.9% but less than 100% are rounded down to 99.9%. Due to rounding, percentages may not always add to 100%.

ESI Claims Not Found in the MMIS Encounters

- ***Rejected or Denied.*** *Approximately 253,800 (27.9 percent) ESI pharmaceutical claim lines appear to be rejected or denied in the subcontractor's claims, but do not appear to exist in the MMIS. It appears that ESI may not be submitting all rejected or denied encounter claim lines to the MMIS.*
- ***Alternative Found.*** *Approximately 105,900 (11.7 percent) ESI pharmaceutical claim lines in the subcontractor's claims did not appear to exist in the MMIS; however, an alternate version or adjustment of the claim line was found in the MMIS. Of these claim lines, we observed instances of claim lines that appear to be denied or rejected, and a later version of the claim line appears to be paid and reported in the MMIS. Alternatively, approximately 900 (0.1 percent) claim lines appear to have alternate versions with matching line payment amounts when compared to the associated version identified in the MMIS.*
- ***Other.*** *Approximately 3,200 (0.4 percent) ESI pharmaceutical claim lines in the subcontractor's claims did not appear to exist as encounter claim lines in the MMIS and there is no additional information present to explain the absence from the MMIS.*

MMIS Encounters Not Found in the ESI Claims

- ***Other.*** *Approximately 72,000 (7.9 percent) ESI pharmaceutical encounter claim lines in the MMIS did not appear to exist in the subcontractor's claims. There is no additional information present to explain the absence of these claim lines from the subcontractor's claims.*
- ***Alternative Found.*** *Approximately 16,900 (1.9 percent) ESI pharmaceutical encounter claim lines in the MMIS did not appear to exist in the subcontractor's claims; however, an alternate version or adjustment of the claim line was found in the subcontractor's claims.*
- ***Rejected or Denied.*** *Approximately 7,300 (0.8 percent) ESI pharmaceutical encounter claim lines in the MMIS appear to be rejected or denied, but do not appear to exist in the subcontractor's claims.*

Encounter Submission Accuracy

Myers and Stauffer reviewed claim lines which appeared to exist in both the subcontractor's claims and MMIS encounters. We compared data values reported in each data source for a series of claim data elements and calculated the percentage of lines with matching data values for each data element.

Myers and Stauffer observed the following ESI data elements whose inaccuracy could have concerning impact on the use of encounters for program management, PI, and regulatory reporting.

- ***Payee Provider Tax ID.*** *Approximately 4.3 percent of the MMIS encounters for ESI appeared to have payee provider tax IDs that were derived from the claim's dispensing provider. They may not accurately reflect the claim payee/billing provider submitted on the claim itself.*
- ***Dispensing Provider NPI.*** *For approximately 1.7 percent of the MMIS encounters, the dispensing provider NPI did not match the value found in the claims extracts submitted by ESI.*
- ***Amount Billed.*** *The billed amount reported in the MMIS encounters did not appear to match the value found in the claims extracts submitted by ESI. The billed amount reported in the MMIS encounters appears to represent the claim paid amount.*

Exhibit II: Supporting Detail for Encounter Submissions and Payment Systems, Table 21 comprises additional detail concerning the accuracy of all ESI pharmaceutical data elements reviewed.

Cash Disbursement Journal Verification

Introduction

Georgia DCH requires that each of their contracted CMOs submit encounter data to the FAC, Gainwell. Myers and Stauffer provides bi-monthly encounter data validations to ensure DCH is receiving complete encounter data. As part of this process, Myers and Stauffer analyzes Medicaid encounter data that has been submitted by the CMOs to Gainwell and completes a reconciliation of the encounters to CDJs provided by each CMO.

Myers and Stauffer receives CDJ files from CS and their subcontractors on a monthly basis. These CDJ files are created to represent all payment transactions made by CS and their subcontractors to providers during each month. We utilize this information as the denominator in the completeness calculation of encounter data for the Georgia Families® program. The encounter reconciliation process uses CDJ files as the primary source document for encounter data validations, so it is important to independently verify the information in the CMO and subcontractor CDJ submissions periodically. In this review, we are comparing the CDJ files for a sample month to an independent financial data source to ensure the encounters are being reconciled against complete and accurate financial information in the CDJ files.

Methodology and Data Sources

In order to verify the CDJ data, Myers and Stauffer requested information from a separate accounting source (e.g., check register, bank statement, or general ledger), independent of the CDJ data, for payments and recoupments made during May 2022 (the sample month) from CS and their subcontractors for Georgia Families®.

Myers and Stauffer sent the request below to CS in September 2022:

> *"Myers and Stauffer is also requesting additional documentation to verify the CDJ data used to determine encounter completeness. Please provide a bank statement, check register, or similar accounting ledger for payments and recoupments made for CS Georgia Medicaid members in the month of **May 2022**. Please reconcile this information against the CDJ file submissions for the month and document any variance you identify. Note any variance you are unable to reconcile and clarify if CDJ resubmission(s) will be necessary.*
>
> *Please provide the requested documentation for Medicaid claim expenditures and recoupments processed by CS, as well as its delegated vendors SKYGEN, Versant Vision, and Express Scripts. Please provide the requested data to Myers and Stauffer by **October 14, 2022** via secure FTP."*

Analysis and Recommendations

The validation documentation received from CS was compared to the CS and subcontractor CDJ submissions for the sample month. A summary of the results of this analysis are presented in the following report sections devoted to our observations for specific subcontractors.

The results of our review of cash disbursement data for CS and their subcontractors indicates that the sample month CDJ file submissions are **not** accurate. The CDJ files appear to be missing or including extra records that do not reflect the checkwrite. Further explanation will be presented in the report below.

During the course of our review, we identified some potential opportunities for the implementation and/or improvement of processes by the CMOs and their subcontractors to validate their CDJ file submissions on a consistent basis. **We recommend the CMOs develop financial reconciliation processes to continuously monitor the completeness and accuracy of their CDJ files submissions against independent financial sources.**

Fee-for-Service Claims, Institutional and Professional – CareSource

CS provided detailed checkwrite expenditure data for this review. Checkwrite expenditures were supplied with the checkwrite date. This date appears to represent the payment posting date, and often occurs after the CDJ transaction date for a given expenditure. To compensate for the difference in dates between the CDJ and checkwrite, we calculated the checkwrite date for all CDJ expenditures based on the CS payment processing schedule. We also expanded our review of FFS CDJ expenditures to those having transaction dates between April 28, 2022 and June 1, 2022 to match the time period covered by the supplied checkwrite expenditures.

Furthermore, checkwrite expenditures were supplied for multiple lines of business in order to reconcile the checkwrite to additional supplied CS bank statements. The line of business for each checkwrite expenditure was identified by the following abbreviations:

- ***GA01** – Georgia Medicaid*
- ***HXGA** – Georgia Marketplace*
- ***DSGA** – Georgia DSNP*
- ***#N/A** – Not tied to a line of business*

We summarized the checkwrite payments by the supplied checkwrite date in the table below, with the corresponding matched claim payments from the CDJ files. The checkwrite paid amount below only includes the GA01 line of business, as CS stated the other lines refer to non-Medicaid transactions. The

checkwrite paid amount for the other lines of business not included in the summary below totaled approximately $17.42 million.

Table 6: CS FFS CDJ to Verification Documentation Comparison

CS FFS CDJ to Verification Documentation Comparison						
Verification Documentation		CDJ Submissions			Comparison	
Checkwrite Date	Paid Amount*	First Transaction Date	Last Transaction Date	Transaction Amount	Variance	Verification Percentage
5/2/2022	$10,128,147	4/28/2022	5/2/2022	$10,209,691	$81,544	100.8%
5/4/2022	$6,527,952	5/3/2022	5/4/2022	$6,487,598	-$40,354	99.4%
5/9/2022	$10,102,608	5/5/2022	5/9/2022	$10,177,088	$74,480	100.7%
5/11/2022	$6,714,576	5/10/2022	5/11/2022	$6,721,352	$6,776	100.1%
5/16/2022	$13,894,517	5/12/2022	5/16/2022	$13,851,161	-$43,356	99.7%
5/18/2022	$7,928,604	5/17/2022	5/18/2022	$7,965,092	$36,488	100.5%
5/20/2022	$3,281	5/19/2022	5/20/2022	$0	-$3,281	0.0%
5/23/2022	$11,052,103	5/21/2022	5/23/2022	$11,244,407	$192,304	101.7%
5/25/2022	$6,405,902	5/24/2022	5/25/2022	$6,240,016	-$165,886	97.4%
5/31/2022	$10,998,622	5/26/2022	5/31/2022	$11,096,668	$98,046	100.9%
6/1/2022	$6,811,013	6/1/2022	6/1/2022	$6,880,132	$69,118	101.0%
TOTAL	**$90,567,327**			**$90,873,205**	**$305,879**	**100.3%**

**Please note that the Paid Amount above only includes line of business GA01 from the checkwrite. Lines HXGA, #N/A, and DSGA are not included above.*

Overall, the verification data reported approximately $305,800 less in payments when compared to the CDJ files, representing a potential over-reporting of payments in the CDJ. Upon further review, we identified several potential issues that contribute to the observed variance, as outlined in *Table 7*. For expenditures processed in May 2023, the net variance from these issues is a relatively small percentage of the overall reported payments; however, these issues may contribute to more significant variances for other months. Additional explanation for each of the potential issues is provided below the table.

Table 7: CS FFS CDJ Verification Potential Issues

CS FFS CDJ Verification Potential Issues			
Potential Issue	Checkwrite Paid Amount	CDJ Transaction Amount†	Variance
CS CDJ expenditures not identified in checkwrite	$0	$5,940,561	$5,940,561
Checkwrite expenditures not identified in the CS CDJs	$4,262,162	$0	-$4,262,162
CS CDJ expenditures potentially matched to non-Medicaid checkwrite expenditures	$0	$812,327	$812,327
Mismatched payment date	$33,148	$0	-$33,148

CS FFS CDJ Verification Potential Issues			
Potential Issue	**Checkwrite Paid Amount**	**CDJ Transaction Amount†**	**Variance**
Sum of CS CDJ transaction amounts do not equal CDJ check amounts	$15,599,927	$13,448,227	-$2,151,700
TOTAL	**$19,895,237**	**$20,201,115**	**$305,878**

†CDJ submissions limited to expenditures having a transaction date between April 28, 2022 and June 1, 2022.

- ***CS CDJ Expenditures not Identified in Checkwrite.*** *We observed approximately 27,650 CDJ records with a transaction date from April 28, 2022 to June 1, 2022 that did not appear in the CS checkwrite data. These expenditures totaled approximately $5.94 million, and the majority of these expenditures had a transaction date of June 1, 2022. CS responded stating that the majority of the records on June 1, 2022 were part of a Friday night batch process with the following Monday being a bank holiday, affecting the timing on when the claims could be processed. CS also stated that some of the identified CDJ records were cashless transactions with a payment recovery associated with the CDJ transaction. The CMO stated that if the CDJ nets to zero, it does not get an associated expenditure record in the checkwrite system.*
- ***Checkwrite Expenditures not Identified in the CS CDJs.*** *We observed approximately 2,170 checkwrite expenditures for the Georgia Medicaid line of business that did not appear to be reported in the CS CDJ. These expenditures totaled approximately $4.26 million. CS explained that the source date for the CDJ is the minimum check status date. CS has reviewed their code and determined that the check status date may not be correct on certain records, causing the date to be different from what is presented in its system.*
- ***CS CDJ Expenditures Potentially Matched to Non-Medicaid Checkwrite Expenditures.*** *CS indicated checkwrite expenditures having a line of business abbreviation GA01 were for Georgia Medicaid expenditures and expenditures having a different line of business abbreviation were for other markets and should not be reported on the CDJ. Nevertheless, we identified approximately 4,960 CDJ expenditures that appear to match to checkwrite expenditures having a line of business abbreviation of #N/A (not tied to a line of business) and HXGA (Georgia Marketplace). These expenditures totaled approximately $0.81 million. CS CDJs may include expenditure transactions for non-Medicaid services.*
- ***Mismatched Payment Date.*** *We identified a large number of checkwrite expenditures that appeared to be reported in the CS CDJs, but where the CDJ transaction dates differed significantly from the CS checkwrite date. Most of the records with different dates differ between the CDJ and the checkwrite by over a month. CS expenditures outside the dates of April 28, 2022 to June 1, 2022 totaled approximately $33,300, affecting roughly 250 records. CS has responded to the records by stating they were stale checks that were re-issued in May 2022 on an instance of a recalled and reissued payment. CS has stated they believe the CDJ is reporting these*

amounts correctly as we have informed the CMO that reissued checks should not be included in the CDJ multiple times.

- ***Sum of CS CDJ Transaction Amounts do not Equal CDJ Check Amounts.*** *CS CDJs include detail transaction amounts for individual encounter services, as well as total check amounts to providers. CDJ check payments often include multiple transactions. In general, we would expect the sum of detail CDJ transaction amounts to equal the total check amount; however, we understand some check payments may include one or more transactions from non-Medicaid lines of business, and we would not expect to observe these non-Medicaid transactions in the CDJ. As such, we expect to observe some mismatch between the sum of CDJ transaction amounts and CDJ total check amounts. Nevertheless, we did observe provider check payments in the CDJ that were matched to CS checkwrite expenditures having a line of business of GA01 (Georgia Medicaid) and where the sum of the CDJ transaction amounts did not match the CDJ total check amount. Since these payments were identified as Georgia Medicaid in the CS checkwrite, we would assume all associated transactions were for Georgia Medicaid and we would expect all associated transactions to be included in the CDJ; however, that may not have been the case. We identified approximately 27,800 CDJ transactions matched to Georgia Medicaid expenditures in the CS checkwrite where the sum of CDJ transactions did not match the CDJ total check amount. The sum of CDJ transactions for these expenditures was approximately $2.15 million less than the sum of the associated CDJ total check amounts.*

Dental Claims – SKYGEN

SKYGEN submitted May 2022 check invoice details as their verification documentation. We summarized the check register payments by the supplied expenditure pay date and the CDJ files by transaction date in *Table 8*.

Table 8: SKYGEN Dental CDJ to Verification Documentation Comparison

SKYGEN Dental CDJ to Verification Documentation Comparison					
Verification Documentation		CDJ Submissions		Comparison	
Pay Date	Paid Amount	Transaction Date	Transaction Amount	Variance	Verification Percentage
5/2/2022	$1,318,224	5/2/2022	$1,318,390	$166	100.0%
5/9/2022	$933,511	5/9/2022	$933,511	$0	100.0%
5/16/2022	$1,164,692	5/16/2022	$1,163,716	-$975	99.9%
5/23/2022	$815,784	5/23/2022	$815,784	$0	100.0%
5/30/2022	$1,231,380	5/30/2022	$1,231,380	$0	100.0%
TOTAL	**$5,463,590**		**$5,462,781**	**-$809**	**100.0%**

Overall, the verification data had approximately $809 more in payments when compared to the CDJ files, but appears to be due to offsets to provider balances. This discrepancy is further explained below.

- ***CDJ Expenditure not Appearing in SKYGEN Check Register.*** *We identified a single CDJ transaction for May 2, 2022 with a payment amount of $166.12 which does not appear to be included in the SKYGEN check register. The total check amount reported in the CDJ for this transaction is $0.*
- ***CDJ Reversal not Appearing in SKYGEN Check Register.*** *We identified a single CDJ reversal (negative) transaction for May 16, 2022 with a reversal amount of -$975.18 which does not appear to be included in the SKYGEN check register. The total check amount reported in the CDJ for this transaction is $0.*

Vision Claims – Versant Vision

Versant Vision submitted check register details and weekly automated clearing house summaries for May 2022 as its verification documentation. We compared the weekly payments to the summarized CDJ files in *Table 9*.

Table 9: Versant Vision CDJ to Verification Documentation Comparison

Versant Vision CDJ to Verification Documentation Comparison					
Verification Documentation		CDJ Submissions		Comparison	
Check Date	Paid Amount	Transaction Date	Transaction Amount	Variance	Verification Percentage
5/1/2022	$28,034	5/1/2022	$27,928	-$106	99.6%
5/2/2022	$306	5/2/2022	$306	$0	100.0%
5/8/2022	$42,973	5/8/2022	$42,846	-$127	99.7%
5/9/2022	$339	5/9/2022	$339	$0	100.0%
5/11/2022	$16,019	5/11/2022	$15,921	-$98	99.4%
5/12/2022	$220	5/12/2022	$220	$0	100.0%
5/15/2022	$27,158	5/15/2022	$27,194	$36	100.1%
5/16/2022	$159	5/16/2022	$159	$0	100.0%
5/18/2022	$18,194	5/18/2022	$18,194	$0	100.0%
5/22/2022	$29,228	5/22/2022	$29,130	-$98	99.7%
5/23/2022	$272	5/23/2022	$272	$0	100.0%
5/25/2022	$12,857	5/25/2022	$12,857	$0	100.0%
5/30/2022	$26,595	5/30/2022	$26,595	$0	100.0%
TOTAL	**$202,354**		**$201,961**	**-$393**	**99.8%**

Overall, the verification data included approximately $393 more in payments when compared to the CDJ files, representing a potential under-reporting of payments in the CDJ. The majority of this variance is due to four transactions being duplicated in the CDJ. Versant has confirmed this issue and has identified and corrected its logic to prevent this issue going forward.

Pharmaceutical Claims – Express Scripts, Inc.

ESI submitted check invoice details for May 2022 as verification documentation. We matched check invoice detail transactions to their corresponding CDJ transactions, and summarized check invoice and CDJ expenditures in *Table 10*. The supplied invoice date is different from the CDJ transaction date, and CDJ transactions associated with a given invoice date can cover a span of transaction dates. The first and last CDJ transaction dates are reported in the summary table below to reflect the span of CDJ transaction dates associated with each invoice date.

Table 10: ESI/Carelon Verification Documentation to CDJ Comparison

ESI/Carelon Verification Documentation to CDJ Comparison						
Verification Documentation		CDJ Submissions			Comparison	
Invoice Date	Paid Amount	First Transaction Date	Last Transaction Date	Transaction Amount	Variance	Verification Percentage
5/3/2022	$2,452,954	4/12/2022	5/13/2022	$2,452,910	-$44	100.0%
5/10/2022	$2,592,254	4/21/2022	5/20/2022	$2,592,483	$229	100.01%
5/17/2022	$2,630,040	5/12/2022	5/27/2022	$2,630,012	-$28	100.0%
5/24/2022	$2,476,618	5/17/2022	6/3/2022	$2,476,551	-$67	100.0%
5/31/2022	$1,887,658	5/19/2022	6/10/2022	$1,887,660	$2	100.0%
TOTAL	**$12,039,524**			**$12,039,616**	**$94**	**100.0%**

Overall, the verification data included approximately $94 less in payments when compared to the CDJ files, representing a potential over-reporting of payments in the CDJ. This discrepancy is due to approximately 56 expenditures in the invoice data that do not appear in the ESI CDJ. ESI provided the following explanation for these expenditures:

- *For nine of the identified invoice expenditures, totaling approximately $134, ESI indicated the expenditure has an invoice date in May 2022, but a CDJ transaction date not in May 2022. Please note, Myers and Stauffer reviewed all ESI CDJ submissions supplied as of April 1, 2023, regardless of transaction date, in an attempt to identify these invoice expenditures, but we were unable to find the apparent missing expenditures.*
- *For 31 of the identified invoice expenditures, totaling approximately -$126, ESI indicated the expenditures were part of an interim step in an adjustment, were not included in the encounter file, and therefore, were not included in the CDJ (e.g., in-cycle adjustments).*
- *For 16 of the identified invoice expenditures, totaling approximately -$102, ESI indicated the expenditures represented MCO price adjustment claims and were reported on the encounters.*

Differences between the invoice date and CDJ transaction date prevented us from fully validating the completeness of the CDJ for expenditures processed in May 2022. *Table 11* presents a summary of daily CDJ expenditures in May 2022 compared to associated ESI invoice expenditures. We were able to

confirm that all CDJ transactions with a transaction date between May 9, 2022 and May 31, 2022 appear to reconcile to the supplied invoice data. CDJ transactions between May 1, 2022 and May 8, 2022 partially reconcile to the supplied invoice data, and we expect the observed variance for these transaction dates is due to the limited scope of the supplied invoice data.

Table 11: ESI/Carelon CDJ to Verification Documentation Comparison

ESI/Carelon CDJ to Verification Documentation Comparison						
CDJ Submissions		Verification Documentation			Comparison	
Transaction Date	Transaction Amount	First Invoice Date	Last Invoice Date	Paid Amount	Variance	Verification Percentage
5/2/2022	$815,276	5/3/2022	5/3/2022	$120,640	$694,637	14.8%
5/3/2022	$655,729	5/3/2022	5/10/2022	$246,875	$408,855	37.6%
5/4/2022	$9,848	5/3/2022	5/10/2022	$515	$9,332	5.2%
5/5/2022	$1,180,714	5/3/2022	5/10/2022	$745,513	$435,200	63.1%
5/6/2022	$3,283	5/3/2022	5/3/2022	$2,363	$920	72.0%
5/9/2022	$767,151	5/3/2022	5/10/2022	$767,151	$0	100.0%
5/10/2022	$650,306	5/3/2022	5/10/2022	$650,306	$0	100.0%
5/11/2022	$63,218	5/3/2022	5/10/2022	$63,218	$0	100.0%
5/12/2022	$976,203	5/3/2022	5/17/2022	$976,203	$0	100.0%
5/13/2022	$16,680	5/3/2022	5/10/2022	$16,680	$0	100.0%
5/16/2022	$800,162	5/10/2022	5/17/2022	$800,162	$0	100.0%
5/17/2022	$706,016	5/10/2022	5/24/2022	$706,016	$0	100.0%
5/18/2022	$19,360	5/10/2022	5/17/2022	$19,360	$0	100.0%
5/19/2022	$1,053,205	5/10/2022	5/31/2022	$1,053,205	$0	100.0%
5/20/2022	$53,566	5/10/2022	5/17/2022	$53,566	$0	100.0%
5/23/2022	$827,727	5/17/2022	5/24/2022	$827,727	$0	100.0%
5/24/2022	$667,606	5/17/2022	5/24/2022	$667,606	$0	100.0%
5/25/2022	$21,007	5/17/2022	5/31/2022	$21,007	$0	100.0%
5/26/2022	$1,001,255	5/17/2022	5/31/2022	$1,001,255	$0	100.0%
5/27/2022	-$4,824	5/17/2022	5/24/2022	-$4,824	$0	100.0%
5/30/2022	$779,231	5/24/2022	5/31/2022	$779,230	$0	100.0%
5/31/2022	$663,531	5/24/2022	5/31/2022	$663,531	$0	100.0%
TOTAL	**$11,726,250**			**$10,177,305**	**$1,548,944**	**86.8%**

Findings and Recommendations

Table 12 summarizes the findings and recommendations identified during this engagement and are based on the data and documentation provided by CS and the information obtained during virtual interviews.

Table 12: Findings and Recommendations

Findings and Recommendations			
Entity	**Functional Area**	**Findings**	**Recommendation**
DCH	**Program Integrity**	During a virtual interview discussion, CS indicated that they do not pursue overpayments under $500.00.	DCH should consider updating its contract with the CMOs to include language that addresses establishing parameters and thresholds for overpayment recoveries.
CS	**Encounter Submissions and Payment Systems**	During a virtual interview discussion, CS indicated that CDJs are being created from the claim system and not from the financial system. There is no reconciliation of the CDJs to financial documentation to ensure accuracy. Additionally, there is no reconciliation of delegated vendor CDJs to any financial reporting.	CS should reconcile their CDJs created from the claims system against financial data/information in order to ensure accurate payments and/or financial transactions, effective cash management, and responsible use of Medicaid funding.
CS	**Encounter Submissions and Payment Systems**	Myers and Stauffer observed potentially missing data in the MMIS, in particular, denied claim lines missing from the encounters submitted to the MMIS by ESI.	CS and its subcontractors should review their policies and procedures for the reporting of encounters to the MMIS and adjust their processes to ensure reliable reporting of claim lines.
CS	**Encounter Submissions and Payment Systems**	Myers and Stauffer observed mismatching claim data elements between the CS FFS claims, subcontractor encounters extracts, and the MMIS encounters.	CS and its subcontractors should review their policies and procedures for the reporting of encounters to the MMIS and adjust their processes to ensure reliable reporting of claim data elements.
CS	**Subcontractor Oversight**	During a virtual interview discussion, CS indicated they are not auditing or validating the data found	In order to ensure the appropriate oversight is occurring, CS should develop procedures to audit and

Findings and Recommendations			
Entity	**Functional Area**	**Findings**	**Recommendation**
		in the regulatory reports that they receive from subcontractors.	validate the data reported in their subcontractor's regulatory reports.
ESI	**Encounter Submissions and Payment Systems**	During a virtual interview discussion, ESI indicated they are not required to submit POS denials into encounters, so denials are not submitted.	CS should work with ESI to review its policies and procedures for the reporting of encounters to the MMIS and adjust its processes to ensure reliable reporting of all adjudicated claims, including denied claims. This will allow for a more accurate reconciliation of claims to encounters.
ESI	**Member Enrollment**	During a virtual interview discussion, ESI stated there is no file currently provided to allow ESI to confirm total enrollment matches with enrollment in the CS system.	CS should work with ESI to implement procedures that will include the submission of a master member data file (by CS) that can be used (by ESI) as the most accurate source of truth for member information.
SKYGEN	**Encounter Submissions and Payment Systems**	During a virtual interview discussion, SKYGEN disclosed that they are sending voids as adjustments in its 837 for encounter submissions. CS is then interpreting voids from the information provided.	CS should consider requiring SKYGEN to submit voided transactions as actual "voids" within the 837 file. This will mitigate the risk of incorrectly interpreting voided transactions within the 837 file.
SKYGEN	**Encounter Submissions and Payment Systems**	During a virtual interview discussion, SKYGEN disclosed that they are not performing any additional quality review of the encounter files or the claims proprietary formats prior to sending them to CS.	CS should work with SKYGEN to implement procedures to ensure complete and reliable reporting of encounters to CS. SKYGEN should consider implementing procedures to reconcile encounter submissions against applicable source supporting documentation. CS may also consider implementing procedures that will include the submission of control total response files (by CS to SKYGEN) upon receipt of encounter submissions from SKYGEN. SKYGEN may utilize these response files to further reconcile encounter data submissions in order to verify the completeness of SKYGEN encounters in CS systems.
SKYGEN	**Encounter Submissions and Payment Systems**	SKYGEN disclosed during virtual interview discussions that during the monthly claims audits,	SKYGEN should develop procedures in order to limit the number of claim errors made as a result of human invention. All errors should be reviewed to determine

Findings and Recommendations			
Entity	**Functional Area**	**Findings**	**Recommendation**
		they identified a limited number of errors due to human intervention.	if additional procedures should be implemented or if staff training is required to prevent future claim errors.
Versant	**Encounter Submissions and Payment Systems**	Based on virtual interview discussions with Versant staff, it appears that some claim sequences may not be submitted into the encounters in instances of adjustments occurring in the same week as original claims (only final state claims are submitted). This can also occur in cases where the original encounter is rejected and not corrected prior to an adjustment claim being finalized.	CS should work with Versant to implement procedures that will include the reporting of all claims sequences in encounters including adjustments resulting in a more accurate and detailed reconciliation.
Versant	**Encounter Submissions and Payment Systems**	Based on virtual interview discussions with Versant staff, there does not appear to be quality control and/or a reconciliation of the CDJ against source financial documentation to confirm completeness of the file.	CS should work with Versant to implement procedures that will include reconciling the CDJ against applicable source financial documentation to ensure accurate payments and/or financial transactions, effective cash management, and responsible use of Medicaid funding.

Exhibit I: Virtual Interview Schedules

Interviews with CS

In order to gain a better understanding of CS's policies and procedures for contract compliance, PI, encounter submissions, and subcontractor oversight, Myers and Stauffer interviewed the individuals listed in *Table 13* on the dates and at the locations indicated.

Table 13: CS Interviews

Date	Location	Interviewees	Title
10/25/2022	Atlanta Office	Andrea Hundley	Plan Compliance offer
10/25/2022	Atlanta Office	Dr. Csukas	Vice President, Market Chief Medical Officer
10/25/2022	Atlanta Office	Tracy Leslie, RN	Compliance Analyst II
10/25/2022	Atlanta Office	Katy Kuntz	Compliance Analyst II
10/25/2022	Atlanta Office	Amber Jones	Manager, Grievance and Appeals
10/25/2022	Atlanta Office	Celeste Acuna	Director, Grievance and Appeals
10/25/2022	Atlanta Office	Karen Spiers	Team Lead, Clinical Appeals
10/25/2022	Atlanta Office	Tiffany Parr	Assistant Vice President, Market Quality
10/25/2022	Atlanta Office	Brendan Ibe	Director, Enterprise Performance
10/25/2022	Atlanta Office	Susan Meece-Hinh	Quality Improvement Advisor
10/25/2022	Atlanta Office	Chasity Harvey	Team Lead, Member Engagement
10/25/2022	Atlanta Office	Candice Green	Regulatory Contract Manager
10/25/2022	Atlanta Office	Sheryl-Anne Murray	Vice President, Market Operations
10/26/2022	Atlanta Office	Becky Katzowitz	Senior Director, Network Performance and Engagement
10/26/2022	Atlanta Office	Melissa Nichols	Vice President, Network Strategy and Contracting
10/26/2022	Atlanta Office	Mike Woodley	Director of Provider Contracting
10/26/2022	Atlanta Office	Tynetra Bracken	Investigator III
10/26/2022	Atlanta Office	Lora Jones	Manager, Program Integrity
10/26/2022	Atlanta Office	Alexis Johnson	Director, Program Integrity
10/26/2022	Atlanta Office	Sangeet Rattan	Director, Pharmacy Operations (Lock In)
11/1/2022	Corporate	Paula Cissell	Compliance Director
11/1/2022	Corporate	Deronda Honig	Director of Clinical Operations
11/1/2022	Corporate	Kim Snowden	Manager Clinical Operations
11/1/2022	Corporate	Micahel Spivey	Senior Enrollment Operations

Date	Location	Interviewees	Title
11/1/2022	Corporate	Ryan Shafer	Senior Director, Claims Operations Claim Adjustments
11/1/2022	Corporate	Tammy Tominich	Senior Director, Front End Operations
11/1/2022	Corporate	Kristen Halsey	Director, Vendor Risk Management
11/1/2022	Corporate	Valarie Dubuc	Manager, Vendor Oversight
11/1/2022	Corporate	Alexandria McAdams	Resource Operations Analyst II
11/1/2022	Corporate	Tony Collins	Manager, Service Integration
11/1/2022	Corporate	Stephanie Beans	Manager, Service Center Customer Advocacy
11/1/2022	Corporate	Stacy Burns	Team Lead, Customer Care Training Delivery
11/1/2022	Corporate	Sean McDade	Director, Customer Care
11/1/2022	Corporate	Chris Gaier	Manager, Service Center
11/1/2022	Corporate	Dan Wilikins	Senior Director, Information Security Cyber Defense
11/1/2022	Corporate	Chris Harlow	Director, Information Security- IAM and 3rd Party Risk IAM Third Party Risk
11/1/2022	Corporate	Angi Moots	Director, Information Security- IT Risk and Compliance
11/1/2022	Corporate	Joydeep Mukherjee	Vice President Data Services, Senior Vice President IT Data and Enterprise Services
11/1/2022	Corporate	Roger Turner	Associate Director, Data Operations Senior Vice President IT Data and Enterprise Services
11/2/2022	Corporate	Nicole Johnson	Director, Enterprise HEDIS Operations and Analytics
11/2/2022	Corporate	Sami Hadaya	Application Developer III, Senior Vice President Data and Enterprise Services
11/2/2022	Corporate	Elizabeth Brady	Director, Market Intelligence
11/2/2022	Corporate	Kelly Valley	Associate Director, Data Governance and Data Solutions
11/2/2022	Corporate	Anna Stamper	Manager Finance Market Finance
11/2/2022	Corporate	Sarah North	Associate Director Accounting and Finance
11/2/2022	Corporate	Kyle Hollenbacher	Manager of Accounting Finance
11/2/2022	Corporate	Duyen Ngyuyen	Associate Director of Accounting and Finance
11/2/2022	Corporate	Jamie Kreitzer	Senior Director, National Vendor Network
11/2/2022	Corporate	Chelsi Hall	Manager Claims Encounter Data
11/2/2022	Corporate	Akbar Shareef	Associate Vice President Encounter Data
11/2/2022	Corporate	Michele Goode	Team Lead Claims Ebusiness
11/2/2022	Corporate	Sam Herbert	Technical Associate, Director IT Integration
11/2/2022	Corporate	Hariharan Naraimhan	Architect II, IT Integration
11/2/2022	Corporate	Ted Price	Attendee

Date	Location	Interviewees	Title
11/2/2022	Corporate	Nicole McCord	Attendee
11/2/2022	Corporate	Chelsie Lane	Attendee
11/2/2022	Corporate	Denise Craven	Senior Manager Operations Regulatory
11/2/2022	Corporate	Heather Weisbarth	Operations Specialist
11/2/2022	Corporate	Turkesia Robertson Jones	Assistant Vice President of Pharmacy

Interviews with Subcontractors

Express Scripts, Inc.

ESI provides PBM services for CS members. Myers and Stauffer met virtually with ESI staff on December 15-16, 2022. The individuals listed in *Table 14* were interviewed.

Table 14: Express Scripts, Inc.

Date	Interviewees	Interviewees
12/15/2022	Austin Andrews	Quality Review and Audit Advisor
12/15/2022	Kyle Joyner	Account Management Advisor
12/15/2022	Janet Sedon	Account Management Advisor
12/15/2022	Julianne Sanning	Account Management Lead Associate
12/15/2022	Eric Riebel	Account Management Senior Manager
12/15/2022	Katy Pikop	Account Management Senior Advisor
12/15/2022	Kyle Joyner	Account Manager
12/15/2022	Janet Sedon	Sr. Account Manager
12/15/2022	Julianne Sanning	Account Manager
12/15/2022	Eric Riebel	Operations Director
12/15/2022	Katy Pikop	Sr. Account Executive
12/15/2022	Doug Wurtzbacher	Clinical Account Executive
12/15/2022	Rhonda Graack	Legal Compliance Managing Director
12/15/2022	Matt Lynch	Financial Audit Managing Director
12/15/2022	Alethia Crespo	Fraud Senior Manager (Pharmacy SIU)
12/15/2022	Valerie Nielson	Fraud Senior Manager (Investigations)
12/15/2022	Michael Klein	Fraud Director
12/15/2022	Rhonda Graack	Legal Compliance Managing Director
12/15/2022	Alan Brandon	Legal Compliance Manager
12/15/2022	Kate Keller	Legal Compliance Director
12/15/2022	Linda Leppig	Eligibility Senior Manager

Date	Interviewees	Interviewees
12/15/2022	Lorraine Assade	IT Project Management Senior Manager
12/15/2022	Debbi Baumgartner	Agile Product Management Senior Director
12/15/2022	Jenny Birk	Agile Product Owner Senior Director
12/15/2022	Tara DeCosta	Agile Product Owner Director
12/15/2022	Jackie Bross	Product Management Advisor
12/15/2022	Clayton Graber	Product Management Senior Manager
12/15/2022	Erin Panfile	Product Management Advisor
12/15/2022	Paul Tschida	Product Management Senior Advisor
12/15/2022	Christel Joslyn	Product Management Senior Advisor

SKYGEN

SKYGEN provides specialty PBM services. Myers and Stauffer met virtually with SKYGEN staff on November 17, 2022. The individuals listed in *Table 15* were interviewed.

Table 15: SKYGEN

Date	Interviewees	Title
11/7/2022	Jenny Lubinski	Account Manager
11/7/2022	Stephanie Winget	Service Manager
11/7/2022	Dave Irish	Director of Compliance
11/7/2022	Tina Marcel Tetzlaff	Vice President Dental Benefits Management
11/7/2022	Kathy Lotz	Quality Improvement Manager
11/7/2022	Sherri Fleener	EDI Analyst IV
11/7/2022	Wendy Ryder	Reimbursement Analyst IV
11/7/2022	Artur Khachikyan	EDI Analyst IV

Versant

Versant provides vision services to CS members. Myers and Stauffer met virtually with Versant on November 16 through 17, 2022. The individuals listed in *Table 16* were interviewed.

Table 16: Versant

Date	Interviewees	Title
11/16/2022	Kerri Manley	Senior Client Manager
11/16/2022	Theresa Canavers	Senior Director, Regulatory Compliance and Affairs
11/16/2022	Kevin Hoelscher	Senior Manager, Compliance Monitoring Audit and Monitoring

Date	Interviewees	Title
11/16/2022	William Moore	Director, Network Operations
11/16/2022	Rebecca Nicholas-Rubitsky	Business and Quality Analyst, Complaints and Appeals
11/16/2022	Christine Turano	Director, Quality
11/16/2022	Andrew Guillaume	Director, Operations
11/17/2022	Tracy Murphy	Quality Assurance Audit Analyst
11/17/2022	Albert Cromling	Manager, Encounter Client Data
11/17/2022	Kristina Boemio	Director, Accounting

Exhibit II: Supporting Detail for Encounter Submissions and Payment Systems

Myers and Stauffer requested specific claim data elements to be included in the claim and encounter data samples submitted by the subcontractors for this review. Claim elements requested varied by claim type (e.g., tooth number codes were only assessed for dental claims). For all claims and encounters found to exist in both the data samples and the MMIS encounters, Myers and Stauffer measured the percentage of such claims where the data element value in the data samples exactly matched the value in the MMIS encounters. Results of the comparison were presented in five tables, broken out by subcontractor and claim type as:

- *CS Health Plan*

Table 17 – Institutional (837I/UB04)

  - *Table 18 – Professional (837P/CMS-1500)*
- *SKYGEN Dental*
  - *Table 19 – Dental (837D/ADA)*
- *Versant Vision*
  - *Table 20 – Vision (837P/CMS-1500)*
- *ESI*
  - *Table 21 – Pharmaceutical (National Council for Prescription Drug Programs [NCPDP])*

The following tables include a listing of all claim data elements assessed for each adjudicating entity and claim type. For each data element, there is a percentage indicating the portion of CMO or subcontractor's claims having values matching the value in their MMIS encounters.

Percentages greater than or equal to 99.95 percent and less than 100 percent were truncated to 99.9 percent. Percentages below 99 percent were reviewed more in-depth. Observations and findings were included for some scenarios of missing or mismatching data values between the CMO and subcontractor claims and MMIS encounters.

Table 17: CS FFS – Institutional (837I/UB04)

CS FFS – Institutional (837I/UB04) Claim Lines Reviewed = 551,400			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Plan by Provider	0.0	The claim receipt date reported in the CS FFS extracts for institutional claim lines did not match the claim receipt date reported in the MMIS encounters. In most cases (98.9%), the claim receipt date reported in the MMIS encounters may represent the date CS paid the claim, since the claim receipt date appears to be the same date as the encounter paid date. Furthermore, the claim receipt date did not appear to be included in the CS FFS extracts for approximately 1,600 institutional claim lines (0.3%).
2	Date Paid	96.9	For approximately 11,200 institutional claim lines (2.0%) it appeared that the paid date in the CS institutional claims extracts did not match the paid date in the MMIS encounters for CS. In most of these cases, the paid date in the MMIS encounters occurred between one and three days after the paid date in the CS institutional claims extracts. Myers and Stauffer was not able to identify a potential cause for this difference; however, this difference may be related to the difference between payment posting dates and payment issue dates. Additionally, the claim paid date did not appear to be included in the CS FFS extracts for approximately 5,900 institutional claim lines (1.0%).
3	Amount Paid - Claim Header	99.6	
4	Amount Paid - Claim Detail Lines	98.4	The claim line paid amount on approximately 4,500 (0.8%) institutional encounter claim lines in the MMIS encounters appeared to be different due to the Georgia Medicaid hospital add-on payment included in the claim line paid amount in the CS extracts.
5	Interest Paid - Claim Header	99.9	

CS FFS – Institutional (837I/UB04) Claim Lines Reviewed = 551,400			
	Claim Data Element	**% Match**	**Notes**
6	Denial Indicator - Claim Header	98.5	For approximately 8,000 institutional claim lines (1.4%), the claim adjudication status reported in the CS claims extracts did not appear to match the claim adjudication status reported in the MMIS encounters. The majority of these claim lines were reported as $0 paid in the CS claims extracts and reported as denied in the MMIS encounters.
7	Member Medicaid ID	99.6	
8	Payee Provider Tax ID	99.3	
9	Rendering Provider NPI	5.7	Myers and Stauffer requested CS include the rendering provider NPI when preparing the claims extracts; however, it appeared the rendering provider NPI was not included in the CS claims extracts for approximately 511,800 institutional claim lines (92.8%). We also observed approximately 5,400 institutional claim lines (0.9%) where the rendering provider NPI reported in the MMIS institutional encounters for CS did not appear to match the rendering provider NPI in the CS claims extracts but did appear to match the payee provider NPI in the CS extracts.
10	Referring Provider NPI	99.9	
11	Attending Provider NPI	99.8	
12	Operating Provider NPI	68.6	We observed approximately 172,900 institutional claim lines (31.3%) where the operating provider NPI appeared to be reported in the CS claims extracts but did not appear to be reported in the MMIS encounters.
13	DRG Code	99.4	
14	Claim ICD Diagnosis Codes	99.5	The majority of diagnosis codes billed on the inbound claims appeared to be reported in the MMIS encounters; however, the ordering of secondary diagnosis codes in the MMIS encounters may not always match the ordering of secondary diagnosis codes as reported on the inbound claim.

CS FFS – Institutional (837I/UB04) Claim Lines Reviewed = 551,400			
	Claim Data Element	**% Match**	**Notes**
15	Claim ICD Surgical Procedure Codes	98.0	Myers and Stauffer requested CS include the surgical procedure codes when preparing the claims extracts; however, it appeared the surgical procedure codes were not included in the CS claims extracts for approximately 13,500 institutional claim lines (2.0%). We were unable to verify the surgical procedure codes reported in the MMIS encounters for these claims.
16	Type of Bill	99.9	
17	Medical Record Number	99.4	
18	Amount Billed - Claim Header	99.9	
19	Amount Billed - Claim Detail Lines	98.5	Approximately 5,500 CS institutional claim lines (1.0%) appeared to have been bundled into fewer claim lines in the MMIS encounters. The sum of bundled line billed amounts in the CS institutional extracts appeared to match the line billed amount reported in the MMIS encounters.
20	Admission Date	99.9	
21	Discharge Date	99.8	
22	First Date of Service – Claim Header	99.6	
23	Last Date of Service – Claim Header	98.2	For approximately 7,800 institutional claim lines (1.4%), it appeared the claim header last date of service in the CS claims extracts did not match the claim header last date of service reported in the MMIS encounters. For these claim lines, the header last date of service reported in the MMIS encounters may have been derived from claim discharge date and may not always accurately represent the claim last date of service.
24	First Date of Service – Claim Detail Lines	99.9	
25	Last Date of Service – Claim Detail Lines	99.6	

CS FFS – Institutional (837I/UB04) Claim Lines Reviewed = 551,400			
	Claim Data Element	**% Match**	**Notes**
26	Claim Detail Line Number	95.2	Approximately 17,000 institutional claim lines (3.0%) appeared to have been reordered in the MMIS encounters. Furthermore, approximately 5,500 additional institutional claim lines (1.0%) appeared to have been bundled into fewer claim lines in the MMIS institutional encounters. As a result of potential claim line reordering and bundling, the line number on approximately 24,200 CS institutional claim lines (4.4%) appeared to have been either renumbered or reordered in the MMIS encounters.
27	Units Billed	98.5	Approximately 5,500 CS institutional claim lines (1.0%) appeared to have been bundled into fewer claim lines in the MMIS encounters. The sum of bundled line billed units in the CS institutional extracts appeared to match the line billed units reported in the MMIS encounters.
28	Revenue Code	100.0	
29	Procedure Code	99.9	
30	Procedure Code Modifier 1	99.9	
31	Procedure Code Modifier 2	99.7	
32	Procedure Code Modifier 3	99.9	This data element appears to be largely not populated in the supplied claims extracts or in the MMIS encounters.
33	Procedure Code Modifier 4	N/A	This data element was not populated in the supplied claims extracts or in MMIS encounters.
34	National Drug Code (NDC)	99.5	

Table 18: CS FFS – Professional (837P/CMS-1500)

CS FFS – Professional (837P/CMS-1500) Claim Lines Reviewed = 1,304,100			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Plan by Provider	0.1	The claim receipt date reported in the CS FFS extracts for professional claim lines did not match the claim receipt date reported in the MMIS encounters. In most cases (99.2%), the claim receipt date reported in the MMIS encounters may represent the date CS paid the claim, since the claim receipt date appears to be the same date as the encounter paid date.
2	Date Paid	96.8	For approximately 33,600 professional claim lines (2.5%), it appeared that the paid date in the CS professional claims extracts did not match the paid date in the MMIS encounters for CS. For these claim lines, the paid date in the MMIS encounters occurred between one and three days after the paid date in the CS professional claims extracts. Myers and Stauffer was not able to identify a potential cause for this difference; however, this difference may be related to the difference between payment posting dates and payment issue dates.
3	Amount Paid – Claim Header	99.5	
4	Amount Paid – Claim Detail Lines	99.4	
5	Interest Paid - Claim Header	99.9	
6	Denial Indicator - Claim Header	99.1	
7	Member Medicaid ID	99.8	
8	Payee Provider Tax ID	91.6	For approximately 106,800 professional claim lines (8.1%) it appeared the Payee Provider Tax ID in the MMIS encounters for CS was derived from the rendering provider. The payee provider in the MMIS may not accurately reflect the claim payee/billing provider reported on the claim submission.
9	Rendering Provider NPI	75.3	Myers and Stauffer requested that CS include the rendering provider NPI when preparing the claims extracts; however, it appeared the rendering provider NPI was not included in the CS claims

CS FFS – Professional (837P/CMS-1500) Claim Lines Reviewed = 1,304,100			
	Claim Data Element	% Match	Notes
			extracts for approximately 268,700 professional claim lines (20.6%). We were unable to verify the rendering provider NPI reported in the MMIS encounters for these claims. We also observed approximately 44,000 professional claim lines (3.3%) where the rendering provider NPI reported in the MMIS encounters did not appear to match the rendering provider NPI in the CS claims extracts but did appear to match the payee provider NPI in the CS extracts.
10	Referring Provider NPI	99.8	
11	Claim ICD Diagnosis Codes	99.8	The majority of diagnosis codes billed on the inbound claims appeared to be reported in the MMIS encounters; however, the ordering of diagnosis codes in the MMIS encounters may not always match the ordering of diagnosis codes as reported on the inbound claim.
12	Amount Billed – Claim Header	99.9	
13	Amount Billed - Claim Detail Lines	99.7	
14	First Date of Service – Claim Header	99.9	
15	Last Date of Service – Claim Header	99.9	
16	First Date of Service – Claim Detail Lines	99.9	
17	Last Date of Service – Claim Detail Lines	99.9	
18	Claim Detail Line Number	99.4	
19	Units Billed	99.7	
20	Place of Service	98.9	For approximately 13,600 professional claim lines (1.0%), the place of service in the CS claims extracts did not appear to match the value in the corresponding MMIS CS professional encounters. For approximately 5,500 of these claim lines (0.4%), the place of service code reported in the MMIS encounters was “99” (other place of service), while the place of service code reported in the claims extract was more specific (not “99”).
21	Procedure Code	99.9	
22	Procedure Code Modifier 1	99.9	

CS FFS – Professional (837P/CMS-1500) Claim Lines Reviewed = 1,304,100			
	Claim Data Element	**% Match**	**Notes**
23	Procedure Code Modifier 2	99.8	
24	Procedure Code Modifier 3	99.9	
25	Procedure Code Modifier 4	99.9	This data element appears to be largely not populated in the supplied claims extracts or in the MMIS encounters.
26	NDC	99.9	
27	Claim Detail Line ICD Diagnosis 1	33.9	We observed approximately 861,900 professional claim lines (66.0%) in the CS professional claims extracts whose claim detail line diagnosis code 1 did not match the value for the corresponding claim line in the MMIS professional encounters. Myers and Stauffer was not able to identify a potential cause for this difference; however, this difference may be related to potential reordering of ICD claim diagnosis codes between the inbound claim receipt and submission of encounters to the MMIS.
28	Claim Detail Line ICD Diagnosis 2	70.1	We observed approximately 389,900 professional claim lines (29.9%) in the CS professional claims extracts whose claim detail line diagnosis code 2 did not match the value for the corresponding claim line in the MMIS professional encounters. Myers and Stauffer was not able to identify a potential cause for this difference; however, this difference may be related to potential reordering of ICD claim diagnosis codes between the inbound claim receipt and submission of encounters to the MMIS.
29	Claim Detail Line ICD Diagnosis 3	83.3	We observed approximately 217,500 professional claim lines (16.6%) in the CS professional claims extracts whose claim detail line diagnosis code 3 did not match the value for the corresponding claim line in the MMIS professional encounters. Myers and Stauffer was not able to identify a potential cause for this difference; however, this difference may be related to potential reordering of ICD claim diagnosis codes between the inbound claim receipt and submission of encounters to the MMIS.

CS FFS – Professional (837P/CMS-1500) Claim Lines Reviewed = 1,304,100			
	Claim Data Element	**% Match**	**Notes**
30	Claim Detail Line ICD Diagnosis 4	90.7	We observed approximately 121,700 professional claim lines (9.3%) in the CS professional claims extracts whose claim detail line diagnosis code 4 did not match the value for the corresponding claim line in the MMIS professional encounters. Myers and Stauffer was not able to identify a potential cause for this difference; however, this difference may be related to potential reordering of ICD claim diagnosis codes between the inbound claim receipt and submission of encounters to the MMIS.

Table 19: SKYGEN Dental (837D/ADA)

SKYGEN Dental (837D/ADA) Claim Lines Reviewed = 280,300			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Subcontractor by Provider	0.0	The claim receipt date reported in the SKYGEN extracts for dental claim lines did not match the claim receipt date reported in the MMIS encounters. In most cases (99.8%), the claim receipt date reported in the MMIS encounters may represent the date SKYGEN paid the claim, since the claim receipt date appears to be the same date as the encounter paid date.
2	Date Paid	99.9	
3	Subcontractor Amount Paid – Claim Header	99.8	
4	Subcontractor Amount Paid – Claim Detail Lines	99.9	
5	Interest Paid - Claim Header	N/A	Interest did not appear to be present in the claims extract or in MMIS encounter data.
6	Denial Indicator - Claim Header	99.9	
7	Member Medicaid ID	99.9	

SKYGEN Dental (837D/ADA) Claim Lines Reviewed = 280,300			
	Claim Data Element	**% Match**	**Notes**
8	Payee Provider Tax ID	93.1	For approximately 19,100 dental claim lines (6.8%) it appeared that the Payee Provider Tax ID in the MMIS encounters for SKYGEN was derived from the rendering provider. The payee provider in the MMIS may not accurately reflect the claim payee/billing provider reported on the claim submission.
9	Rendering Provider NPI	93.5	We observed approximately 13,000 dental claim lines (4.6%) for which the rendering provider NPI reported in the SKYGEN dental claims extracts did not match the rendering provider NPI reported in the MMIS encounters for SKYGEN, but did appear to share a common payee/billing Medicaid provider ID. We also observed approximately 2,800 dental claim lines (1.0%) for which the rendering provider NPI reported in the SKYGEN dental claims extracts appeared to be an individual, whereas the rendering provider NPI in the MMIS encounters appeared to be an institution or organization.
10	Referring Provider NPI	N/A	The referring provider NPI does not appear to be present in the claims extract or in the MMIS encounter data.
11	Claim ICD Diagnosis Codes	N/A	ICD diagnosis codes do not appear to be present in the claims extract or in the MMIS encounter data. This field may not be required for dental claims.
12	Amount Billed - Claim Header	99.9	
13	Amount Billed - Claim Detail Lines	99.1	
14	First Date of Service – Claim Header	99.9	
15	Last Date of Service – Claim Header	99.6	
16	First Date of Service – Claim Detail Lines	99.9	
17	Last Date of Service – Claim Detail Lines	99.8	

SKYGEN Dental (837D/ADA) Claim Lines Reviewed = 280,300			
	Claim Data Element	**% Match**	**Notes**
18	Claim Detail Line Number	98.7	Approximately 2,600 SKYGEN dental claim lines (0.9%) appeared to have been bundled into fewer claim lines in the MMIS encounters. Furthermore, approximately 1,400 dental claim lines (0.5%) appeared to have been reordered in the MMIS encounters. As a result of potential claim line reordering and bundling, the line number on approximately 3,500 SKYGEN dental claim lines (1.2%) appeared to have been either renumbered or reordered in the MMIS encounters.
19	Units Billed	99.0	
20	Place of Service	99.9	
21	Procedure Code	99.9	
22	Procedure Code Modifier 1	N/A	Procedure code modifiers did not appear to be populated in the supplied claims extracts or in MMIS encounters for dental claims.
23	Procedure Code Modifier 2	N/A	
24	Procedure Code Modifier 3	N/A	
25	Procedure Code Modifier 4	N/A	
26	Tooth Number	94.0	For approximately 16,700 SKYGEN dental claim lines (5.9%) the tooth number appeared to be missing in the MMIS encounters.
27	Tooth Surface Code 1	99.9	
28	Tooth Surface Code 2	99.9	
29	Tooth Surface Code 3	99.9	
30	Tooth Surface Code 4	99.9	
31	Tooth Surface Code 5	99.9	
32	Claim Detail Line ICD Diagnosis 1	N/A	ICD diagnosis codes do not appear to be present in the claims extract or in the MMIS encounter data. This field may not be required for dental claims.
33	Claim Detail Line ICD Diagnosis 2	N/A	
34	Claim Detail Line ICD Diagnosis 3	N/A	
35	Claim Detail Line ICD Diagnosis 4	N/A	

Table 20: Versant Vision (837P/CMS-1500)

Versant Vision (837P/CMS-1500) Claim Lines Reviewed = 23,000			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Subcontractor by Provider	0.0	The claim receipt date reported in the Versant Vision extracts for vision claim lines did not match the claim receipt date reported in the MMIS encounters. It appears that in the majority of the vision claim lines (64.2%), the claim receipt date reported in the MMIS encounters represents the date Versant Vision paid the claim, since the claim receipt date appears to be the same date as the encounter paid date.
2	Date Paid	99.9	
3	Subcontractor Amount Paid – Claim Header	99.5	
4	Subcontractor Amount Paid – Claim Detail Lines	99.9	
5	Interest Paid - Claim Header	99.9	The occurrence of interest payments on Versant Vision claims was very rare (0.01%). We observed a single claim in the Versant Vision extracts having a non-zero interest amount; however, the interest amount did not appear to be reported in the MMIS encounters for this claim. Interest may not be accurately reported in the MMIS encounters for all Versant Vision claims.
6	Denial Indicator - Claim Header	98.5	For approximately 340 vision claim lines (1.5%), the claim adjudication status reported in the claims extracts did not appear to match the claim status reported in the MMIS encounters. These claim lines were reported as $0 paid in the claims extracts and reported as denied in the MMIS encounters.
7	Member Medicaid ID	100.0	
8	Payee Provider Tax ID	76.2	For approximately 5,090 vision claim lines (22.1%) it appeared the Payee Provider Tax ID in the MMIS encounters for Versant Vision was derived from the rendering provider. The payee provider in the MMIS may not accurately reflect the claim payee/billing provider reported on the claim

Versant Vision (837P/CMS-1500) Claim Lines Reviewed = 23,000			
	Claim Data Element	**% Match**	**Notes**
			submission. Additionally, Payee Provider Tax IDs did not appear to be populated in the MMIS encounters for approximately 100 vision claims (0.6%).
9	Rendering Provider NPI	99.0	
10	Referring Provider NPI	N/A	Referring Provider NPI does not appear to be present in the claims extract or in the MMIS encounter data. This field may not be required for vision claims.
11	Claim ICD Diagnosis Codes	99.9	
12	Amount Billed - Claim Header	98.3	We observed approximately 380 vision claim lines (1.6%) where the claim header billed amount reported in the Versant Vision claims extracts did not match the amount reported in the MMIS encounters. For the majority of these, the header billed amount reported in the MMIS encounters appeared to equal the sum of the line billed amounts reported in the Versant Vision claims extracts.
13	Amount Billed - Claim Detail Lines	99.9	
14	First Date of Service – Claim Header	100.0	
15	Last Date of Service – Claim Header	100.0	
16	First Date of Service – Claim Detail Lines	100.0	
17	Last Date of Service – Claim Detail Lines	100.0	
18	Claim Detail Line Number	99.9	
19	Units Billed	100.0	
20	Place of Service	100.0	
21	Procedure Code	100.0	
22	Procedure Code Modifier 1	78.5	For approximately 4,900 vision claim lines (21.4%), the procedure code modifier 1 reported in the Versant Vision claims extracts did not appear to match the value reported in the corresponding MMIS encounters. For many of these claim lines, a variety of different values were reported in the Versant Vision claims extracts, but “RA” was the only value reported in the corresponding MMIS encounters.

Versant Vision (837P/CMS-1500) Claim Lines Reviewed = 23,000			
	Claim Data Element	**% Match**	**Notes**
23	Procedure Code Modifier 2	100.0	Procedure Code Modifier 2 appeared to be reported on approximately 50 Versant Vision claim lines (0.2%), and all values reported in the Versant Vision claims extracts appeared to match values reported in the MMIS encounters.
24	Procedure Code Modifier 3	100.0	Procedure Code Modifier 3 appeared to be reported on approximately six Versant Vision claim lines (0.03%), and all values reported in the Versant Vision claims extracts appeared to match values reported in the MMIS encounters.
25	Procedure Code Modifier 4	N/A	Procedure Code Modifier 4 did not appear to be populated in either the Versant Vision claims extracts or the MMIS encounters for Versant Vision. The sample review period may not include any vision claim lines with more than three procedure code modifiers, which may explain the absence of values.
26	NDC	N/A	NDC's do not appear to be present in the claims extract or in the MMIS encounter data. This field may not be required for vision claims.
27	Claim Detail Line ICD Diagnosis 1	90.7	We observed approximately 2,140 vision claim lines (9.3%) in the Versant Vision claims extracts whose claim detail line diagnosis code 1 did not match the value for the corresponding claim line in the MMIS encounters. Myers and Stauffer was not able to identify a potential cause for this difference; however, this difference may be related to potential reordering of ICD claim diagnosis codes between the inbound claim receipt and submission of encounters to the MMIS.
28	Claim Detail Line ICD Diagnosis 2	93.2	We observed approximately 1,560 vision claim lines (6.8%) in the Versant Vision claims extracts whose claim detail line diagnosis code 2 did not match the value for the corresponding claim line in the MMIS encounters. Myers and Stauffer was not able to identify a potential cause for this difference; however, this

Versant Vision (837P/CMS-1500) Claim Lines Reviewed = 23,000			
	Claim Data Element	**% Match**	**Notes**
			difference may be related to potential reordering of ICD claim diagnosis codes between the inbound claim receipt and submission of encounters to the MMIS.
29	Claim Detail Line ICD Diagnosis 3	99.2	
30	Claim Detail Line ICD Diagnosis 4	99.8	

Table 21: ESI (NCPDP)

ESI (NCPDP) Claim Lines Reviewed = 449,100			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Subcontractor by Provider	99.9	
2	Date Paid	99.9	
3	Subcontractor Amount Paid	100.0	
4	Denial Indicator	99.9	
5	Member Medicaid ID	99.9	
6	Payee Provider Tax ID	95.7	For approximately 19,300 pharmacy claim lines (4.3%), it appeared the Payee Provider Tax ID in the MMIS encounters for ESI was derived from the rendering provider. The payee provider in the MMIS may not accurately reflect the claim payee/billing provider reported on the claim submission.
7	Dispensing Provider NPI	98.3	We observed approximately 7,300 pharmacy claim lines (1.6%) in the ESI claims extracts where the dispensing provider NPI reported in the MMIS encounters appeared to be an older NPI associated with the Medicaid provider ID reported on the encounter. The NPI reported in the MMIS encounters may not be the most appropriate ID currently used by the dispensing provider.
8	Prescribing Provider	99.9	
9	Claim ICD Diagnosis Codes	84.2	ICD diagnosis codes do not appear to be reported in the MMIS encounter data. We observed approximately 70,800 pharmacy claim lines (15.7%) where one or more ICD diagnosis codes appeared to be reported in the ESI pharmacy

ESI (NCPDP) Claim Lines Reviewed = 449,100			
	Claim Data Element	% Match	Notes
			claims extracts but did not appear to be reported in the MMIS encounters. This field may not be required for submission to the MMIS for pharmacy claims.
10	Prescription Number	100.0	
11	Amount Billed	3.2	For approximately 434,600 pharmacy claim lines (96.7%) in the ESI claims extracts, the amount billed appeared to match the amount paid, and did not appear to match the billed amount reported in the MMIS encounters. The billed amount reported in the ESI claims extracts may not accurately represent the amount billed by the pharmacy.
12	Date Filled	100.0	
13	Dispensed Units	99.9	
14	NDC	99.9	
15	Days' Supply	99.9	
16	Refill Number	100.0	
17	Dispensing Fee	99.9	
18	Ingredient Cost Submitted	0.8	For approximately 445,300 pharmacy claim lines (99.1%), it appeared that the ingredient cost submitted reported in the ESI claims extracts did not match the ingredient cost submitted reported in the MMIS encounters. Myers and Stauffer was not able to identify a potential cause for this difference.
19	Professional Service Fee Submitted	N/A	This data element was not populated in the supplied claims extracts or in MMIS encounters.
20	Sales Tax Submitted	99.9	
21	Gross Amount Due	99.9	
22	Provider Fee Amount	N/A	This data element was not populated in the supplied claims extracts or in MMIS encounters.
23	Patient Paid Amount	100.0	

Exhibit III: Georgia Families® Data Analyses

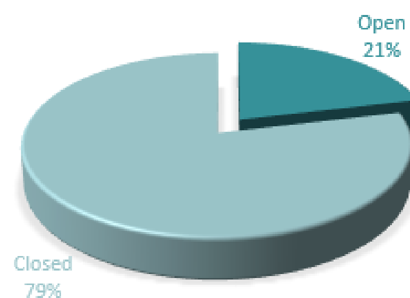
Grievances and Appeals

Myers and Stauffer has completed an analysis on CS's systems for 2022 Quarter 3, and have consolidated our findings to illustrate grievances status, grievances status by appeal type, and grievances processing time compliance, number of appeals by service category, number of appeals by appeal type, expedited appeals by service category, and appeal processing time compliance.

Grievances Status

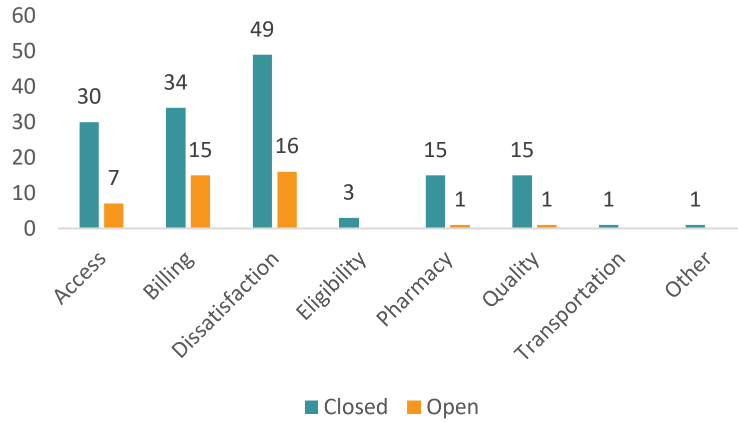
During the review of 188 grievances recorded, we first identified and compared open and closed grievances, as shown in *Figure 9*. We identified 40 cases still open and 148 cases closed.

Figure 9: Grievances Status



Upon doing future analysis, we simplified the grievance types to access, billing, dissatisfaction, eligibility, pharmacy, quality, transportation, and other. We identified open and closed cases within each type and found that access, billing, and dissatisfaction are the most common grievance types with less than 50 percent of their cases still open at date of report as shown in *Figure 10*.

Figure 10: Grievances Status by Grievance Type



Grievances Processing

In accordance with the contract stipulations between DCH and CS in regard to processing time for grievances, we identified that CS is operating in compliance with the contract as shown in *Table 22*. Section 4.14.3.4 states that issuance of disposition on Grievances must be completed within 90 calendar days of the grievance filing date.

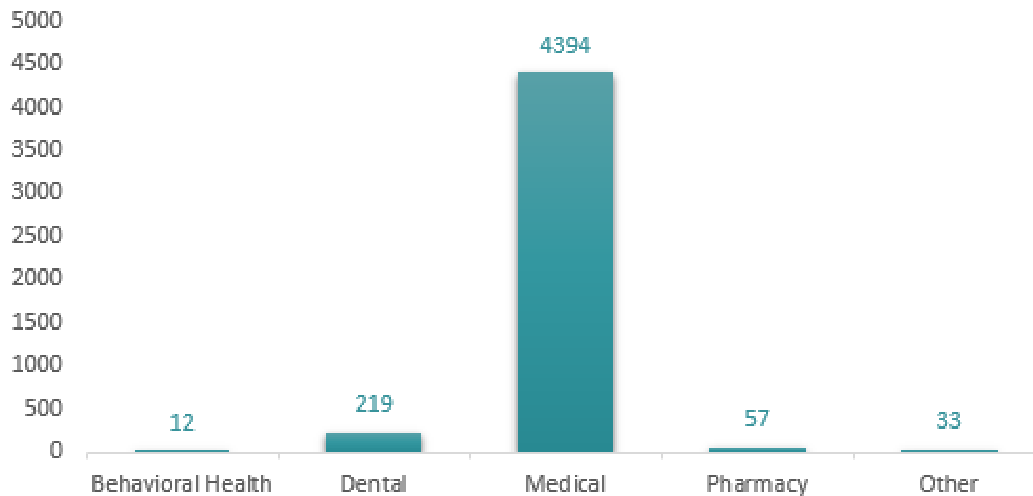
Table 22: Grievances Processing Time Compliance

Greater than 90 days	0
Less than 90 days	142
90 days	7
Total	149
% in Compliance	100%

Appeals by Category and Type

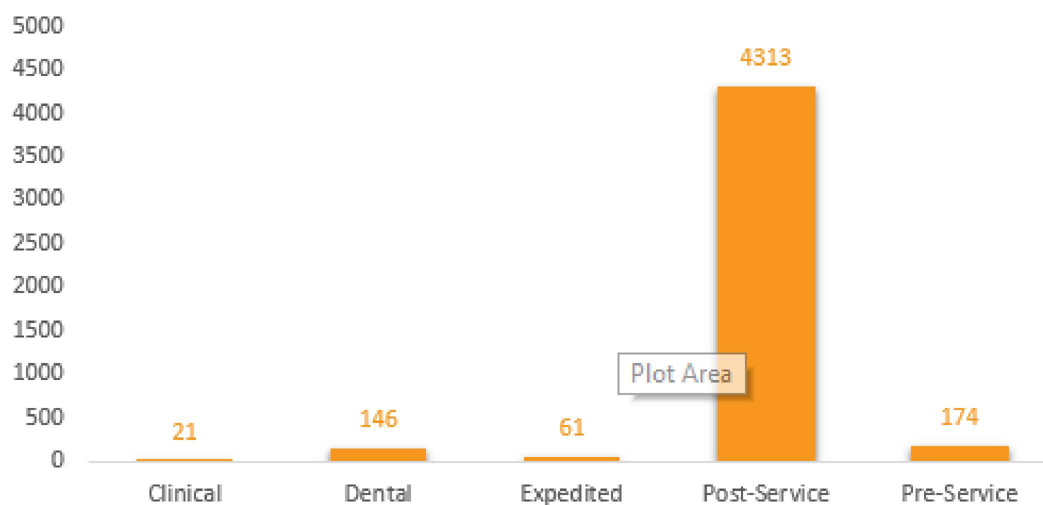
During the review of the 4,715 appeals recorded, we separated and organized the types of services identified in the report in to four service categories. The service categories included behavioral health, dental, medical, and pharmacy, with 33 services falling into the other category. The other category is comprised of services that could not be conclusively classified into any one particular service category. The top three service categories include medical with 4,394 appeals reported, dental with 219 appeals reported, and pharmacy with 57 appeals reported, as shown in *Figure 11*.

Figure 11: Number of Appeals by Service Category



We simplified the appeal types to clinical, dental, expedited, post-service, and pre-service where we witness that the top three appeal types include post-service with 4,313 appeals, pre-service with 174 appeals, and dental with 146 appeals, as shown in *Figure 12*.

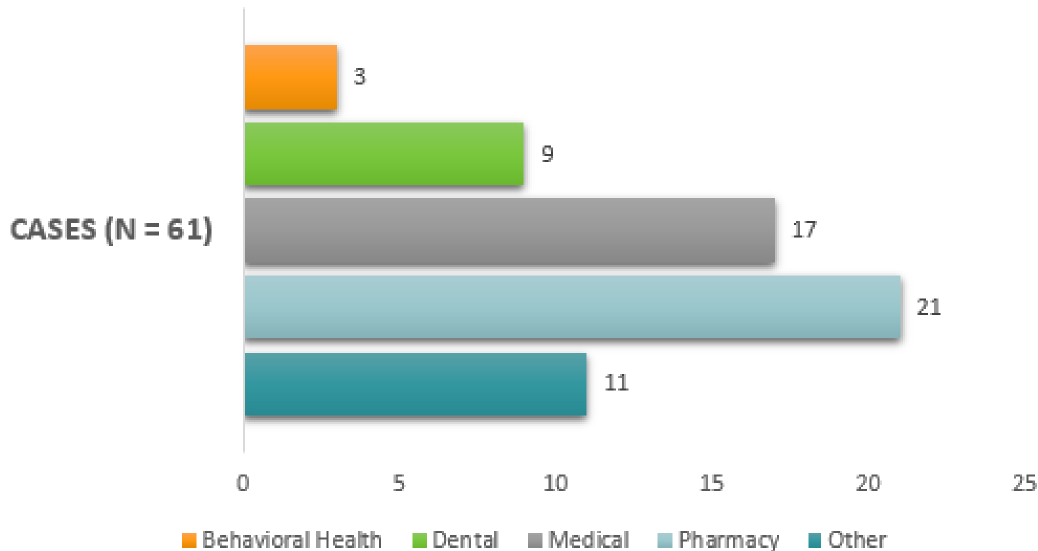
Figure 12: Number of Appeals by Appeal Type



Expedited Appeals

While analyzing deeper into expedited appeals, we separated them again in to four service categories: behavioral health, dental, medical, pharmacy, and the other category with 33 services that could not be classified into the latter. We found that the top two most commonly expedited appeals include pharmacy and medical, with pharmacy making up 34 percent of total expedited appeals, as shown in *Figure 13*.

Figure 13: Expedited Appeals by Service Category



Appeals Processing

In accordance with the contract stipulations between DCH and CS in regard to processing time for appeals, we identified that CS is operating in compliance with the contract as shown in *Table 23*. Section 4.14.2.3.7 states that reviews that are not expedited due to an enrollee's medical condition must be completed within 90 calendar days of the date the request is made. According to Section 4.14.2.3.8, reviews expedited due to an enrollee's medical condition must be decided within 72 clock hours of the receipt of request, but the enrollee's medical condition is not specified within the appeals report.

Table 23: Appeal Processing Time Compliance

	Expedited Appeals	Regular Appeals
Greater than 30 days	0	
Less than or Equal to 30 days	61	
Greater than 90 days		0
Less than or Equal to 90 days		4654
Total:	61	4654
% in Compliance:	100%	100%

Assessment: Internal Grievance/ Appeals System

Myers and Stauffer determined that CS's processing time for grievances and appeals was in compliance with the DCH contract for the data sample analyzed.

Prior Authorizations

CS is contractually required to submit a quarterly report to DCH capturing all prior authorizations received and determined for a respective quarter. Prior authorization reporting is required to include, at a minimum, the:

- *Type of service.*
- *Prior authorization number.*
- *Date prior authorization request received.*
- *Date authorization was approved or denied.*
- *Final authorization status (approved/denied).*

Myers and Stauffer reviewed the third quarter prior authorizations report for CY 2022 containing 31,227 prior authorization requests. We analyzed these prior authorizations in terms of type of service, authorization status, authorization status for the top five most used procedure codes, and compliance for authorization processing time.

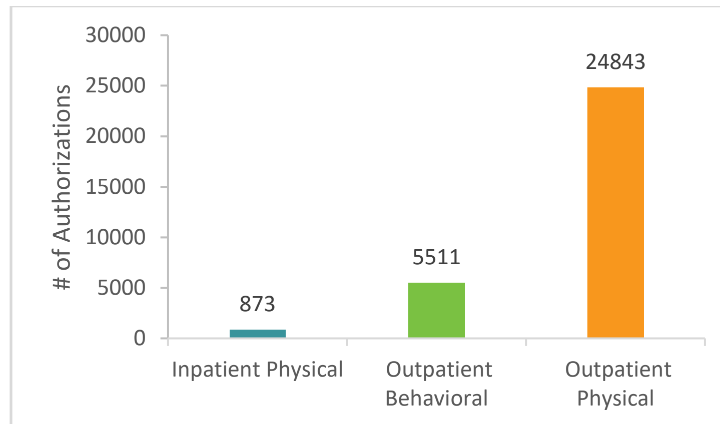
Type of Service

CS's prior authorization requests were categorized under one of three service types: inpatient physical, outpatient behavioral, or outpatient physical. For 2022 Quarter 3, 31,227 prior authorization requests were received and determined, of which outpatient physical had the most number of authorization requests (24,843 requests). Outpatient behavioral (5,511 requests) and inpatient physical (873 requests) followed after. This shows that outpatient physical services is the most utilized service for CS enrollees. Please reference *Table 24* and *Figure 14* below.

Table 24: Prior Authorizations – Outpatient Physical Services

Type of Service	Counts
Inpatient Physical	873
Outpatient Behavioral	5,511
Outpatient Physical	24,843
Grand Total	31,227

Figure 14: Prior Authorizations – Outpatient Physical Services



Authorization Status and Processing Time

Determinations for authorizations involving health care services that have been delivered shall be made within 30 calendar days of receipt of the necessary information, as listed per Section 4.11.2.7.3 of the CS CMO contract. While analyzing the processing time and authorization status for Quarter 3, CS was in compliance processing approximately 99.8 percent (31,172) of authorizations within the mandated contractual timeframe. Of the total number of authorizations received, approximately 77.4 percent (24,184) of authorizations received an approved status, while the remaining 22.6 percent (7,043) of authorizations received a denial.

Most Used Procedure Codes by Service Type

Upon analysis of the procedure codes used for the authorizations received and determined, Myers and Stauffer categorized the top five used procedure codes to capture the most requested treatments and procedures for each service type. Using the American Academy of Professional Coders, we were able to match each Current Procedural Terminology code to its appropriate description. Myers and Stauffer noted that the procedure code descriptions align with its associated service category.

Please reference *Table 25, Table 26,* and *Table 27 b*elow for the number of approvals and denials decided for each procedure code.

Table 25: Top Five Outpatient Physical Code Approvals and Denials

Top 5 Outpatient Physical Codes	Procedure Code Description	Total Count	Approved Count	Denied Count
92507	Under Treatment of Auditory Processing Disorder	2,892	2,883	9
97530	Under Physical Medicine and Rehabilitation Therapeutic Procedures	2,726	2,703	23

Top 5 Outpatient Physical Codes	Procedure Code Description	Total Count	Approved Count	Denied Count
97110	Under Physical Medicine and Rehabilitation Therapeutic Procedures	2,238	2,220	18
81420	Under Genomic Sequencing Procedures and Other Molecular Multi-analyte Assays	1,656	0	1,656
97112	Under Physical Medicine and Rehabilitation Therapeutic Procedures	1,572	1,562	10

Figure 15: Number of Approved and Denied Outpatient Physical Authorizations by Top Five Used Procedure Codes

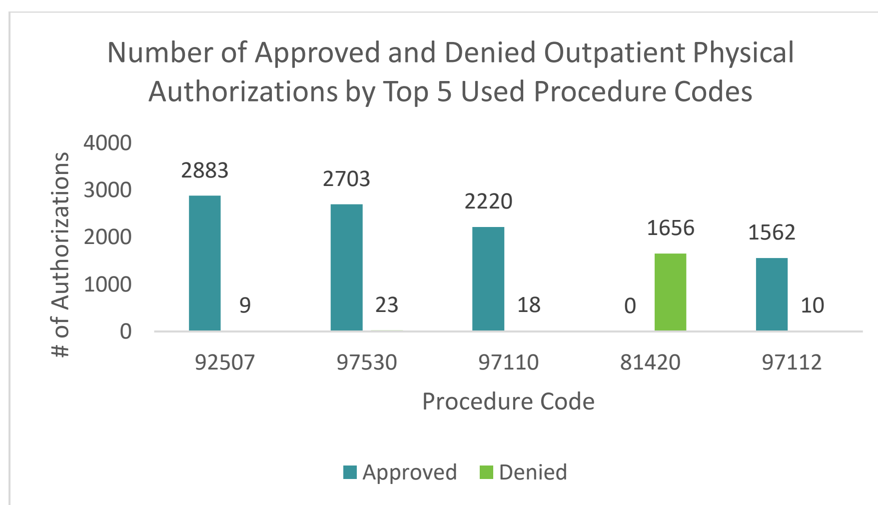


Table 26: Top Five Outpatient Behavioral Code Approvals and Denials

Top 5 Outpatient Behavioral Codes	Procedure Code Description	Total Count	Approved Count	Denied Count
H2015	For Comprehensive Community Support Services, Per 15 Minutes	1,384	1,276	108
90837	Under Psychotherapy Services and Procedures	1,183	996	187
97151	Under Adaptive Behavior Assessment Procedures	543	433	110
97155	Under Adaptive Behavior Treatment Procedures	485	301	184
97153	Under Adaptive Behavior Treatment Procedures	452	308	144

Figure 16: Number of Approved and Denied Outpatient Behavioral Authorizations by Top Five Used Procedure Codes

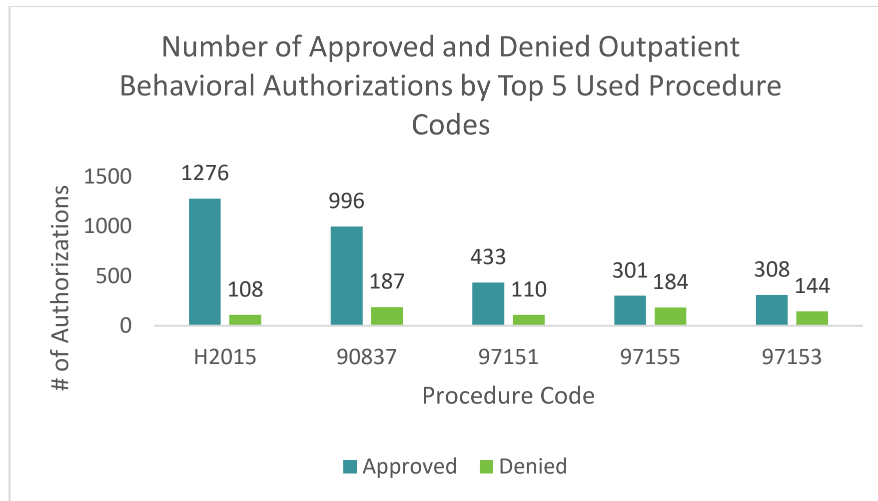
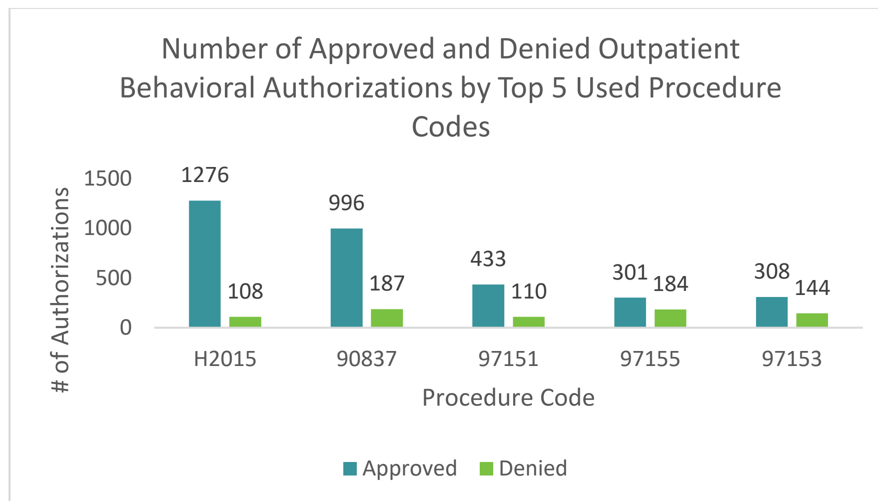


Table 27: Top Five Inpatient Physical Code Approvals and Denials

Top 5 Inpatient Physical Codes	Procedure Code Description	Total Count	Approved Count	Denied Count
99221	Under New or Established Patient Initial Hospital Inpatient Care Services	64	64	0
43775	Under Laparoscopic Bariatric Surgery Procedures	49	37	12
96361	Under Hydration Infusion	31	31	0
96413	Under Injection and Intravenous Infusion Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration	29	29	0
96415	Under Injection and Intravenous Infusion Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration	29	29	0

Figure 17: Number of Approved and Denied Outpatient Behavioral Authorizations by Top Five Used Procedure Codes



Assessment: Prior Authorizations

Myers and Stauffer determined that CS's processing time for prior authorizations was in compliance with the DCH contract for the data sample analyzed.

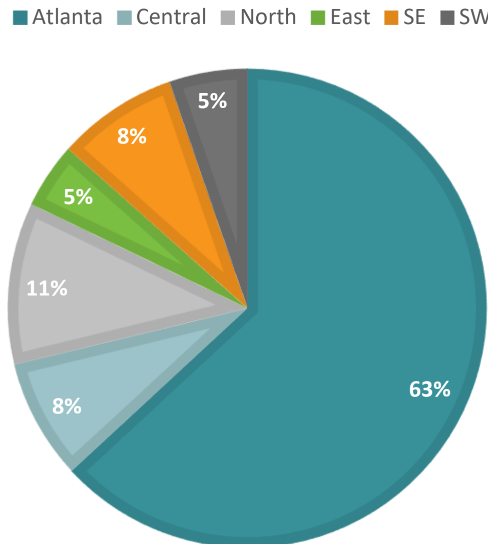
Provider Network Analyses

Section 4.8.1 of the contract requires CS to develop and maintain a network of providers and facilities that is robust enough to deliver covered Medicaid services to its members. The network must ensure adequate coverage exists for both rural and urban areas, while making telemedicine an option when appropriate for the member's health care needs. The network should consist of physicians, pharmacies, hospitals, physical therapists, occupational therapists, speech therapists, border providers, and other health care providers. The network providers must be appropriately credentialed by DCH or its agent, maintain current license(s), and have appropriate locations to provide covered Medicaid services.

Myers and Stauffer has completed an analysis on CS's provider network for Quarter 3 and Quarter 4 of 2022. We have consolidated our findings to illustrate providers by region, providers by service category, providers by specialty, and top terminated provider specialties for each quarter.

Providers by Region

During the analysis of 56,297 provider listings in Quarter 3, and 57,101 provider listings in Quarter 4, we were able to identify that the Atlanta region is the most covered region, while the Southwest is the least



covered, as shown in *Figure 18*.

Upon doing further analysis, we separated and totaled provider listings by service category. We found that 78 percent of provider listings were for specialist services, while only five percent were for ancillary, as shown in *Figure 19*.

Figure 18: Provider Listings by Region

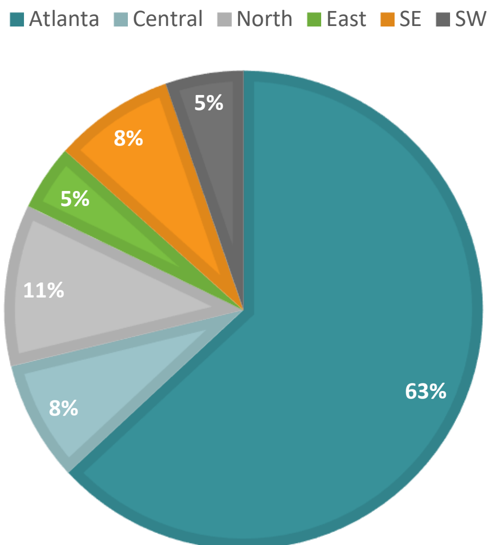
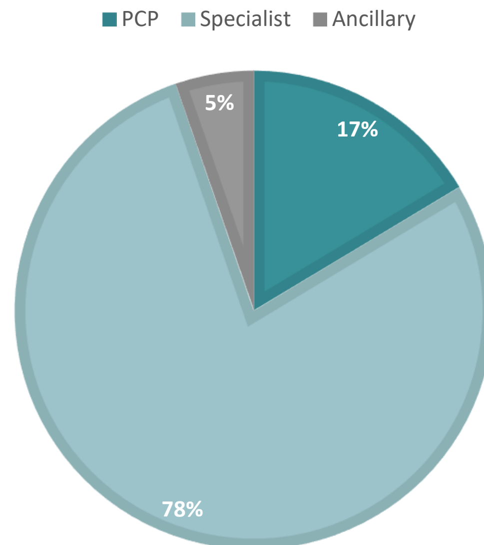


Figure 19: Provider Listings by Service Category



Providers by Specialty

Myers and Stauffer further identified providers listed for each quarter by their specialties. For each quarter, behavioral health specialty providers make up the vast majority of providers listed. Providers for obstetrics and gynecology services follow second with a little more than half of the amount of providers listed for behavioral health services, as shown in *Figure 20* and *Figure 21.*

Figure 20: Quarter 3 Provider Listings by Specialty

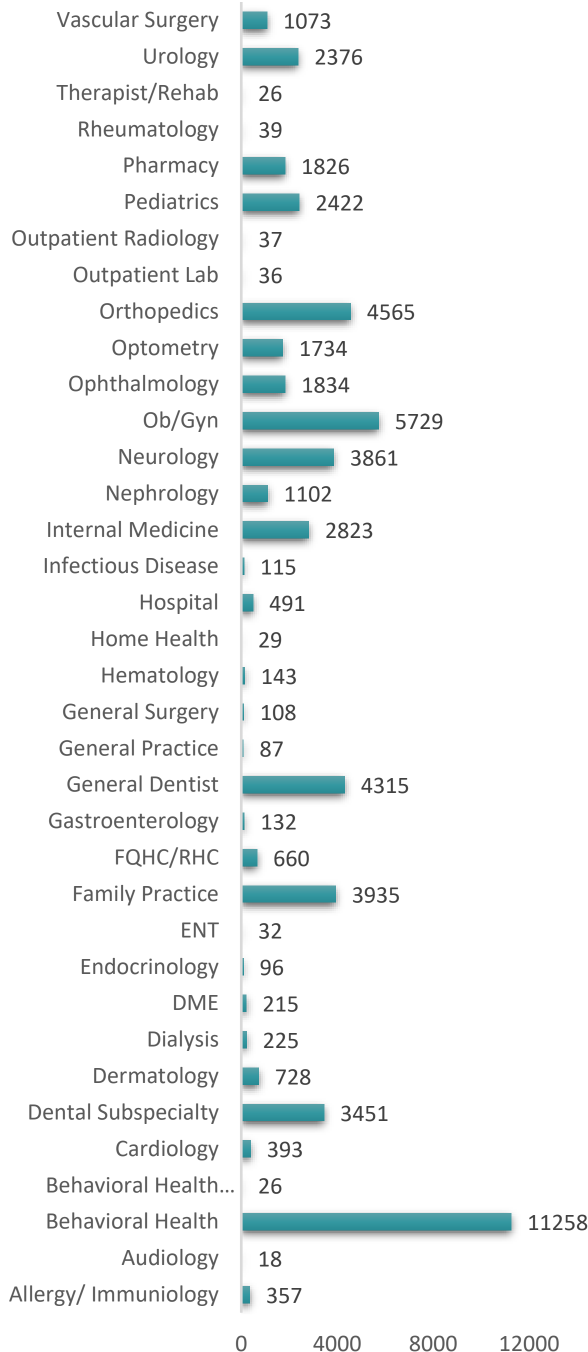
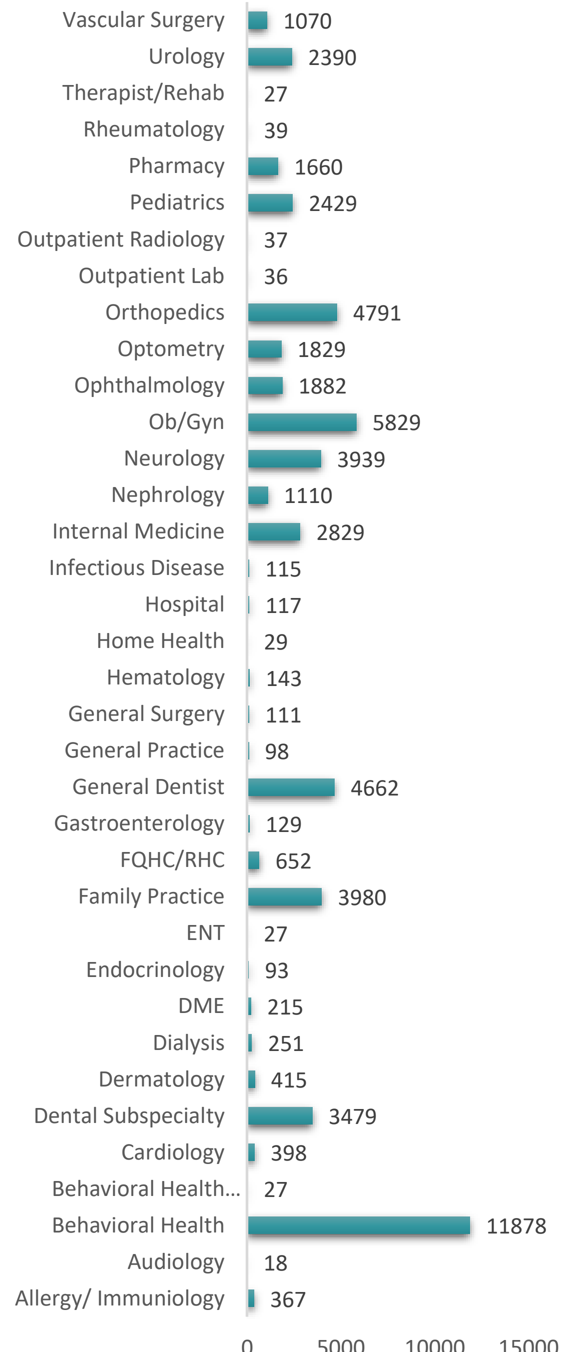


Figure 21: Quarter 4 Provider Listings by Specialty



Terminated Provider Listings

When analyzing provider listings and terminated providers reported across Quarter 3 and Quarter 4, we identified the top five specilaities terminated withing the quarter. During Quarter 3, the top two

specialities with providers terminated were internal medicine and physician assistant, while in Quarter 4, it was orthopedic surgey and emergency medicine specialties, as shown in *Table 28* and *Table 29.*

Table 28: Quarter 3 Top Five Terminated Provider Specialties

Specialty	Listings	Terminated
Certified Registered Nurse Anesthetist	6,851	42
Internal Medicine	28,514	91
Neurology	3,251	29
Physician Assistant	14,770	76
Radiology	20,454	64

Table 29: Quarter 4 Top Five Terminated Provider Specialties

Specialty	Listings	Terminated
Diagnostic Radiology	353	29
Emergency Medicine	2,952	34
Internal Medicine	29,295	33
Obstetrics & Gynecology	5,604	31
Orthopedic Surgery	5,020	57

Assessment: Provider Network Analysis

Myers and Stauffer determined that CS's network appears to be robust. Access to providers is enhanced with telemedicine to ensure compliance with the DCH contract for the provider data sample analyzed.

Appendix A: Glossary

- ***837 Health Care Claim Transaction*** *– An electronic transaction designed to submit one or more encounters from the care management organization (CMO) to the fiscal agent contractor (FAC).*
- ***CareSource Community Care-GA (CareSource or CS)*** *– An organization that has entered into a risk-based contractual arrangement with the Department to obtain and finance care for enrolled Medicaid and PeachCare for Kids members. CMOs receive a per capita or capitation payment from the Department for each enrolled member.*
- ***Appeal*** *– A request for review of an action, as "action" is defined in 42 Code of Federal Regulations (CFR) §438.400.*
- ***Appeal Process*** *– The overall process that includes appeals at the contractor level and access to the state fair hearing process (the State's administrative law hearing).*
- ***Appeal System*** *– The system used to track and process appeals at the contractor level and access to the state fair hearing process (the State's Administrative Law Hearing).*
- ***CMO*** *– An organization that has entered into a risk-based contractual arrangement with the Department to obtain and finance care for enrolled Medicaid and PeachCare for Kids members. CMOs receive a per capita or capitation claim payment from the Department for each enrolled member.*
- ***Cash Disbursement Journal (CDJ)*** *– A listing of individual cash payments made to providers by a CMO or subcontractor for a given period. Cash, in this case, refers to amounts paid via cash, check, or electronic funds transfer.*
- ***Children's Health Insurance Program*** *– Provides health coverage to children in families with incomes too high to qualify for Medicaid, but cannot afford private coverage.*
- ***Claim*** *– An electronic or paper record submitted by a Medicaid provider to the CMO detailing the health care services provided to a patient for which the provider is requesting payment. A claim may contain multiple health care services.*
- ***Claim Adjudication*** *– The determination of the CMO's payment or financial responsibility, after the member's insurance benefits are applied to a claim.*
- ***Claims Processing System*** *– A computer system or set of systems that determine the reimbursement amount for services billed by the Medicaid provider and adjudicates claims according to the applicable coverage and payment policies.*
- ***Claims Universe*** *– The population parameters for claims to be tested, including the type of claim, the categories of service, and paid dates.*

- ***Clean Claim*** *– A claim received by the CMO for adjudication, in a nationally-accepted format in compliance with standard coding guidelines, which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the CMO.*
- ***Contract Compliance*** *– A form of contract management that seeks to ensure contractors are not in violation of the terms to which they have agreed.*
- ***Coordination of Benefits*** *– The practice of determining the order in which the health plans will pay when an individual is covered under multiple plans.*
- ***Credentialing Verification Organization (CVO)*** *– The entity contracted by DCH to determine the qualifications and ascribed privileges of providers to render specific health care services and make all decisions for whether a provider meets requirements to enroll in Medicaid and in Georgia Families®.*
- ***Department of Community Health (DCH or Department)*** *– The Department within the state of Georgia that oversees and administers the Medicaid and PeachCare for Kids programs.*
- ***Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit*** *– A comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children, and adolescents under age 21.*
- ***Encounter*** *– A distinct set of health care services provided to a member enrolled with a CMO on the dates that the services were delivered.*
- ***Encounter Claim (Encounter)*** *– A record of a health care service that was delivered to an eligible health plan member that is subsequently submitted by the CMO or the CMO's subcontractor to the Medicaid FAC to load and maintain in the Georgia Medicaid and PeachCare for Kids MMIS. The Medicaid FAC does not generate a payment for the encounter claim, rather, it is maintained for program management, rate setting, and a variety of program oversight functions.*
- ***Enrollment*** *– The process by which an individual eligible for Medicaid or PeachCare for Kids® applies (whether voluntary or mandatory) to utilize the contractor's plan in lieu of the fee-for-service (FFS) program and such application is approved by DCH or its agent.*
- ***FFS Medicaid*** *– For purposes of this engagement, FFS delivery is the portion of the Medicaid and PeachCare for Kids® program which provides benefits to eligible members who were not participants in the Georgia Families® program and where providers were paid for each service.*
- ***FAC*** *– The entity contracted with the Department to process Medicaid and PeachCare for Kids® claims and other non-claim-specific payments, and receive and store encounter claim data from each of the CMOs. Also sometimes referred to as the fiscal intermediary.*
- ***Fraud, Waste, and Abuse (FWA)*** *– Intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, himself, or some other person (any act that constitutes fraud under applicable federal*

or state law); thoughtless or careless use, consumption, or spending of program resources; and improper use of program resources for personal gain or benefit.

- ***Georgia Families®** – The risk-based managed care delivery program for Medicaid and PeachCare for Kids® where the Department contracts with CMOs to manage and finance the care of eligible members.*
- ***Grievance** – An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided or aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.*
- ***Grievance System** – The overall system that addresses the manner in which the CMO handles grievances at the contractor level.*
- ***Health Insurance Portability and Accountability Act (HIPAA)** – The 1996 Act and its implementing regulations (45 CFR sections 142, 160, 162, and 164), all as may be amended.*
- ***Inter Rater Reliability (IRR) –** A performance measurement tool used to compare and evaluate the level of consistency in healthcare determinations between two or more medical and/or behavioral health utilization management clinicians.*
- ***List of Excluded Individuals and Entities** – A list maintained by the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) comprising individuals and entities excluded from federally-funded health care programs pursuant to sections 1128 and 1156 of the Social Security Act.*
- ***Medicaid Fraud Control Unit (MFCU**) – Investigates and prosecutes Medicaid provider fraud, as well as patient abuse or neglect in health care facilities and board and care facilities. The MFCUs, usually a part of the State Attorney General's office, employ teams of investigators, attorneys, and auditors; are constituted as single, identifiable entities; and must be separate and distinct from the state Medicaid agency.*
- ***Medicaid Management Information System (MMIS)** – Computerized system used for the processing, collecting, analyzing, and reporting of information needed to support Medicaid and PeachCare for Kids functions. The MMIS consists of all required subsystems as specified in the State Medicaid Manuals.*
- ***Member** – An individual who is eligible for Medicaid or PeachCare for Kids benefits. An individual who is eligible for Medicaid or PeachCare for Kids benefits might also be eligible to participate in the Georgia Families® program.*
- ***Member Call Center** – A toll-free number staffed by call center employees trained to accurately assist members with general inquiries, identify the need for crisis intervention, and provide referrals to the appropriate resources in order to meet the Medicaid member's needs.*

- ***Member Disenrollment** – The process by which an individual seeks to terminate their Medicaid or PeachCare for Kids participation.*
- ***Member Enrollment** – The process by which an individual eligible for Medicaid or PeachCare for Kids applies to become a Medicaid recipient/participant.*
- ***National Provider Identifier (NPI)** – A unique 10-digit identification number required in administrative and financial transactions adopted under HIPAA for covered health care providers.*
- ***Ombudsman** – CS employees responsible for coordinating services with local community organizations and working with local advocacy organizations to ensure members have access to covered and non-covered services and collaborating with DCH to identify and resolve issues such as access to health care service.*
- ***PeachCare for Kids®** – A comprehensive health care program for uninsured children living in Georgia. Premiums are required for children ages six and older.*
- ***Planning for Healthy Babies (P4HB)** – A DCH comprehensive prevention program to reduce the incidence of low birth weight infants.*
- ***Prescription Medication** – Medications prescribed for mental and substance use. There are many different types of medication for mental health problems, including anti-depressants, medication for attention issues, anti-anxiety medications, mood stabilizers, and antipsychotic medications.*
- ***Prior Authorization** – The process of reviewing a requested medical service or item to determine if it is medically necessary and covered under the member's plan.*
- ***Program Integrity (PI)** – Initiatives or efforts by the Department and the CMO to ensure compliance, efficiency, and accountability within the Georgia Families® program. Efforts may include detecting and preventing fraud, waste, and abuse (FWA) and ensuring Medicaid dollars are paid appropriately.*
- ***Prompt Pay Law** – Georgia's prompt pay law requires insurers to pay physicians within 15 days for electronic claims or 30 days for paper claims. If the insurer denies the claim, they must send a letter or electronic notice which addresses the reasons for failing to pay the claim.*
- ***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 timeframes provided in 42 CFR 438.408(b).*
- ***Provider** – Any person (including physicians or other health care professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or*

registered by the state of Georgia to provide health care services that has contracted with a CMO to provide health care services to members.

- ***Provider Complaint*** *– A written expression by a provider which indicates dissatisfaction or dispute with the contractor's policies, procedures, or any aspect of a contractor's administrative functions.*
- ***Provider Network*** *– A provider network is a list of hospitals, physicians, and health care other that a CMO has contracted with to provide medical care to its members.*
- ***Provider Services –*** *The primary liaison between their organization and health care providers, such as medical doctors and dentists. Specific job duties vary, depending on the employer.*
- ***Quality and Performance Improvement*** *– Consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups with the intent to better services or outcomes, and prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement.*
- ***Required Assessments and Screenings*** *– Assessments and screenings used as tools to identify immediate needs for members transitioning into and out of Georgia Families® 360°.*
- ***Special Investigations Unit*** *– CS/Anthem department responsible for the detection, prevention, investigation, reporting, correction, and deterrence of FWA.*
- ***State Fiscal Year*** *– The fiscal period utilized by the state of Georgia that begins on July 1 of each year and ends on June 30 of the following year.*
- ***Subcontracted Services*** *– Medical services the CMO pays to be performed by another company that are outside the normal day-to-day operations of their company.*
- ***Subcontractor*** *– A vendor who is overseeing or administering the approval, payment, and administration of medical, dental, vision, or other services to the Georgia Families® population on behalf of a CMO.*
- ***Subcontractor Oversight*** *– Procedures to ensure subcontractors supply the services agreed to under the financial terms and programmatic requirements outlined. Good oversight holds subcontractors accountable, while poor oversight may lead to waste, poor quality of care, fraud, and abuse of taxpayer dollars.*
- ***Third-Party Liability (TPL)*** *– TPL refers to the legal obligation of any other health insurance plan or carrier (i.e., individual, group, employer-related, self-insured, commercial carrier, automobile insurance, and/or worker's compensation) or program to pay all or part of the member's health care expenses.*

- ***U.S.HHS-OIG*** *– The office of the federal government tasked with oversight of Medicare and Medicaid programs.*
- ***Utilization Management (UM)*** *– A service performed by the contractor which seeks to ensure covered services provided to members and P4HB participants are in accordance with, and appropriate under, the standards and requirements established by the contract, or a similar program developed, established, or administered by DCH.*
- ***Waiver Program*** *– Medicaid program(s) allowing health care professionals to provide care to members with disabilities and/or chronic health conditions in the home or community instead of a long-term care facility.*
- ***Waste*** *– Over-utilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.*

Appendix B: Agreed-Upon Procedures

The agreed-upon procedures (AUPs) described below will be applied to CS and its subcontractors regarding contract compliance, claims management (including encounter submissions), program integrity, and subcontractor oversight as it relates to the Georgia Families® program.

Introduction

This document provides a summary, methodology, and agreed-upon procedures to be used to assess CareSource's business practices as it relates to the Georgia Families program. CareSource is a Georgia Families contracted Care Management Organization to the Department of Community Health (the "Department"). These procedures will be completed for the Department and no other specified parties. The Department will determine the applicability and use of the results from applying these agreed-upon procedures.

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

The following terms are used throughout this document:

- ***Abuse*** – Payment for items or services when there is no legal entitlement to that payment and the individual or entity has not knowingly and/or intentionally misrepresented facts to obtain payment.
- ***Appeal*** – A request for review of an action, as "action" is defined in 42 C.F.R. §438.400.
- ***Appeal System*** – The system used to track and process appeals at the Contractor level and access to the State Fair Hearing process (the State's Administrative Law Hearing).
- ***Care Management Organization (CMO)*** – An organization that has entered into a risk-based contractual arrangement with the Department to obtain and finance care for enrolled Medicaid and PeachCare for Kids® members. CMOs receive a per capita or capitation claim payment from the Department for each enrolled member.
- ***CareSource*** – CareSource is a Care Management organization contracted by the Department of Community Health to deliver health care services to Georgia Families members.
- ***Cash Disbursement Journal (CDJ)*** – A listing of individual cash payments made to providers by a Care Management Organization or subcontractor for a given period. Cash, in this case, refers to amounts paid via cash, check, or electronic funds transfer.

- ***Claim*** – An electronic or paper record submitted by a Medicaid provider to the CMO detailing the healthcare services provided to a patient for which the provider is requesting payment. A claim may contain multiple healthcare services.
- ***Claim Adjudication*** – The determination of the CMO's payment or financial responsibility after the member's insurance benefits are applied to a claim.
- ***Claims Management*** – The end-to-end process of receiving, organizing and adjudicating health care claims, utilizing information regarding the diagnosis, procedures, medications and other forms of treatment, resulting in payments issued to the individual(s), entity, or entities who rendered the service(s).
- ***Claims Processing System*** – A computer system or set of systems that determine the reimbursement amount for services billed by the Medicaid provider and adjudicates claims according to the applicable coverage and payment policies.
- ***Claims Universe*** – The population parameters for claims to be tested, including the type of claim, the categories of service, and paid dates.
- ***Contract Compliance*** – A form of contract management that seeks to ensure that contractors are not in violation of the terms to which they have agreed.
- ***Encounter*** – A distinct set of health care services provided to a Member enrolled with a CMO on the dates that the services were delivered.
- ***Encounter Claim*** – A record of a health care service that was delivered to an eligible member and submitted for payment by a CMO or Subcontractor that is subsequently submitted by the CMO or CMO Subcontractor to the Medicaid fiscal agent contractor to load and maintain in the Georgia Medicaid and PeachCare for Kids® MMIS. The Medicaid fiscal agent contractor does not generate a payment for the encounter claim, but rather it is maintained for program management, rate setting, and a variety of program oversight functions.
- ***Fraud*** – Generally defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.
- ***Georgia Families*** – The risk-based managed care delivery program for Medicaid and PeachCare for Kids® where the Department contracts with Care Management Organizations to manage and finance the care of eligible members.
- ***Grievance*** – An expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances include, but are not limited to, the quality of care or services

provided or aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights.

- ***Grievance System*** – The overall system that addresses the manner in which the CMO handles Grievances at the Contractor level.

- ***Medicaid Management Information System (MMIS)*** – A computerized system used for the processing, collecting, analyzing, and reporting of information needed to support Medicaid and PeachCare for Kids® functions. The MMIS consists of all required subsystems as specified in the State Medicaid Manuals.

- ***Member*** – An individual who is eligible for Medicaid or PeachCare for Kids® benefits. An individual who is eligible for Medicaid or PeachCare for Kids® benefits might also be eligible to participate in the Georgia Families program.

- ***Member Call Center*** – A toll free number staffed by call center employees trained to accurately assist members with general inquiries, identify the need for crisis intervention and provide referrals to the appropriate resources in order to meet the Medicaid member's needs.

- ***PeachCare for Kids®*** – A comprehensive health care program for uninsured children living in Georgia. Premiums are required for children ages six and older.

- ***Planning for Healthy Babies (P4HB)*** – A DCH comprehensive prevention program to reduce the incidence of low birth weight infants

- ***Prior Authorization*** – The process of reviewing a requested medical service or item to determine if it is medically necessary and covered under the member's plan.

- ***Program Integrity*** – As mandated in section 4.13 of the contract between DCH and CareSource, a compliance program to be maintained by the CMO designed to guard against fraud and abuse. This Program Integrity program shall include policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for suspected cases of fraud and abuse in the administration and delivery of services under the contract.

- ***Provider*** – Any person (including physicians or other Health Care Professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or registered by the State of Georgia to provide Health Care Services that has contracted with a Care Management Organization to provide health care services to Members.

- ***Provider Complaint*** – A written expression by a Provider, which indicates dissatisfaction or dispute with the Contractor's policies, procedures, or any aspect of a Contractor's administrative functions.

- ***Provider Network*** – A provider network is a list of hospitals, physicians, and health care organizations that a CMO has contracted with to provide medical care to its members.

- ***Provider Services –*** The primary liaison between their organization and health care providers, such as medical doctors and dentists. Specific job duties vary, depending on the employer.

- ***Quality Improvement*** – Consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups. The goal is to provide better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent, systemic problems and/or barriers to improvement for the targeted patient population.

- ***Subcontracted Services*** – Medical services the CMO pays to be performed by another company that are outside the normal day-to-day operations of their company.

- ***Subcontractor*** – A vendor who is overseeing or administering the approval, payment, and administration of medical services to the Georgia Families population on behalf of a CMO.

- ***Subcontractor Oversight*** – Procedures to ensure that subcontractors supply the services agreed to under the financial terms and programmatic requirements outlined. Good oversight holds subcontractors accountable while poor oversight may lead to waste, poor quality of care, fraud, and abuse of taxpayer dollars.

- ***Utilization Management*** – A service performed by the Contractor which seeks to assure that Covered Services provided to Members and Planning for Health Babies (P4HB) Participants are in accordance with, and appropriate under, the standards and requirements established by the Contract, or a similar program developed, established or administered by DCH.

- *Waste* – Over-utilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

Project Team

The following key personnel will be used for this engagement:

Michael D. Johnson, CPA, CFE – project director
Savombi Fields, CFE, CPC-P – project manager
Stephen Fader, CFE – project manager
Ron Beier, CPA – quality assurance

We anticipate that managers and analysts from our Atlanta office will participate in this engagement, as necessary.

Objectives

The objective of this engagement is to apply agreed-upon procedures to assess CareSource's health plan operations as it relates to the Georgia Families. Specifically, this engagement will focus on the internal controls and processes related to:

- Contract Compliance
- Claims Management including Encounter Submissions
- Program Integrity
- Subcontractor Oversight

Scope of Activities

The scope of the engagement will include the following activities:

- **Planning and Preparation** – This activity will include preparation for testing and analysis of background materials. The engagement team will analyze the contracts between DCH and CareSource along with contracts between CareSource and its subcontractors. We will submit to CareSource a data, CDJ, documentation request, and a questionnaire in order to gain insight into CareSource's operations. We will use the obtained responses to develop specific focus topics, interview questions, and a general template for the CareSource staff interview procedures.

- **CareSource Staff Interviews, and Document Analysis** – The engagement team will meet with selected staff from CareSource and its subcontractors to discuss their policies and procedures. Depending on the nature of the information provided, it may also be necessary to conduct demonstrations of certain CareSource or subcontractor procedures. A high-level overview of the findings will be conducted during an exit conference on the last day of interview sessions, if necessary.

- **Synthesis, Clarification, and Additional Procedures** – The engagement team may request any additional documents that may be necessary. Additional meetings with CareSource and its subcontractor(s) may be required at this stage, if applicable.

- **Tabulation Activities** – Findings from the agreed-upon procedures will be tabulated and summarized. A draft report of findings will be prepared and submitted to the Department. DCH will share the report with CareSource as DCH deems appropriate.

- **CareSource Review and Response to Draft Report** – CareSource may provide comments and clarifications to any part of the report. Responses from CareSource and/or its subcontractors may be included as an attachment or exhibit to the report. We will assist the Department with the development of corrective action plans, if deficiencies exist.

- **Synthesis, Clarification, and Final Report** – The engagement team will consider any additional documentation, clarification, and corrective action plans provided by CareSource. Findings from the agreed-upon procedures are only amended to correct errant findings or misstatements. The report will not be amended to reflect CareSource or its subcontractor comments. A final report will be submitted to the Department.

The scope of activities above and the agreed upon procedures noted herein may be modified at the request of the Department.

Agreed Upon Procedures

The agreed-upon procedures described below will be applied to CareSource and its subcontractors regarding Contract Compliance, Claims Management including Encounter Submissions, Program Integrity, and Subcontractor Oversight as it relates to the Georgia Families program.

1. We will request that CareSource and its subcontractors identify and provide policies and procedures related to Contract Compliance in the following areas:
    - Internal Grievance/Appeal System;
    - Member and Provider Call Center Operations;
    - Member Services including Ombudsman;
    - Provider Network;
    - Provider Services;
    - Quality Management and Performance Improvement;
    - Regulatory Reporting and Monitoring; and
    - Utilization Management

    The following procedures will be performed:
    - We will:
        i. Review then determine if the policies are in accordance with the contract between DCH and CareSource.
        ii. Review the information provided during the CareSource staff interviews then determine if responses are in accordance with the contract between DCH and CareSource.

2. We will request that CareSource and its subcontractors identify and provide their policies and procedures related to Claims Management including Encounter Submissions. We will also request claims data for analyses. The following procedures will be performed:
    - We will:
        i. Review then determine if the policies are in accordance with the contract between DCH and CareSource.
        ii. Review the information provided during the CareSource staff interviews then determine if responses are in accordance with the contract between DCH and CareSource.
        iii. Analyze the claims workflows and processes within CareSource and between CareSource and its subcontractors.
        iv. Analyze the encounter workflows and processes within CareSource and between CareSource and its subcontractors.
        v. Assess the effectiveness of internal controls used to ensure complete, timely, and accurate encounters are reported.
        vi. Select a sample of encounters submitted to the Department's Fiscal Agent Contractor and trace the reported information to CareSource's (and subcontractor's) payment system.
        vii. Research then determine the cause of any discrepancies.

viii. Analyze the claims payment system and accuracy of claim pay dates, particularly on adjustments and voids.

3. We will request that CareSource and its subcontractors identify and provide their policies and procedures related to Program Integrity. The following procedures will be performed:
   - We will:
     i. Review then determine if the policies are in accordance with the contract between DCH and CareSource.
     ii. Review the information provided during the CareSource staff interviews then determine if responses are in accordance with the contract between DCH and CareSource.
     iii. Confirm that CareSource's program integrity policies and procedures address prevention, detection, investigation, reporting, and corrective action of suspected cases of fraud, waste, and abuse (FWA).
     iv. Determine whether CareSource has a monitoring system to address program integrity cases, along with methods and criteria for identifying, tracking, and resolving FWA cases.
     v. Ensure that CareSource have adopted and implemented training programs, which include FWA components.
     vi. Review reports to confirm evidence of the CareSource's oversight activities.
     vii. Review the CareSource's organizational structure, including local and corporate staff. Determine whether they have dedicated local health plan staff performing oversight and monitoring activities.

4. We will request that CareSource identify and provide their policies and procedures related to Subcontractor Oversight The following procedures will be performed:
   - We will:
     i. Review then determine if the policies are in accordance with the contract between DCH and CareSource and CareSource and its Subcontractors.
     ii. Review the information provided during the staff interviews then determine if responses are in accordance with the contract between DCH and CareSource and CareSource and its Subcontractors.

iii. Review CareSource's approach to providing oversight of its Subcontractors.
iv. Analyze the claims workflows and processes within the Subcontractors and between the Subcontractors and CareSource.
v. Analyze the encounter workflows and processes within the Subcontractors and between the Subcontractors and CareSource.
vi. Analyze the member and provider enrollment workflows and processes within the Subcontractors and between the Subcontractors and CareSource.
vii. Analyze the member and provider data workflows and processes within the Subcontractors and between the Subcontractors and CareSource.
viii. Determine whether the Subcontractors has program integrity policies and procedures in place for the prevention, detection, investigation, reporting, and corrective action of suspected cases of FWA.
ix. Determine whether the Subcontractors has a monitoring system to address program integrity cases, along with methods and criteria for identifying, tracking, and resolving FWA cases.
x. Ensure that Subcontractors have adopted and implemented training programs, which include FWA components.
xi. Review reports to confirm evidence of the Subcontractors' oversight activities.
xii. Review the Subcontractors' organizational structure, including local and corporate staff. Determine whether they have dedicated local health plan staff performing oversight and monitoring activities.
xiii. Confirm that contracts between CareSource and Subcontractors outline program integrity responsibilities and include sanctions for non-performance.
xiv. Review corrective action procedures administered, if any, by CareSource as a result of Subcontractor contractual non-compliance.

Environment for Interview Procedures

Myers and Stauffer will meet with key staff at CareSource and its subcontractor's staff to establish the environment for the agreed-upon procedures. Timeframes for the staff interviews, procedures for conducting interviews, and other logistics will be discussed. Below are general guidelines for the preferred conditions in which interview activities will be conducted.

- One to four Myers and Stauffer engagement team members will be speaking directly to a single staff member. Exceptions may be made where representatives have shared responsibilities. This exception must be noted and approved in advance. A DCH staff member may choose participate in this engagement. All interviews are recorded for note taking purposes only.

- Documents may be requested at any time by the engagement team before, during, or after the interview process. CareSource should make every effort to provide those documents at its earliest convenience.

- Interviews, either planned or unplanned, may be requested during the staff interview sessions. We will be cautious to minimize interruptions to normal business operations.

- An attestation form is required to certify that the data, CDJ, and documentation provided, and statements made to Myers and Stauffer, DCH, and/or other DCH designated representatives by the management or staff of CareSource during the course of this engagement are accurate, complete, and truthful.

Other Information

Myers and Stauffer Workpapers
Myers and Stauffer's workpapers are proprietary and are for internal use only. At the Department's request, we may provide copies of the workpapers to the Department and specified users of the report.

DCH Interview Staffing
The Department may wish to assign a representative to be available during CareSource staff interviews. This assignment is at the Department's discretion. In order to preserve the independence of Myers and Stauffer and DCH and ensure the value of the final deliverable, it is expected that DCH's role will be limited to observation and encouraging cooperation with the plan.

Updates
We will provide regular updates to the Department and other necessary parties. These updates will identify factors that could cause delays with the overall timelines and will include issues for the Department's resolution, key communications, and other status information. These updates will continue over the course of the engagement.

Estimated Timelines
We anticipate the project will take approximately six to eight months for completion through the draft report phase. CareSource staff interviews are projected to begin in October 2022. Please note that this timeframe an estimate and subject to the on-going completion of activities by all parties, including the DCH, Myers and Stauffer, CareSource, and other parties. Dates may require adjustment based on project events and other unforeseen situations.

Appendix C: Georgia Families® Policy and Procedure Review

Contract Compliance

Contract Compliance	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
4.13.2.1 The Contractor's compliance plan shall include, at a minimum, the following: 4.13.2.1.1 The designation of a Compliance Officer who is accountable to the Contractor's senior management and is responsible for ensuring that policies to establish effective lines of communication between the Compliance Officer and the Contractor's staff, and between the Compliance Officer and DCH staff, are followed.	Yes
4.13.2.1.2 Provision for internal monitoring and auditing of reported Fraud , Waste and Abuse violations, including specific methodologies for such monitoring and auditing;	Yes
4.13.2.1.3 Policies to ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's Fraud, Waste and Abuse compliance plan;	Yes
4.13.2.1.4 Policies to establish a compliance committee that meets quarterly and reviews Fraud, Waste and Abuse compliance issues;	Yes
4.13.2.1.5 Policies to ensure that any individual who reports CMO violations or suspected Fraud, Waste and Abuse will not be retaliated against;	Yes
4.13.2.1.6 Policies of enforcement of standards through well-publicized disciplinary standards;	Yes
4.13.2.1.7 Provision of a data system, resources and staff to perform the Fraud, Waste and Abuse and other compliance responsibilities;	Yes
4.13.2.1.8 Procedures for the detection of Fraud, Waste and Abuse that includes, at a minimum, the following: 4.13.2.1.8.1 Prepayment review of claims; 4.13.2.1.8.2 Claims edits; 4.13.2.1.8.3 Post-processing review of Claims; 4.13.2.1.8.4 Provider profiling; 4.13.2.1.8.5 Quality Control; and 4.13.2.1.8.6 Utilization Management.	Yes
4.13.2.1.9 Written standards for organizational conduct;	Yes
4.13.2.1.10 Effective training and education for the Compliance Officer and the organization's employees, management, board Members, and Subcontractors;	Yes
4.13.2.1.11 Inclusion of information about Fraud, Waste and Abuse identification and reporting in Provider and Member materials;	Yes

Contract Compliance	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
4.13.2.1.12 Provisions for the investigation, corrective action and follow-up of any suspected Fraud, Waste and Abuse reports;	Yes
4.13.2.1.13 Procedures for notification to DCH Office of the Inspector General requesting permission before initiating an investigation, notifying a provider of the outcome of an investigation, and/or recovery of any overpayments identified;	Yes
4.13.2.1.14 Procedures for reporting suspected Fraud, Waste and Abuse cases to the Georgia Medicaid Fraud Control Unit, through the State Program Integrity Unit, including timelines and use of State approved forms.	Yes

Internal Grievance/Appeal System

Internal Grievance/Appeal System	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
4.14.1.1 The Contractor's Grievance System shall include a process to receive, track, resolve and report on Grievances from its Members. The Contractor's Appeals Process shall include an Administrative Review process and access to the State's Administrative Law Hearing (State Fair Hearing) system. The Contractor's Appeals Process shall include an internal process that must be exhausted by the Member prior to accessing an Administrative Law Hearing. See O.C.G.A. §49-4-153.	Yes
4.14.1.2 The Contractor shall develop written Grievance System and Appeals Process Policies and Procedures that detail the operation of the Grievance System and the Appeals Process. The Contractor's policies and procedures shall be available in the Member's primary language. The Grievance System and Appeals Process Policies and Procedures shall be submitted to DCH for initial review and approval, and as updated thereafter.	Yes
4.14.1.3 The Contractor shall process each Grievance and Administrative Review using applicable State and federal laws and regulations, the provisions of this Contract, and the Contractor's written policies and procedures. Pertinent facts from all parties must be collected during the investigation.	Yes
4.14.1.4 The Contractor shall give Members any reasonable assistance in completing forms and taking other procedural steps for both Grievances and Administrative Reviews. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTD and interpreter capability.	Yes
4.14.1.5 The Contractor shall acknowledge receipt of each filed Grievance and Administrative Review in writing within ten (10) Business Days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Grievance and Appeal resolutions.	Yes

Internal Grievance/Appeal System	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
4.14.1.6 The Contractor shall ensure that the individuals who make decisions on Grievances and Administrative Reviews were not involved in any previous level of review or decision making; and are Health Care Professionals who have the appropriate clinical expertise, as determined by DCH, in treating the Member's Condition or disease if deciding any of the following:	Yes
4.14.1.6.1 An Appeal of a denial that is based on lack of Medical Necessity;	Yes
4.14.1.6.2 A Grievance regarding denial of expedited resolutions of an Administrative Review; and	Yes
4.14.1.6.3 Any Grievance or Administrative Review that involves clinical issues.	Yes
4.14.3.3 The Contractor shall acknowledge receipt of each filed Grievance in writing within ten (10) Calendar days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Grievance resolutions.	Yes
4.14.3.4 The Contractor shall issue disposition of the Grievance as expeditiously as the Member's health Condition requires but such disposition must be completed within ninety (90) Calendar Days of the filing date.	Yes
4.14.3.1 A Member or Member's Authorized Representative may file a Grievance to the Contractor either orally or in writing. A Grievance may be filed about any matter other than a Proposed Action. A Provider cannot file a Grievance on behalf of a Member.	Yes
4.14.3.2 The Contractor shall ensure that the individuals who make decisions on Grievances that involve clinical issues are Health Care Professionals, under the supervision of the Contractor's Medical Director, who have the appropriate clinical expertise, as determined by DCH, in treating the Member's Condition or disease and who were not involved in any previous level of review or decision-making.	Yes
4.14.3.3 The Contractor shall acknowledge receipt of each filed Grievance in writing within ten (10) Calendar days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Grievance resolutions.	Yes
4.14.3.4 The Contractor shall issue disposition of the Grievance as expeditiously as the Member's health Condition requires but such disposition must be completed within ninety (90) Calendar Days of the filing date.	Yes

Member and Provider Call Center Operations

Member and Provider Call Center Operations	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
Member Call Center Operations	
4.3.7.1 The contractor shall operate a toll-free telephone line to respond to Member questions and comments.	Yes
4.3.7.2 The contractor shall develop call center policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.	Yes
4.3.7.3 The contractor shall submit these call center policies and procedures, including performance standards, to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date, and as updated thereafter.	Yes
4.3.7.4 The call center must comply with Title IV of the Civil Rights Act. The call center shall be equipped to handle calls from non-English speaking callers, as well as calls from Members who are hearing impaired.	Yes
4.3.7.5 The contractor shall fully staff the call center between the hours of 7:00 a.m. and 7:00 p.m. EST, Monday through Friday, excluding State holidays. The call center staff shall be trained to accurately respond to Member questions in all areas, including, but not limited to, Covered Services, the Provider Network, and Non-Emergency Transportation (NET). Additionally, Amerigroup shall have an automated system available between the hours of 7:00 a.m. and 7:00 p.m. EST Monday through Friday and at all hours on weekends and State holidays. This automated system must provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. A Contractor's Representative shall return messages on the next Business Day.	Yes
4.3.7.6 The contractor shall achieve performance standards and monitor call center performance by recording calls and employing other Monitoring activities Amerigroup shall develop Call Center Quality Criteria and Protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the Toll-free Call Center. Amerigroup shall submit the Call Center Quality Criteria and Protocols to DCH Provider Services for review and approval annually. At a minimum, the standards shall require that, on a Calendar month basis:	Yes
4.3.7.6.1 Average Speed of Answer: Ninety percent (90%) of calls shall be answered by a person within thirty (30) seconds with the remaining ten percent (10%) answered within an additional thirty (30) seconds by a live operate measured weekly. "Answer" shall mean for each caller who elects to speak, is connected to a live representative. The caller shall not be placed on hold immediately by the live representative.	Yes
4.3.7.6.2 Abandoned Call Rate of five percent (5%) or less. DCH considers a call to be "abandoned" if the caller elects an option and is either (i) not	Yes

Member and Provider Call Center Operations	
Contract Language	CS Policy Is Consistent with Contract Requirement(s) *Yes or No*
permitted access to that option, or (ii) the system disconnects the call while the Member is on hold.	
4.3.7.6.3 Blocked Call Rate, or a call that was not allowed into the system, does not exceed one percent (1%).	Yes
4.3.7.6.4 Average Hold Time of less than one (1) minute ninety-nine percent (99%) of the time. Hold time refers to the average length of time callers are placed on hold by a Call Center Representative.	Yes
4.3.7.6.5 Timely Response to Call Center Phone Inquiries: One hundred percent (100%) of call center open inquiries will be resolved and closed within seventy-two (72) clock hours. DCH will provide the definition of "closed" for this performance measure.	Yes
4.3.7.6.6 Accurate Response to Call Center Phone Inquiries: Call center representatives accuracy rate must be ninety percent (90%) or higher.	Yes
4.3.7.7 The contractor shall establish remote phone monitoring capabilities for at least five (5) DCH staff. DCH or its Agent shall be able, using a personal computer and/or phone, to monitor call center and field office calls in progress and to identify the number of call center staff answering calls and the identity of the individual call center staff answering the calls.	Yes
4.3.10.1 The Contractor shall provide oral interpretation 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. Amerigroup shall 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 interpretation services.	Yes
4.9.5.1 The Contractor shall operate a toll-free call center to respond to Provider questions, comments, and concerns.	Yes
4.9.5.2 The Contractor shall develop call center Policies and Procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.	Yes
4.9.5.3 The Contractor shall submit these call center Policies and Procedures, including performance standards, to DCH for initial review and approval as updated thereafter.	Yes
4.9.5.4 The Contractor's call center systems shall have the capability to track call management metrics identified in Attachment K.	Yes
4.9.5.5 Pursuant to O.C.G.A. 33-20A-7.1(c), the call center shall be staffed twenty-four (24) hours a day, seven (7) days a week to respond to Prior Authorization and Pre-Certification requests. This call center 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. The Contractor shall ensure that after regular business hours the non-Prior	Yes

Member and Provider Call Center Operations	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
Authorization/ Pre-certification line is answered by an automated system with the capability to provide callers with operating hours information and instructions on how to verify enrollment for a Member with an Emergency or Urgent Medical Condition. The call center shall have the capability for callers to leave a message, which shall be returned within twenty-four (24) clock hours. The requirement that the Contractor shall provide information to Providers on how to verify enrollment for a Member with an Emergency or Urgent Medical Condition shall not be construed to mean that the Provider must obtain verification before providing Emergency Services.	
4.9.5.6 The Contractor shall develop Call Center Quality Criteria and Protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the Toll-free Call Center. The Contractor shall submit the call center Quality Criteria and Protocols to DCH Provider Services for initial review and approval and as updated thereafter. At a minimum, the standards shall require that, on a Calendar month basis:	Yes
4.9.5.6.1 Average Speed of Answer: Eighty percent (80%) of calls shall be answered by a person within thirty (30) seconds. “Answer” shall mean for each caller who elects to speak, is connected to a live representative. The caller shall not be placed on hold immediately by the live representative. The remaining twenty percent (20%) of calls shall be answered within one (1) minute of the call.	Yes
4.9.5.6.2 Abandoned Call Rate of five percent (5%) or less. DCH considers a call to be "abandoned" if the caller elects an option and is either (i) not permitted access to that option, or (ii) the system disconnects the call while the Member is on hold.	Yes
4.9.5.6.3 Blocked Call Rate, or a call that was not allowed into the system, does not exceed one percent (1%).	Yes
4.9.5.6.4 Average Hold Time of less than one (1) minute ninety-nine percent (99%) of the time. Hold time refers to the average length of time callers are placed on hold by a live Call Center Representative.	Yes
4.9.5.6.5 Timely Response to call center Phone Inquiries: One hundred percent (100%) of call center open inquiries will be resolved and closed within seventy-two (72) clock hours. DCH will provide the definition of “closed” for this performance measure.	Yes
4.9.5.6.6 Accurate Response to Call Center Phone Inquiries: Call Center representatives accuracy rate must be ninety percent (90%) or higher.	Yes
4.9.5.7 The Contractor shall set up remote phone monitoring capabilities for at least ten (10) DCH staff. DCH shall be able, using a personal computer or phone, to monitor call Center and field office calls in progress and to identify the number of call center staff answering calls and the call center staff identifying information. The Contractor will facilitate bi-annual calibration sessions with DCH. The purpose of the calibration sessions is to ensure call center monitoring findings conducted by DCH and the Contractor are consistent.	Yes

Member and Provider Call Center Operations	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
Provider Call Center Operations	
4.9.5.1 The Contractor shall operate a toll-free call center to respond to Provider questions, comments, and concerns.	Yes
4.9.5.2 The Contractor shall develop call center Policies and Procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.	Yes
4.9.5.3 The Contractor shall submit these call center Policies and Procedures, including performance standards, to DCH for initial review and approval as updated thereafter.	Yes
4.9.5.4 The Contractor's call center systems shall have the capability to track call management metrics identified in Attachment K.	Yes
4.9.5.5 Pursuant to O.C.G.A. 33-20A-7.1(c), the call center shall be staffed twenty-four (24) hours a day, seven (7) days a week to respond to Prior Authorization and Pre-Certification requests. This call center 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. The Contractor shall ensure that after regular business hours the non-Prior Authorization/ Pre-certification line is answered by an automated system with the capability to provide callers with operating hours information and instructions on how to verify enrollment for a Member with an Emergency or Urgent Medical Condition. The call center shall have the capability for callers to leave a message, which shall be returned within twenty-four (24) clock hours. The requirement that the Contractor shall provide information to Providers on how to verify enrollment for a Member with an Emergency or Urgent Medical Condition shall not be construed to mean that the Provider must obtain verification before providing Emergency Services.	Yes
4.9.5.6 The Contractor shall develop Call Center Quality Criteria and Protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the Toll-free Call Center. The Contractor shall submit the call center Quality Criteria and Protocols to DCH Provider Services for initial review and approval and as updated thereafter. At a minimum, the standards shall require that, on a Calendar month basis:	Yes
4.9.5.6.1 Average Speed of Answer: Eighty percent (80%) of calls shall be answered by a person within thirty (30) seconds. "Answer" shall mean for each caller who elects to speak, is connected to a live representative. The caller shall not be placed on hold immediately by the live representative. The remaining twenty percent (20%) of calls shall be answered within one (1) minute of the call.	Yes
4.9.5.6.2 Abandoned Call Rate of five percent (5%) or less. DCH considers a call to be "abandoned" if the caller elects an option and is either (i) not permitted access to that option, or (ii) the system disconnects the call while the Member is on hold.	Yes

Member and Provider Call Center Operations	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
4.9.5.6.3 Blocked Call Rate, or a call that was not allowed into the system, does not exceed one percent (1%).	Yes
4.9.5.6.4 Average Hold Time of less than one (1) minute ninety-nine percent (99%) of the time. Hold time refers to the average length of time callers are placed on hold by a live Call Center Representative.	Yes
4.9.5.6.5 Timely Response to call center Phone Inquiries: One hundred percent (100%) of call center open inquiries will be resolved and closed within seventy-two (72) clock hours. DCH will provide the definition of “closed” for this performance measure.	Yes
4.9.5.6.6 Accurate Response to Call Center Phone Inquiries: Call Center representatives accuracy rate must be ninety percent (90%) or higher.	Yes
4.9.5.7 The Contractor shall set up remote phone monitoring capabilities for at least ten (10) DCH staff. DCH shall be able, using a personal computer or phone, to monitor call Center and field office calls in progress and to identify the number of call center staff answering calls and the call center staff identifying information. The Contractor will facilitate bi-annual calibration sessions with DCH. The purpose of the calibration sessions is to ensure call center monitoring findings conducted by DCH and the Contractor are consistent.	Yes

Member Services including Ombudsman

Member Services including Ombudsman	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
4.3.1.1 The Contractor shall ensure that Members are aware of the following:	
4.3.1.1.1 Member rights and responsibilities	Yes
4.3.1.1.2 The role of PCPs and Dental Home	Yes
4.3.1.1.3 The role of the Family Planning Provider and PCP (for IPC P4HB Participants only)	Yes
4.3.1.1.4 How to obtain care	Yes
4.3.1.1.5 What to do in an emergency or urgent medical situation (for P4HB participants information must address what to do in an emergency or urgent medical situation arising from the receipt of Demonstration related Services)	Yes
4.3.1.1.6 How to request a Grievance, Appeal, or Administrative Law Hearings	Yes
4.3.1.1.7 How to report suspected Fraud and Abuse	Yes
4.3.1.1.8 Providers who have been terminated from the Contractor’s network	Yes
4.3.1.2 The Contractor must be prepared to utilize all forms of population-appropriate communication to reach the most Members and engender the most responses. Examples of communications include but are not limited to telephonic; hard copy via mail; social media; texting; and email that allow	Yes

Member Services including Ombudsman	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
Members to submit questions and receive responses from the Contractor while protecting the confidentiality and PHI of the Members in all instances. The Contractor shall attempt to collect/obtain Member email addresses from Members. Upon request, the Contractor must provide materials in the format preferred by the Member.	
4.3.2.1 The Contractor shall make all written materials available in a manner that takes into consideration the Member's needs, including those who are visually impaired or have limited reading proficiency. The Contractor shall notify all Members that information is available in alternative formats and how to access those formats.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.3.2.2 The Contractor shall make all written information available in English, Spanish and all other prevalent non-English languages, as defined by DCH. For the purposes of this Contract, prevalent means a non-English language spoken by a significant number or percentage of Medicaid and PeachCare for Kids® eligible individuals in the State, as defined by DCH.	Yes
4.3.2.3 All written materials distributed to Members shall include a language block, printed in Spanish and all other prevalent non-English languages, that informs the Member that the document contains important information and directs the Member to call the Contractor to request the document in an alternative language or to have it orally translated.	Yes
4.3.2.4 All written materials shall be worded such that they are understandable to a person who reads at the fifth (5th) grade level.	Yes
4.3.2.5 The Contractor shall provide written notice to DCH of any changes to any written materials provided to the Members. Written notice shall be provided at least thirty (30) Calendar Days before the effective date of the change.	Yes
4.3.2.6 The Contractor must submit all written materials, including information for the Contractor's Web site, to DCH for approval prior to use or mailing. DCH will approve or identify any required changes to the Member materials within thirty (30) Calendar Days of submission. DCH reserves the right to require the discontinuation of any Member materials that violate the terms of this Contract.	Yes
4.3.3.1 The Contractor shall provide a Member Handbook, a P4HB participant Handbook, and other programmatic information to Members. The Contractor shall make the Member and P4HB participant Handbook available to Members through the Contractor's web site. Upon request, the Contractor shall mail a hard copy of the Member Handbook to enrolled Member households and a P4HB participant information packet to P4HB participant households.	Yes
4.3.3.2 The Member Handbook shall include all requirements set forth in 42 CFR 438.10.	Yes

Member Services including Ombudsman	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
4.3.6.1 The Contractor shall mail via surface mail a Member ID Card to all new Members according to the following timeframes: 4.3.6.1.1 Within seven (7) Calendar Days of receiving the notice of Enrollment from DCH or the Agent for Members who have selected a CMO and a PCP.	Yes
4.3.6.3 The Contractor shall reissue the Member ID Card within seven (7) Calendar Days of notice if a Member reports a lost card, there is a Member name change, the PCP changes, or for any other reason that results in a change to the information disclosed on the Member ID Card.	Yes
4.3.6.4 The Contractor shall submit a front and back sample Member ID Card to DCH for initial review and approval, within sixty (60) Calendar Days of the Contract Effective Date and approval and as updated thereafter.	Yes
4.3.6.5 The Contractor shall mail via surface mail a P4HB participant ID Card to all new P4HB participants in the Demonstration within Seven (7) Calendar Days of receiving the notice of Enrollment from DCH or its Agent. The P4HB participant's ID Card will meet the requirements set forth for Member ID Cards in Sections 4.3.6.2 (excluding Section 4.3.6.2.4), 4.3.6.3 and 4.3.6.4, and will identify the Demonstration component in which the P4HB participant is enrolled:	Yes
4.3.6.5.1 A Pink color will signify the P4HB participants as eligible for Family Planning Services Only.	Yes
4.3.6.5.2 A Purple color will signify the P4HB participants as eligible for Interpregnancy Care Services and Family Planning Services.	Yes
4.3.6.5.3 A Yellow color will signify the P4HB participant as eligible for Case Management – Resource Mothers Outreach Only.	Yes
4.3.6.6 Each time the P4HB participant's ID card is issued or re-issued to a P4HB participant, the Contractor shall provide written materials that explain the meaning of the color coding of the ID card and its relevance to Demonstration benefits.	Yes
16.1.5.21 Ombudsman Staff including Ombudsman Coordinator and Ombudsman Liaison. The Contractor must consider and monitor current Enrollment levels when evaluating the number of Ombudsman Liaisons necessary to meet Member needs. The Ombudsmen staff is responsible for collaborating with DCH's designated staff in the identification and resolution of issues. Such collaboration includes working with DCH staff on issues of access to health care services, and communication and education Members and Providers.	Yes

Program Integrity

Program Integrity	
Contract Language	CS Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.13.1.1 The Contractor shall have a Program Integrity Program, including a mandatory compliance plan, designed to guard against Fraud and Abuse. This Program Integrity Program shall include policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for suspected cases of Fraud, Waste and Abuse in the administration and delivery of services under this Contract.	Yes
4.13.1.2 The Contractor shall submit its Program Integrity Policies and Procedures, which include the compliance plan and pharmacy lock-in program described below.	Yes
4.13.1.3 The Contractor shall provide DCH with a copy of any Program Integrity settlement agreement entered into with a Provider including the settlement amount and Provider type within seven (7) Business Days of the settlement.	Yes
4.13.2.1 The Contractor's compliance plan shall include, at a minimum, the following:	
4.13.2.1.1 The designation of a Compliance Officer who is accountable to the Contractor's senior management and is responsible for ensuring that policies to establish effective lines of communication between the Compliance Officer and the Contractor's staff, and between the Compliance Officer and DCH staff, are followed.	Yes
4.13.2.1.2 Provision for internal monitoring and auditing of reported Fraud , Waste and Abuse violations, including specific methodologies for such monitoring and auditing;	Yes
4.13.2.1.3 Policies to ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's Fraud, Waste and Abuse compliance plan;	Yes
4.13.2.1.4 Policies to establish a compliance committee that meets quarterly and reviews Fraud, Waste and Abuse compliance issues;	Yes
4.13.2.1.5 Policies to ensure that any individual who reports CMO violations or suspected Fraud, Waste and Abuse will not be retaliated against;	Yes
4.13.2.1.6 Policies of enforcement of standards through well-publicized disciplinary standards;	Yes
4.13.2.1.7 Provision of a data system, resources and staff to perform the Fraud, Waste and Abuse and other compliance responsibilities;	Yes
4.13.2.1.8 Procedures for the detection of Fraud, Waste and Abuse that includes, at a minimum, the following: 4.13.2.1.8.1 Prepayment review of claims; 4.13.2.1.8.2 Claims edits; 4.13.2.1.8.3 Post-processing review of Claims; 4.13.2.1.8.4 Provider profiling;	Yes

Program Integrity	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
4.13.2.1.8.5 Quality Control; and 4.13.2.1.8.6 Utilization Management.	
4.13.2.1.9 Written standards for organizational conduct;	Yes
4.13.2.1.10 Effective training and education for the Compliance Officer and the organization's employees, management, board Members, and Subcontractors;	Yes
4.13.2.1.11 Inclusion of information about Fraud, Waste and Abuse identification and reporting in Provider and Member materials;	Yes
4.13.2.1.12 Provisions for the investigation, corrective action and follow-up of any suspected Fraud, Waste and Abuse reports;	Yes
4.13.2.1.13 Procedures for notification to DCH Office of the Inspector General requesting permission before initiating an investigation, notifying a provider of the outcome of an investigation, and/or recovery of any overpayments identified; and	Yes
4.13.2.1.14 Procedures for reporting suspected Fraud, Waste and Abuse cases to the Georgia Medicaid Fraud Control Unit, through the State Program Integrity Unit, including timelines and use of State approved forms.	Yes
4.13.2.2 As part of the Program Integrity Program, the Contractor may implement a pharmacy lock-in program. The policies, procedures and criteria for establishing a lock-in program shall be submitted to DCH for review and approval as part of the Program Integrity Policies and Procedures described in Section 4.13.1. The pharmacy lock-in program shall:	Yes
4.13.2.2.1 Allow Members to change pharmacies for good cause, as determined by the Contractor after discussion with the Provider(s) and the pharmacist. Valid reasons for change should include recipient relocation or the pharmacy does not provide the prescribed drug;	Yes
4.13.2.2.2 Provide Case Management and education reinforcement of appropriate medication use;	Yes
4.13.2.2.3 Annually assess the need for lock in for each Member;	Yes
4.13.2.2.4 Require that the Contractor's Compliance Officer report on the program on a monthly basis to DCH; and	Yes
4.13.2.2.5 Not allow a Member to transfer to another pharmacy, PCP, or CMO while enrolled in their existing CMO's pharmacy lock-in program.	Yes
4.13.3.1 The Contractor shall cooperate and assist any State or federal agency charged with the duty of identifying, investigating, or prosecuting suspected Fraud, Waste and Abuse cases, including permitting access to the Contractor's place of business during normal business hours, providing requested information, permitting access to personnel, financial and Medical Records, and providing internal reports of investigative, corrective and legal actions taken relative to the suspected case of Fraud and Abuse.	Yes
4.13.3.2 The Contractor's Compliance Officer shall work closely, including attending quarterly meetings, with DCH's PI staff to ensure that the activities	Yes

Program Integrity	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s) *Yes or No***
of one entity do not interfere with an ongoing investigation being conducted by the other entity.	
4.13.3.3 The Contractor shall inform DCH immediately about known or suspected fraud cases and it shall not investigate or resolve the suspicion without making DCH aware of, and if appropriate involved in, the investigation, as determined by DCH.	Yes
4.13.4.1 The Contractor shall submit to DCH a quarterly Fraud and Abuse Report, as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein. This Report shall include information on the pharmacy lock-in program described in Section 4.13.2.2. This report shall also include information on the prohibition of affiliations with individuals debarred and suspended described in Section 33.20.	Yes

Provider Network

Provider Network	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s) *Yes or No***
4.8.1.1 The Contractor shall develop and maintain a network of Providers and facilities adequate to deliver Covered Services as described in the RFP and this Contract while ensuring adequate and appropriate provision of services to Members in rural areas, and which may include the use of telemedicine when appropriate to the condition and needs of the Member. The Contractor is solely responsible for providing a network of physicians, pharmacies, hospitals, physical therapists, occupational therapists, speech therapists, Border Providers and other health care Providers through whom it provides the items and services included in Covered Services.	Yes
4.8.1.2 The Contractor shall include in its network only those Providers that have been appropriately credentialed by DCH or its Agent, that maintain current license(s), and that have appropriate locations to provide the Covered Services.	Yes
4.8.1.3 The Contractor's Provider Network shall reflect, to the extent possible, the diversity of cultural and ethnic backgrounds of the population served, including those with limited English proficiency.	Yes
4.8.1.4 The Contractor shall notify DCH sixty (60) Calendar Days in advance when a decision is made to close network enrollment for new Provider contracts and also notify DCH when network enrollment is reopened. The Contractor must notify DCH sixty (60) Calendar Days prior to closing a Provider panel.	Yes
4.8.1.5 The Contractor shall not include any Providers who have been excluded from participation by the United States Department of Health and	Yes

Provider Network	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
Human Services, Office of Inspector General, or who are on the State's list of excluded Providers. The Contractor shall check the exclusions list on a monthly basis and shall immediately terminate any Provider found to be excluded and notify the Member per the requirements outlined in this Contract.	

Provider Services

Provider Services	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
4.9.1.1 The Contractor shall provide information to all Providers about Georgia Families in order to operate in full compliance with the GF Contract and all applicable federal and State regulations.	Yes
4.9.1.2 The Contractor shall monitor Provider knowledge and understanding of Provider requirements, and take corrective actions to ensure compliance with such requirements.	Yes
4.9.1.3 Within sixty (60) Calendar Days of the Contract Effective Date, the Contractor shall submit to DCH for initial review and approval all materials and information to be distributed and/or made available to Providers about Georgia Families. Any proposed revisions to such materials and information thereafter shall also be submitted to DCH for prior review and approval. DCH will attempt to complete its review of such materials within thirty (30) Calendar Days of its receipt of such materials.	Yes
4.9.1.4 All Provider Handbooks and bulletins must be in compliance with State and federal laws.	Yes
4.9.1.5 Contractor must seek DCH's written approval of the Contractor's interpretation of policies in the Georgia Medicaid Policy Manual when such policies are referenced in Provider contracts or communications. DCH's review and response will be completed within sixty (60) Calendar Days of the Contractor's written request for approval of its policy interpretation. DCH's written response shall be final regarding any dispute of the meaning of that policy language. In the event the Contractor misinterprets a Medicaid policy which is communicated to Providers, the Contractor must submit a written corrective action plan to DCH within three (3) Business Days of notice from DCH. Contractor will be required to retroactively correct and adjust any previously adjudicated Claims or correct any other actions resulting from the misinterpreted policy language within thirty (30) Calendar Days of approval of the corrective action plan.	Yes
4.9.2.1 The Contractor shall provide a Provider Handbook to all Providers. Upon request, the Contractor shall mail a hard copy to the Provider. The Provider Handbook shall serve as a source of information regarding GF	

Provider Services	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
Covered Services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all Contract requirements are being met. At a minimum, the Provider Handbook shall include the following information:	
4.9.2.1.1 Georgia Families Covered Services;	Yes
4.9.2.1.2 Member eligibility categories;	
4.9.2.1.3 Medical Necessity standards and practice guidelines;	Yes
4.9.2.1.4 Role of the PCP;	Yes
4.9.2.1.5 Link to the NCQA and Joint Commission web sites;	Yes
4.9.2.1.5 Role of the Dental Home;	Yes
4.9.2.1.6 Emergency Service responsibilities;	Yes
4.9.2.1.7 Health Check/EPSDT Benefit;	Yes
4.9.2.1.8 Prior Authorization, Pre-Certification, and Referral procedures;	Yes
4.9.2.1.9 Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;	Yes
4.9.2.1.10 Physical Health and Behavioral Health Coordination including the requirement for Behavioral Health Providers to send status reports to PCPs and PCPs to send status reports to Member's Behavioral Health Providers;	Yes
4.9.2.1.11 Provider Complaint System Policies and Procedures, including, but not be limited to, specific instructions for contacting the Contractor's Provider services to file a complaint and which individual(s) have the authority to review a complaint;	Yes
4.9.2.1.12 Policies and procedures for the Provider Grievance and Appeals process;	Yes
4.9.2.1.13 Information on the Member Grievance System, including the Member's right to a State Administrative Law Hearing, the timeframes and requirements, the availability of assistance in filing, the toll-free numbers and the right to request continuation of Benefits while utilizing the Grievance System;	Yes
4.9.2.1.14 The role of the CVO and link to the CVO web site;	Yes
4.9.2.1.15 Information about the GaHIN including how information will be used by the CMOs and DCH and an explanation of any service limitations or exclusions from coverage;	Yes
4.9.2.1.16 Link to the DCH web site;	Yes
4.9.2.1.17 Role of the DCH fiscal agent and link to the fiscal Agent's web site;	Yes
4.9.2.1.18 Information about the Georgia Families Value-based Purchasing;	Yes
4.9.2.1.19 Transition of Care Planning;	Yes
4.9.2.1.20 Care Coordination Policies;	Yes
4.9.2.1.21 Protocol for Encounter Claims element reporting/records;	Yes
4.9.2.1.22 Medical Records standards;	Yes
4.9.2.1.23 Claims submission protocols and standards, including instructions and all information necessary for a clean or complete Claim;	Yes
4.9.2.1.24 Payment policies;	Yes

Provider Services	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
4.9.2.1.25 The Contractor's Cultural Competency Plan;	Yes
4.9.2.1.26 Member rights and responsibilities;	Yes
4.9.2.1.27 Other Provider or Subcontractor responsibilities; and	Yes
4.9.2.1.28 Information about the 1115 Demonstration, Planning for Healthy Babies, including:	Yes
4.9.2.1.28.1 Demonstration description;	Yes
4.9.2.1.28.2 Covered Demonstration Services;	Yes
4.9.2.1.28.3 Practice protocols;	Yes
4.9.2.1.28.4 Other Provider responsibilities;	Yes
4.9.2.1.28.5 Coding requirements;	Yes
4.9.2.1.28.6 Prior Authorization, Pre-Certification, and Referral procedures; and	Yes
4.9.2.1.28.7 P4HB participants' rights and responsibilities.	Yes
4.9.2.2 The Contractor shall disseminate bulletins as needed to incorporate any needed changes to the Provider Handbook. These bulletins can be mailed hard copy or can be disseminated via email, provided hard copies are available and Providers are informed of how to request in hard copy.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.9.2.3 The Contractor shall submit the Provider Handbook to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date and as updated thereafter. Any updates or revisions shall be submitted to DCH for review and approval at least thirty (30) Calendar Days prior to distribution.	Yes
4.9.3.1 The Contractor shall provide training to all Providers and their staff regarding the requirements of the Contract and special needs of Members. The Contractor shall conduct initial training within thirty (30) Calendar Days of executing a contract with a newly contracted Provider. The Contractor shall also conduct ongoing training which may include webinars and web-based tutorials, as deemed necessary by the Contractor or DCH in order to ensure compliance with program standards and the GF Contract and meet the needs of Providers.	Yes
4.9.3.2 The Contractor shall also provide Provider workshops, data, trainings and technical assistance, webinars and web-based tutorials about the emergence and ongoing operations of Medical Homes and other service delivery innovations, evidence-based and emergency best practices, delivering a person-centered approach to care and the System of Care approach to care delivery.	Yes
4.9.3.3 The Contractor shall provide training to all Demonstration Family Planning and IPC service Providers and their staffs regarding the requirements of the Demonstration and the Contract provisions related to the Demonstration and special needs of the P4HB participants. The Contractor shall conduct initial training within thirty (30) Calendar Days of placing a	Yes

Provider Services	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
newly contracted Provider on active status. The Contractor shall also conduct ongoing training as deemed necessary by the Contractor or DCH in order to ensure compliance with the Demonstration's standards and the Contract.	
4.9.3.4 The Contractor's Demonstration Provider network will utilize the Preconception Care Toolkit for Georgia for preconception health education and counseling available at http://fpm.emory.edu/preventive/research/projects/index.html.	Yes
4.9.3.5 The Contractor shall develop and submit the Provider Training Manual and Training Plan, including topics, schedule and languages spoken, to DCH for initial review and approval at least thirty (30) Calendar Days prior to any scheduled trainings and as updated thereafter.	Yes
4.9.3.6 DCH may attend any training sessions specific to this Contract at its discretion.	Yes
4.9.4.1 The Contractor shall establish and maintain a formal Provider relations function to timely and adequately respond to inquiries, questions and concerns from network Providers. The Contractor shall implement policies addressing the compliance of Providers with the requirements included in this RFP and institute a mechanism for Provider dispute resolution and execute a formal system of terminating Providers from the network.	Yes
4.9.4.2 The Contractor shall provide for at least one (1) Provider Relations Liaison per Service Region to Conduct the Provider Relations functions.	Yes

Quality Management

Quality Management and Performance Improvement	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
4.12.1.1 The Contractor shall provide for the delivery of Quality care with the primary goal of improving the health status of Members and, where the Member's Condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in Condition or deterioration of health status. This shall include the identification of Members at risk of developing Conditions, the implementation of appropriate interventions and designation of adequate resources to support the intervention(s).	Yes
4.12.1.2 The Contractor shall seek input from, and work with, Members, Providers, community resources and agencies to actively improve the Quality of care provided to Members.	Yes
4.12.1.3.1 The Contractor shall obtain National Committee for Quality Assurance (NCQA) Interim Status by the Operational Start Date. Contractors shall apply for NCQA accreditation, or at other times as required by DCH as	Yes

Quality Management and Performance Improvement	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
follows: 4.12.1.3.1.1 July 1, 2016: Apply for NCQA Interim Status 4.12.1.3.1.2 July 1, 2017: Apply for provisional status (first survey) 4.12.1.3.1.3 December 31, 2017: Notify NCQA of intent to submit data 4.12.1.3.1.4 June 15, 2018: Submit CY 2017 data	
4.12.1.3.2 The Contractor shall achieve NCQA Commendable or Excellent accreditation status within three (3) years after the Operational Start Date. Contractors that lose NCQA Commendable or Excellent status must regain the status within one (1) year.	Yes
4.12.1.4.1 The Contractor shall establish a multi-disciplinary Quality Oversight Committee to oversee all Quality functions and activities. This committee shall meet at least quarterly, but more often if warranted. The formal organizational structure must include at a minimum, the following: 4.12.1.4.1.1 A designated health care practitioner, qualified by training and experience, to serve as the QM Director; 4.12.1.4.1.2 A committee which includes representatives from the provider groups as well as clinical and non-clinical areas of the organization; 4.12.1.4.1.3 A senior executive who is responsible for program implementation; 4.12.1.4.1.4 Substantial involvement in QM activities by the Contractor's Medical Director; and 4.12.1.4.1.5 Accountability to the governing body of the organization to which it reports on activities, findings, recommendations, actions, and results on a scheduled basis.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.1.4.2 The Quality Management Committee must: 4.12.1.4.2.1 Maintain Records that document the committee's activities, findings, recommendations, actions, and results; and 4.12.1.4.2.2 Obtain DCH's approval of membership of the Quality Oversight Committee.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.2.1 The Contractor shall support and comply with the Georgia Families DCH Quality Strategic Plan. The Quality Strategic Plan is designed to improve the Quality of Care and Service rendered to Georgia Families and Georgia Families 360 Members (as defined in Title 42 of the Code of Federal Regulations (42 CFR) 431.300 et seq. (Safeguarding Information on Applicants and Recipients); 42 CFR 438.200 et seq. (Quality Assessment and Performance Improvement Including Health Information Systems), and 45 CFR Part 164 (HIPAA Privacy Requirements).	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.2.2 The DCH Quality Strategic Plan promotes improvement in the Quality of care provided to enrolled Members through established processes. DCH staff within the Performance, Quality and Outcomes Unit is responsible for oversight of the Contractor's Quality program including:	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews

Quality Management and Performance Improvement	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
4.12.2.2.1 Monitoring and evaluating the Contractor's service delivery system and Provider network, as well as its own processes for Quality management and performance improvement; 4.12.2.2.2 Implementing action plans and activities to correct deficiencies and/or increase the Quality of care provided to enrolled Members; 4.12.2.2.3 Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, Provider profiling, Utilization Management reviews, etc.; 4.12.2.2.4 Monitoring compliance with Federal, State and DCH requirements; 4.12.2.2.5 Ensuring the Contractor's coordination with State registries; 4.12.2.2.6 Ensuring Contractor executive and management staff participation in the quality management and performance improvement processes; 4.12.2.2.7 Ensuring that the development and implementation of Quality management and performance improvement activities include Provider participation and information provided by Members, their families and guardians; and 4.12.2.2.8 Identifying the Contractor's best practices, lessons learned and other findings for performance and Quality improvement.	with CS staff supported that these functions are occurring.
4.12.3.1 The Contractor shall comply with the GF DCH Quality Strategic Plan requirements to improve the health outcomes for all GF Members. Improved health outcomes will be documented using established performance measures. DCH uses the CMS issued CHIPRA Core Set and the Adult Core Set of Quality Measures technical specifications along with the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Agency for Healthcare Research and Quality (AHRQ) technical specifications for the quality and health improvement performance measures. DCH will monitor Performance Measure and incent Contractor improvement through the Value-based Purchasing program.	Yes
4.12.3.2 Several of the Adult and Child Core Set measures along with certain other HEDIS® measures utilize hybrid methodology, that is, they require a medical record review in addition to the administrative data requirement for measurement reporting. The number of required record reviews is determined by the specifications for each hybrid measure.	Yes
4.12.3.3 DCH establishes Performance Measure Targets for each measure. It is important that the Contractor continually improve health outcomes from year to year. The performance measure targets, as amended from time to time, for each performance measure can be accessed at http://dch.georgia.gov/medicaid-quality-reporting. Performance targets are based on national Medicaid Managed Care HEDIS® percentiles as reported by NCQA or other benchmarks as established by DCH.	Yes
4.12.3.4 DCH may also require a Corrective Action (CA) or Preventive Action (PA) form that addresses the lack of performance measure target achievements and identifies steps that will lead toward improvements. This evidence-based CA or PA form must be received by DCH within thirty (30)	Yes

Quality Management and Performance Improvement	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
Calendar Days of receipt of notification of lack of achievement of performance targets. The CA or PA response must be approved by DCH prior to implementation. DCH may conduct follow up on-site reviews to verify compliance with a CA or PA response. DCH may assess Liquidated Damages on Contractors who do not meet the performance measure targets for any one performance measure.	
4.12.3.5 The performance measures apply to the Member populations as specified by the measures' technical specifications. Contractor performance is evaluated annually on the reported rate for each measure. Performance Measures, benchmarks, and/or specifications may change annually to comply with industry standards and updates.	Yes
4.12.3.6 The Contractor must provide for an independent Validation of each performance measure rate and submit the validated results to DCH no later than June 30 of each year.	Yes
4.12.4 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys 4.12.4.1 The Contractor shall deliver to DCH the results of CAHPS Surveys conducted by an NCQA certified CAHPS survey vendor. The survey report must include but not limited be to the following items: 4.12.4.1.1 An Executive Summary with the description of the survey process conducted according to the CAHPS Health Plan Survey guidelines of the HEDIS protocol; 4.12.4.1.2 Protocols for the administration of the survey via mail, telephone or mixed mode; 4.12.4.1.3 Definition of the sample size, number of completed surveys and response rates achieved. Response rates should, at a minimum, be no less than the NCQA average Medicaid response rates for the period; and 4.12.4.1.4 Detailed survey results and trend analysis.	Yes
4.12.4.2 The Contractor shall submit, on an annual basis to DCH, Adult and Child CAHPS Survey reports as stated in Section 4.12.16.	Yes
4.12.5 Member and Provider Incentives 4.12.5.1 The Contractor shall implement Member and Provider incentives to increase Member and Provider participation in reaching program goals. The Contractor may provide: 4.12.5.1.1 Incentives to Members and/or Providers to encourage compliance with periodicity schedules. Such incentives shall be established in accordance with all applicable State and federal laws, rules and regulations. Member incentives must be of nominal value ($10.00 or less per item and $50.00 in the aggregate on an annual basis per Member) and may include gift cards so long as such gift cards are not redeemable for cash or Copayments. The Contractor shall submit the proposed incentive methods to DCH for review and receive DCH approval prior to implementation. Upon request by DCH, the Contractor shall provide DCH with reports detailing incentives provided to Members and/or Providers and illustrating efficacy of incentive programs. In	Yes

Quality Management and Performance Improvement	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
accordance with 42 CFR 1003.101, the Nominal Value requirement stated herein is not applicable where the incentive is offered to promote the delivery of preventive care services, provided: 4.12.5.1.1.1 The delivery of the preventive services is not tied (directly or indirectly) to the provision of other services reimbursed in whole or in part by Medicare or Medicaid; 4.12.5.1.1.2 The incentive is not cash or an instrument convertible to cash; and 4.12.5.1.1.3 The value of the incentive is not disproportionally large in relationship to the value of the preventive care service (i.e., either the value of the service itself or the future health care costs reasonably expected to be avoided as a result of the preventive care).	
4.12.5.1.2 Provider incentives for the specific purpose of supporting necessary costs to transform and sustain NCQA PCMH recognition or TJC PCH accreditation through enhanced payment or performance based incentives for achieving the necessary parameters.	Yes
4.12.5.1.3 Provider incentive strategies to improve Provider compliance with clinical practice guidelines and ensure consistent application of the guidelines.	Yes
4.12.6 Quality Assessment Performance Improvement (QAPI) Program 4.12.6.1 The Contractor shall have in place an ongoing QAPI program consistent with 42 CFR 438.240. The program must be established utilizing strategic planning principles with defined goals, objectives, strategies and measures of effectiveness for the strategies implemented to achieve the defined goals. The Contractor's QAPI program shall be based on the latest available research in the area of Quality assurance and at a minimum must include: 4.12.6.1.1 A method of monitoring, analysis, evaluation and improvement of the delivery, Quality and appropriateness of Health Care furnished to all Members (including under and over Utilization of services), including those with special Health Care needs; 4.12.6.1.2 Written policies and procedures for Quality assessment, Utilization Management and continuous Quality improvement that are periodically assessed for efficacy; 4.12.6.1.3 A health information system sufficient to support the collection, integration, tracking, analysis and reporting of data; 4.12.6.1.4 Designated staff with expertise in Quality assessment, Utilization Management and Care Coordination;	Yes
4.12.6.2 The Contractor shall conduct PCP and other Provider profiling activities as part of its QAPI Program. Provider profiling must include multi-dimensional assessments of PCPs or Provider's performance using clinical, administrative and Member satisfaction indicators of care that are accurate, measurable and relevant to Members.	Yes
4.12.6.3 The Contractor's QAPI Program Plan must be submitted to DCH for initial review and approval and as updated thereafter.	Yes

Quality Management and Performance Improvement	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s) *Yes or No***
4.12.6.4 The Contractor shall submit any changes to its QAPI Program Plan to DCH for review and prior approval sixty (60) Calendar Days prior to implementation of the change.	Yes
4.12.6.5 Upon the request of DCH, the Contractor shall provide any information and documents related to the implementation of the QAPI program.	Yes
4.12.6.6 Annually, the Contractor shall submit to DCH a comprehensive QAPI Report, utilizing the report template that integrates all aspects of the QAPI Plan and tells the story of the effectiveness of the Contractor's QAPI Plan in meeting defined goals and objectives and achieving improved health outcomes for the Contractor's Members. DCH may require interim reports more frequently than annually to demonstrate progress.	Yes
4.12.7.1 As part of its QAPI program, the Contractor shall conduct clinical and non-clinical Performance Improvement Projects in accordance with DCH and federal protocols. In designing its performance improvement projects, the Contractor shall: 4.12.7.1.1 Show that the selected area of study is based on a demonstration of need and is expected to achieve measurable benefit to the Member (rationale); 4.12.7.1.2 Establish clear, defined and measurable goals and objectives that the Contractor shall achieve in each year of the project; 4.12.7.1.3 Utilize Rapid Cycle Process Improvement and Plan Do Study Act (PDSA) processes; 4.12.7.1.4 Measure performance using Quality indicators that are objective, measurable, clearly defined and that allow tracking of performance and improvement over time; 4.12.7.1.5 Implement interventions designed to achieve Quality improvements; 4.12.7.1.6 Evaluate the effectiveness of the interventions; 4.12.7.1.7 Establish standardized performance measures (such as HEDIS® or another similarly standardized product); 4.12.7.1.8 Plan and initiate activities for increasing or sustaining improvement; and 4.12.7.1.9 Document the data collection methodology used (including sources) and steps taken to assure data is valid and reliable.	Yes
4.12.7.2 Each performance improvement project must be completed in a period determined by DCH, to allow information on the success of the project in the aggregate to produce new information on Quality of care each year.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.7.3 The Contractor shall perform the required performance improvement projects (PIPs), as specified by DCH and agreed upon by the	No. There was no specific reference to this section of the

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Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
Parties, on an annual basis. Plan Do Study Act cycles must be incorporated into each PIP process.	contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.7.4 Each PIP will use a study period approved by DCH.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.7.5 Each PIP must include AIM statements and Driver Diagrams and align with the EQRO prepared PIP template. PIP components will be included as agreed upon by DCH and the CMOs.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.7.6 The Contractor shall submit the designated PIPs to the EQRO Contractor using the DCH specified template and format as defined in the PIP protocol approved by DCH.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.7.7 The EQRO will evaluate the CMOs' PIPs performance, using CMS approved Rapid Cycle PIP and/or other EQRO protocols. DCH reserves the right to request modification of the PIPs based on this evaluation. Modifications will be discussed with each CMO prior to implementation.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.7.8 The Contractor shall submit PIP documentation to DCH and/or the EQRO using the DCH specified template and format as specified in the CMS approved Rapid Cycle PIP and/or other EQRO protocols.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.7.9 The Contractor shall submit a PIP Annual Improvement Strategy Plan to DCH and/or the EQRO using the DCH specified template and format by October 31st of each contract year. This Plan will describe the improvement strategies to be implemented in the upcoming plan year (January 1st – December 31st).	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.8 Clinical Practice Guidelines (CPGs) 4.12.8.1 The Contractor shall adopt a minimum of three (3) evidence-based clinical practice guidelines. Such guidelines shall: 4.12.8.1.1 Be based on the health needs and opportunities for improvement	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews

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Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
identified as part of the QAPI program; 4.12.8.1.2 Be based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field; 4.12.8.1.3 Consider the needs of the Members; 4.12.8.1.4 Be adopted in consultation with network Providers; and 4.12.8.1.5 Be reviewed and updated periodically as appropriate.	with CS staff supported that these functions are occurring.
4.12.8.2 The Contractor shall submit to DCH for review and prior approval and as updated thereafter all Clinical Practice Guidelines in use, which shall include a methodology for measuring and assessing compliance as part of the QAPI program plan.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.8.3 The Contractor shall disseminate the guidelines to all affected Providers and, upon request, to Members.	Yes
4.12.8.4 The Contractor shall ensure that decisions for Utilization Management, Member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	Yes
4.12.9.5 To ensure consistent application of the guidelines, the Contractor shall require Providers to utilize the guidelines, and shall measure compliance with the guidelines, until ninety percent (90%) or more of the Providers are consistently in compliance. The Contractor will conduct this review on a quarterly basis. The Contractor may use Provider incentive strategies to improve Provider compliance with guidelines.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.9.6 To further ensure consistent application of the Clinical Practice Guidelines, the Contractor shall perform a review of a minimum random sample of fifty (50) Members' medical records per evidence-based CPG, each quarter.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.9 Focused Studies 4.12.9.1 Focused Studies examine a specific aspect of health care (such as prenatal care) for a defined point in time. These studies are usually based on information extracted from medical records or Contractor administrative data such as Enrollment files and Encounter/claims data. Steps that may be taken by the Contractor when conducting focused studies are: 4.12.9.1.1 Selecting the Study Topic(s) 4.12.9.1.2 Defining the Study Questions or Aim Statement 4.12.9.1.3 Selecting the Study Indicator(s) 4.12.9.1.4 Identifying a representative and generalizable study population 4.12.9.1.5 Documenting sound sampling techniques utilized (if applicable) 4.12.9.1.6 Collecting reliable data 4.12.9.1.7 Analyzing data and interpreting study results	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.

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Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
4.12.9.2 The Contractor may perform, at DCH discretion, a Focused Study to examine a specific aspect of health care (such as prenatal care) for a defined point in time. The Focused Study will have a calendar year study period and the results will be reported to DCH by June 30th following the year of the study. DCH shall retain the right to approve or disapprove all proposed Focus Studies.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.10 Patient Safety Plan 4.12.10.1 The Contractor shall have a structured Patient Safety Plan, Report, and Analysis to address incidents and concerns regarding clinical care. This plan must include written policies and procedures for processing Member complaints regarding the care received and addressing incidents and concerns with clinical care. Such policies and procedures shall include: 4.12.10.1.1 A system of classifying incidents, concerns, and complaints according to severity; 4.12.10.1.2 A review by the Medical Director and a mechanism for determining which incidents will be forwarded to Peer Review; and 4.12.10.1.3 A summary of incident(s), including the final disposition, included in the Provider profile.	Yes
4.12.10.2 At a minimum, the Patient Safety Program process shall: 4.12.10.1.4.1 Report and analyze the patient safety programs and outcomes in place within the CMO's network of hospitals; 4.12.10.1.4.2 Report and analyze Medication recalls; 4.12.10.1.4.3 Report and analyze Medication errors; 4.12.10.1.4.4 Describe the results of site Inspections; and 4.12.10.1.4.5 Report and analyze Patient Quality of Care Concerns, including those arising from patient grievances.	Yes
4.12.10.3 The Contractor shall submit the Patient Safety Plan to DCH for initial review and approval and as updated and submit to DCH on an annual basis no later than June 30 of the Contract year a Patient Safety Program Report inclusive of the program components described in 4.12.10.1 and 4.12.10.2.	Yes
4.12.11 External Quality Review 4.12.11.1 DCH will contract with an External Quality Review Organization (EQRO) to conduct independent reviews of the Quality outcomes, timeliness of, and access to, the services covered in this Contract. The Contractor shall collaborate with DCH and its 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 improvement. To facilitate this process the Contractor shall supply data, as requested by DCH or its EQRO, to the EQRO.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.12 Value-Based Purchasing (VBP) Program 4.12.12.1 The Contractor shall collaborate with DCH to implement a Value-Based Purchasing (VBP) model. A VBP model is an enhanced approach to purchasing and program management that focuses on value over volume. It is part of a cohesive strategy that aligns incentives for Members, Providers,	Yes

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Contractors and the State to achieve the program's overarching goals. The impact of initiatives is measured in terms of access, outcomes, quality of care and savings.	
4.12.12.2 Prior to the Operational Start Date, DCH will establish a VBP performance management team ("VBP Performance Management Team"). The VBP Performance Management Team will have responsibility for planning, implementing, and executing the VBP initiative. The Team will work collaboratively with the Contractor to review the Contractor's progress on a monthly, quarterly and/or annual basis, determine incentive payments, and determine the need to modify priority areas, measures and targets.	Yes
4.12.12.3 In addition to DCH staff, key leadership from the Contractor such as the Medical Director, Chief Operating Officer, or other designee approved by DCH will provide input and feedback on planned priorities and initiatives. As appropriate, DCH will engage operational-level Contractor staff.	Yes
4.12.12.4 Through the VBP Performance Management Team, the Contractor and DCH shall meet at least quarterly to discuss progress on initiatives. Rapid cycle feedback is key to the success of a VBP model. The Contractor shall regularly review and provide real-time information focused on the initiatives it is undertaking to achieve required targets on a monthly and quarterly basis to DCH. The Contractor shall provide ongoing and ad hoc reports to DCH to highlight status and progress of initiatives, as well as successes and challenges. Regularly reviewing data is necessary for DCH and the Contractor to identify where initiatives are not resulting in improvements necessitating adjustments to the implemented approach. When adjustments are necessary, the Contractor shall report to DCH changes the Contractor will make to continually work towards improvements.	Yes
4.12.12.5 Attachment U outlines the performance measures and related targets that the Contractor must achieve under the VBP model. The Contractor must establish in collaboration with DCH initiatives that it will undertake to achieve the specified targets. Such initiatives may differ from or include other required initiatives, such as Performance Improvement Projects (PIPs) and Focused Studies. Beginning in Calendar Year (CY) 2017, DCH will withhold five percent (5%) of the Contractor's Capitation Rates ("VBP withhold)" from which incentive payments will be made to the Contractor for achieving identified VBP targets. DCH will make incentive payments for achieving performance targets based on the HEDIS reporting and validation cycle. Therefore, the first incentive payments, if any, will be made in CY 2018.	Yes
4.12.12.6 The Contractor will only receive incentive payments when meeting or exceeding specified targets (e.g., if one target is achieved, but others are not, the Contractor will only receive agreed upon incentive payment for the target achieved). The withhold amount will be allotted equally to each of the performance targets. The total amount of the incentive payments will be based on the Contractor's performance relative to the targets for the fourteen (14) performance measures. The maximum incentive payment to	Yes

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Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
the Contractor will be the full five percent (5%) withhold. Contractor Payout Amount = (Number of Performance Targets Achieved/Total Number of Performance Targets) x Total VBP Withhold	
4.12.12.7 While the current performance measures are HEDIS measures, DCH reserves the right to change the measures over the term of this Contract. Should DCH identify performance measures that are not HEDIS measures, DCH shall develop and the Contractor shall agree to a methodology for quantifying the Contractor's success in achieving targets and payments for each measure.	Yes
4.12.12.8 The Contractor shall incentivize Providers to participate in VBP and may also incentivize Members. The Contractor shall develop a plan for distributing to Providers fifty (50) percent of the Value-Based Purchasing incentive payments it receives from DCH for achieving targets. The frequency of incentive payments to the Providers is at the discretion of the Contractor (e.g., the Contractor may elect to incentivize Providers on a more frequent schedule than DCH's schedule for payment to the Contractor). Contractors are encouraged to collaborate to develop and implement interventions and solutions. The Contractor shall submit the plan to DCH for prior approval. The Contractor shall submit such plan for Provider incentives to DCH for review and approval within ninety (90) Calendar Days of the Contract Effective Date. The plan shall include details of how the Contractor will collaborate with Providers to determine the frequency of incentive payments to Providers and how the Contractor will encourage participation in the program.	Yes
4.12.12.9 The Contractor shall comply with the requirements set forth in the VBP Operations Manual.	Yes
4.12.13 Monitoring and Oversight Committee 4.12.13.1 The Contractor shall participate in the Georgia Families Monitoring and Oversight Committee ("GFMOC") and associated subcommittees as requested by DCH. The GFMOC and associated subcommittees will assist DCH in assessing the performance of the Contractor and developing improvements and new initiatives specific to the Georgia Families program. The GFMOC will serve as a forum for the exchange of best practices and will foster communication and provide opportunity for feedback and collaboration between State agencies, the Contractor and external stakeholders. Members of the GFMOC will be appointed by the DCH Commissioner or his designee. The GFMOC meetings must be attended by Contractor decision makers defined as one or more of the following: Chief Executive Officer, Chief Operations Officer, or equivalent named position; and Chief Medical Officer.	Yes
4.12.14 Member Advisory Committee 4.12.14.1 The Contractor shall establish and maintain a Member Advisory Committee consisting of persons served by the Contractor including current and past Members and/or Authorized Representatives, and representatives from community agencies that do not provide Contractor-covered services but are important to the health and well-being of Members. The Committee	Yes

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Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
shall meet at least quarterly, and its input and recommendations shall be employed to inform and direct Contractor Quality management activities and policy and operational changes. The Contractor must provide meeting schedules and minutes to DCH upon request. DCH may conduct onsite reviews of the membership of the Committee to ensure: 4.12.14.1.1 The Committee is discussing issues pertinent to the Member population; 4.12.14.1.2 The Committee is meeting as scheduled; and 4.12.14.1.3 The Committee members are in attendance.	
4.12.15 Provider Advisory Committee 4.12.15.1 The Contractor shall establish and maintain a Provider Advisory Committee consisting of Providers contracted with the Contractor to serve Members. At least two (2) Providers on the Committee shall maintain health care practices that predominantly serve Medicaid beneficiaries. The Committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Contractor Quality management activities and policy and operational changes. The Contractor must provide meeting schedules and minutes to DCH upon request. DCH may conduct onsite reviews of the Committee meetings to ensure: 4.12.15.1.1 The Committee is discussing issues pertinent to the Member population; 4.12.15.1.2 The Committee is meeting as scheduled; and 4.12.15.1.3 The Committee members are in attendance.	Yes
4.12.16 Reporting Requirements 4.12.16.1 Contractors must submit the following data reports as indicated. 1.Performance Improvement Project Proposal(s), Annually October 31, DCH PQO Unit 2.Quality Assurance Performance Improvement Plan, Annually June 30, DCH PQO Unit 3.Quality Assessment Performance Improvement Program Evaluation, Annually June 30, DCH PQO Unit 4.Performance Improvement, Project Report, Annually June 30, EQRO vendor 5.Performance Measures Report, Annually June 30, DCH PQO Unit 6.Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys, Annually July 31, DCH PQO Unit	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.16.2 If an extension of time is needed to complete a report, the Contractor may submit a request in writing to the DCH PQO Unit.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.16.3 The Contractor's Quality Oversight Committee shall submit to DCH Quality Oversight Committee Reports - Ad Hoc as described in the RADs, as	No. There was no specific reference to this section of the

Quality Management and Performance Improvement	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.	contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.16.4 The Contractor shall submit to DCH Performance Improvement Project Reports no later than June 30 of the Contract year or per protocol described in Section 4.12.7.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.16.5 The Contractor shall submit to DCH Focused Studies Reports no later than June 30 of the Contract year as described in Section 4.12.9.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.12.16.6 The Contractor shall submit to DCH annual Patient Safety Plan Reports no later than June 30 of the Contract year as described in Section 4.12.10.	Yes

Regulatory Reporting and Monitoring

Regulatory Reporting and Monitoring	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
4.18.1.1 The Contractor shall support DCH in its program monitoring and reporting efforts for program performance and trending analyses through submission of ongoing, dashboard and ad hoc reports to DCH for all activities described in the Contract. The Contractor shall provide ad hoc reports to DCH upon request and within timeframes agreed to by DCH and the Contractor.	Yes
4.18.1.2 The Contractor shall meet with DCH Business Owners during implementation to discuss all data requirements and the Contractor's recommended reports. The Contractor shall accommodate DCH's requests for data and reporting based on implementation decisions as well as for ongoing requests during operations.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.18.2.1 The Contractor shall collect, validate and report required program data to DCH in an accurate and timely manner. The Contractor's Chief Executive or Financial Officer, or a designee vested with their authority, shall attest to the accuracy and completeness of all submitted reports, in accordance with 42 CFR §438.604. In addition, the Contractor shall comply	Yes

Regulatory Reporting and Monitoring	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
with all state and federal requirements set forth in this Section and throughout this Contract.	
4.18.2.2 The Contractor shall comply with all the reporting requirements established by this Contract and shall submit all Reports included in this Contract. The Contractor shall create Reports using the formats, including electronic formats, instructions, and timetables as specified by DCH, at no cost to DCH. DCH may modify reports, specifications, templates, or timetables as necessary during the Contract year. Contractor changes to the format must be approved by DCH prior to implementation. The Contractor shall transmit and receive all transactions and code sets required by the HIPAA regulations in accordance with Section 23.2. The Contractor's failure to submit the Reports as specified may result in the assessment of liquidated damages as described in Section 25.0.	Yes
4.18.2.2.1 The Contractor shall submit the Deliverables and Reports for DCH review and approval according to the following timelines, unless otherwise indicated.	Yes
4.18.2.2.1.1 Weekly Reports shall be submitted on the same day of each week as determined by DCH;	Yes
4.18.2.2.1.2 Monthly Reports shall be submitted within fifteen (15) Calendar Days of the end of each month;	Yes
4.18.2.2.1.3 Quarterly Reports shall be submitted by April 30, July 30, October 30, and January 30, for the quarter immediately preceding the due date;	Yes
4.18.2.2.1.4 Annual Reports shall be submitted within thirty (30) Calendar Days following the twelfth (12th) month of the contract year ending June 30th;	Yes
4.18.2.2.1.5 Ad-Hoc, as determined by DCH; and	Yes
4.18.2.2.1.6 Other Reports (bi-annual, according to the due date of the respective report).	Yes
4.18.2.2.2 For reports required by DOI and DCH, the Contractor shall submit such reports according to the DOI schedule of due dates, unless otherwise indicated. While such schedule may be duplicated in this Contract, should the DOI schedule of due dates be amended at a future date, the due dates in this Contract shall automatically change to the new DOI due dates.	Yes
4.18.2.2.3 The Contractor shall, upon request of DCH, generate any additional data or reports at no additional cost to DCH within a time period prescribed by DCH. The Contractor's responsibility shall be limited to data in its possession.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.
4.18.3.1 DCH will periodically publish information or receive requests from audiences such as legislators that may require data from the Contractor. DCH will provide the Contractor with information about the data DCH would like to publish or must produce, and the Contractor shall produce all reports or	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews

Regulatory Reporting and Monitoring	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s) *Yes or No***
summary data for DCH to incorporate into a larger report. The Contractor shall develop these reports considering the audience to be targeted.	with CS staff supported that these functions are occurring.
4.18.3.2 The Contractor shall not publish reports on its website or any other forum without prior consent from DCH.	Yes
4.18.4.1 The Contractor must be prepared to participate in regularly scheduled meetings with DCH staff to review decisions, resolve issues and define operational enhancements. These meeting schedules will be determined by DCH.	Yes
4.18.4.2 The Contractor and its various levels of staff as determined by DCH must also attend an onsite meeting at DCH to report on all activities, trends, opportunities for improvement and recommendations for programmatic and policy changes at the frequency determined by DCH. Contractors must provide best practices and lessons learned to reach GF program goals.	Yes

Subcontractor Oversight

Subcontractor Oversight	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s) *Yes or No***
18.1.1 The Contractor will not subcontract or permit anyone other than Contractor personnel to perform any of the work, services, or other performance required of the Contractor under this Contract, or assign any of its rights or obligations hereunder, without the prior written consent of DCH. Prior to hiring or entering into an agreement with any Subcontractor, any and all Subcontractors and Subcontracts shall be approved by DCH. DCH must also approve any replacement Subcontractors in the same manner. Upon request from DCH, the Contractor shall provide in writing the names of all proposed or actual Subcontractors. DCH reserves the right to reject any or all Subcontractors that, in the judgment of DCH, lack the skill, experience, or record of satisfactory performance to perform the work specified herein.	Yes
18.1.2 Contractor is solely responsible for all work contemplated and required by this Contract, whether Contractor performs the work directly or through a Subcontractor. No subcontract will be approved which would relieve Contractor or its sureties of their responsibilities under this Contract. In addition, DCH reserves the right to terminate this Contract if Contractor fails to notify DCH in accordance with the terms of this paragraph.	Yes
18.1.3 All contracts between the Contractor and Subcontractors must be in writing and must specify the activities and responsibilities delegated to the Subcontractor. The contracts must also include provisions for revoking delegation or imposing other sanctions if the Subcontractor's performance is	Yes

Subcontractor Oversight	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
inadequate. DCH reserves the right to inspect all subcontract agreements at any time during the Contract period.	
18.1.4 All contracts entered into between Contractor and any Subcontractor related to this Contract must contain provisions which require Contractor to monitor the Subcontractor's performance on an ongoing basis and subject the Subcontractor to formal review according to a schedule established by DCH and consistent with industry standards or State laws and regulations. Contractor shall identify any deficiencies or areas for improvement related to any Subcontractor's performance related to this Contract, and upon request from DCH, provide evidence that corrective action has been taken to address the deficiency.	Yes
18.1.5 For any subcontract, there must be a designated project manager who is a member of the Subcontractor's staff that is directly accessible by the State. This individual's name and contact information must be provided to the State when the subcontract is executed. The subcontract agreement must contain a provision which requires the Contractor and its Subcontractors to seek binding arbitration to resolve any dispute between those parties and to provide DCH with written notice of the dispute.	Yes
18.1.6 Contractor shall give DCH immediate notice in writing by registered mail or certified mail of any action or suit filed by any Subcontractor and prompt notice of any Claim made against the Contractor by any Subcontractor or vendor that, in the opinion of Contractor, may result in litigation related in any way to this Contract.	Yes
18.1.7 All Subcontractors must fulfill the requirements of 42 CFR 438.6 as appropriate.	Yes
18.1.8 All Provider contracts shall comply with the requirements and provisions as set forth in Section 4.10 of this Contract.	Yes
18.1.9 The Contractor shall submit a Subcontractor Information and Monitoring Report to include, but is not limited to: Subcontractor name, services provided, effective date of the subcontracted agreement.	Yes
18.1.10 The Contractor shall submit to DCH a written notification of any subcontractor terminations at least ninety (90) days prior to the effective date of the termination.	Yes

Utilization Management

Utilization Management	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
4.11.1.1 The Contractor shall implement innovative and effective Utilization Management processes to ensure a high quality, clinically appropriate yet	Yes

Utilization Management	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
highly efficient and cost effective delivery system. The Contractor shall continually evaluate the cost and Quality of medical services provided by Providers and identify the potential under and over-utilization of clinical services. The Contractor must apply objective and evidence-based criteria that take the individual Member's circumstances and the local delivery system into account when determining the medical appropriateness of Health Care services.	
4.11.1.2 The Contractor shall enable Pre-Certification of service requests when required and direct providers in making appropriate clinical decisions for the Member in the right setting and at the right time. As part of its regular processes for conducting Utilization Review, the Contractor must evaluate all review requests for Medical Necessity and make recommendations that are more appropriate and more cost-effective. The Contractor should leverage findings from current federal efforts around comparative effectiveness research to support its evaluation of requests.	Yes
4.11.1.3 The Contractor shall provide assistance to Members and Providers to ensure the appropriate Utilization of resources, using the following program components: Prior Authorization and Pre-Certification, prospective review, concurrent review, retrospective review, ambulatory review, second opinion. Specifically, the Contractor shall have written Utilization Management Policies and Procedures that:	Yes
4.11.1.3.1 Include protocols and criteria for evaluating Medical Necessity, authorizing services, and detecting and addressing over-Utilization and under-Utilization. Such protocols and criteria shall comply with federal and State laws and regulations.	Yes
4.11.1.3.2 Address which services require PCP Referral; which services require Prior-Authorization and how requests for initial and continuing services are processed, and which services will be subject to concurrent, retrospective or prospective review.	Yes
4.11.1.3.3 Describe mechanisms in place that ensure consistent application of review criteria for authorization decisions.	Yes
4.11.1.3.4 Require that all Medical Necessity determinations be made in accordance with DCH's Medical Necessity definition as stated in Sections 1.4 and 4.5.4.	Yes
4.11.1.3.5 Provide for the appeal by Members, or their representative, of authorization decisions, and guarantee no retaliation will be taken by the Contractor against the Member for exercising that right.	Yes
4.11.1.4 The Contractor shall submit the Utilization Management Policies and Procedures to DCH for review and prior approval annually and as changed. Nothing in this Section shall prohibit or impede the Contractor from applying a person-centric clinical decision that may vary from the written Utilization Management Policies and Procedures insofar as that decision is accompanied by the clinical rationale for such a decision.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with CS staff supported that these functions are occurring.

Utilization Management	
Contract Language	**CS Policy Is Consistent with Contract Requirement(s)** ***Yes or No***
4.11.1.5 Network Providers may participate in Utilization Review activities to the extent that there is not a conflict of interest. The Utilization Management Policies and Procedures shall define when such a conflict may exist and shall describe the remedy.	Yes
4.11.1.5.1.1 The Contractor shall establish a Utilization Management Committee. The Utilization Management Committee is accountable to the Medical Director and governing body of the Contractor. The Utilization Management Committee shall meet no less frequently than a quarterly basis and maintain records of activities, findings, recommendations, and actions. Reports of these activities shall be made available to DCH upon request.	Yes
4.11.1.5.2.1 Emergency Room (ER) Diversion Pilot The Contractor shall develop and implement an ER diversion pilot program with hospital(s) that agree to participate to reduce inappropriate utilization of ERs for non-emergent conditions. The Contractor shall submit to DCH ninety (90) Calendar Days prior to beginning the ER Diversion Pilot program a detailed plan describing how the Contractor will work with providers to reduce inappropriate utilization of ERs for non-emergent conditions. The diversion pilot shall not prohibit or delay a Member’s access to ER services.	Yes