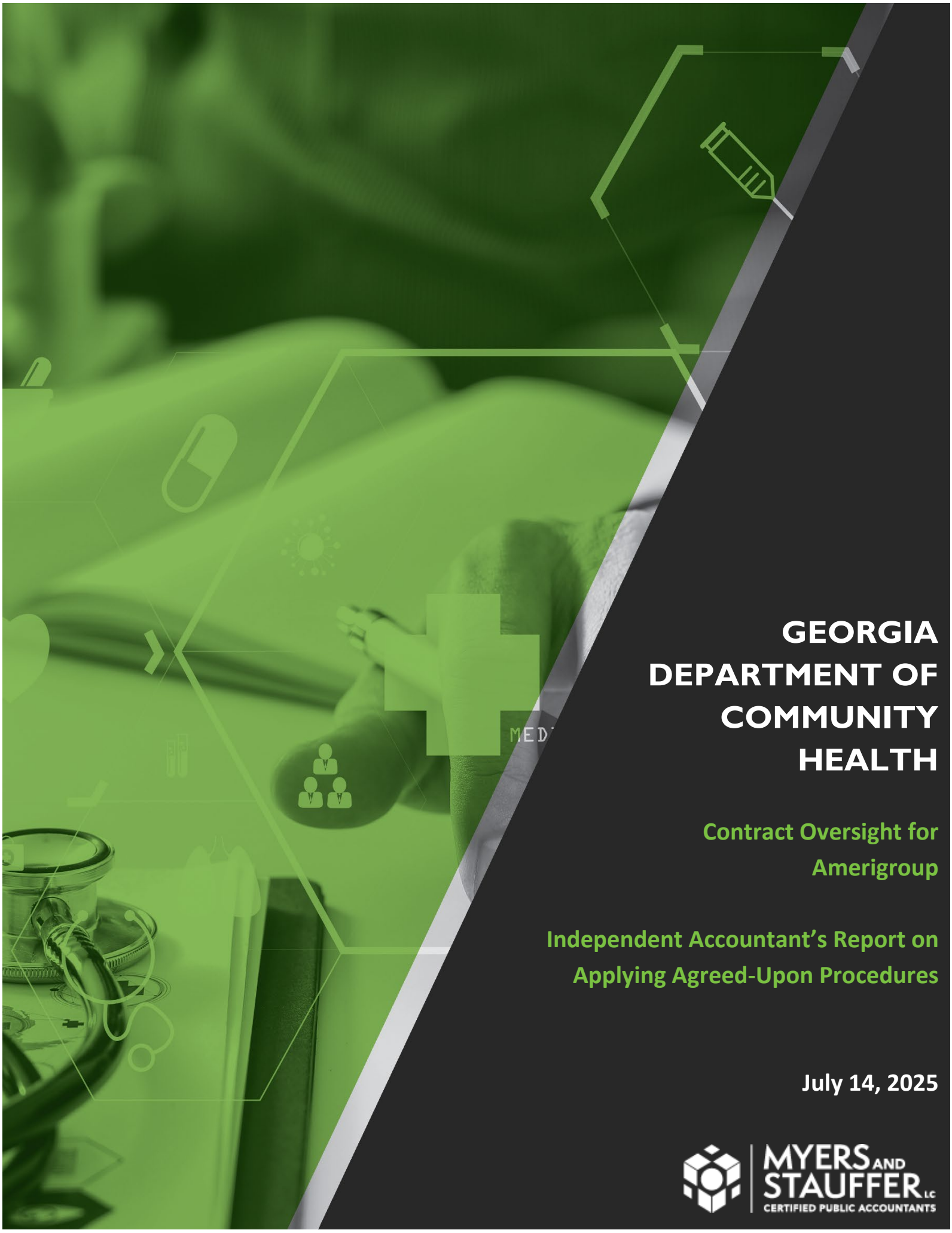

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Contract Oversight for Amerigroup

Independent Accountant's Report on Applying Agreed-Upon Procedures

July 14, 2025

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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CERTIFIED PUBLIC ACCOUNTANTS

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 Amerigroup Community Care (AGP or Amerigroup) from September 30, 2024, through February 28, 2025. We were asked to apply these procedures in order to evaluate AGP's contract compliance, program integrity (PI) oversight, subcontractor oversight, and encounter submissions. AGP'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 of compliance within 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 80 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 AGP'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

Myers and Stauffer LC
Atlanta, Georgia
July 14, 2025

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Project Background

Amerigroup Community Care (AGP) is a subsidiary of Elevance Health, a leading provider of health insurance and managed health care. In the State of GA, AGP is one of three care management organizations (CMOs) providing care management services to Georgia Families®, Medicaid, PeachCare for Kids®, and 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, patients, and health care and other providers for the purpose of improving the health status of this population.

Myers and Stauffer has been engaged to assist the Department in its efforts to evaluate the policies and procedures of the Georgia Families® program. Our evaluation includes 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 to evaluate the effectiveness of contractually mandated monitoring and operational requirements.

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

Methodology

Pre-Interviews

On August 30, 2024, prior to initiating the interviews, we submitted a data and documentation request to AGP. The materials requested for our inspection were designed to provide us with detailed background information specific to the objectives of this engagement. We scrutinized the contracts, policies, procedures, and other documentation related to the engagement's procedures to validate the compliance of AGP and its subcontractors. These pre-interview activities began August 30, 2024, and continued through September 27, 2024. Interviews, both in-person and virtual, were performed between September 30, 2024, and November 5, 2024.

After receiving the data and information requested, we assessed the following:

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

We developed a general template of procedures for the 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:

- *Performed a risk assessment to identify the subcontractors to be included in this engagement.*
- *Obtained DCH approval of the list of subcontractors for inclusion in this engagement.*
- *Identified AGP and subcontractor staff responsible for the oversight of the following operational area:*
    - *Contract compliance.*
    - *PI.*
    - *Subcontractor oversight.*
    - *Encounter submissions.*

- *Prepared and submitted interview schedules referencing AGP and its subcontractor's staff to be questioned.*
- *AGP scheduled all virtual interviews by sending meeting requests to select participants utilizing Microsoft Teams.*

Interviews

Interviews of designated AGP staff members were conducted, in-person and virtually, by Myers and Stauffer staff. General and ad-hoc questions were asked of AGP staff to ensure our thorough understanding of the subject matter being discussed. In the same manner, virtual interviews were conducted with the subcontractors Avesis, CarelonRx, and DentaQuest LLC. Myers and Stauffer identified and interviewed additional AGP or subcontractor staff where further clarification and/or additional information was necessary.

The in-person and virtual interviews began September 30, 2024, and concluded on November 5, 2024. *Table 1* outlines the health plan, interview dates, and the Myers and Stauffer engagement team members.

Table 1: Interview Schedule and Details

Interview Schedule and Details		
Health Plan	**Date**	**Myers and Stauffer Engagement Team**
AGP (Local)	09/30/2024 - 10/02/2024	Savombi Fields Stephen Fader Nickie Turner Hailey Plemons Shawn Finnerty Jay Perrault Sydney Brown
AGP (Corporate)	10/08/2024 - 10/10/2024	Savombi Fields Stephen Fader Nickie Turner Hailey Plemons Shawn Finnerty Jay Perrault
DentaQuest LLC	10/15/2024 - 10/16/2024	Savombi Fields Stephen Fader Nickie Turner Hailey Plemons Shawn Finnerty Jay Perrault
Avesis	10/22/2024 - 10/23/2024	Savombi Fields Stephen Fader

Interview Schedule and Details		
Health Plan	**Date**	**Myers and Stauffer Engagement Team**
		Nickie Turner Hailey Plemons Shawn Finnerty Jay Perrault
CarelonRx	10/29/2024 - 10/30/2024	Savombi Fields Stephen Fader Nickie Turner Hailey Plemons Shawn Finnerty Jay Perrault
CarelonRx/CVS	11/05/2024	Savombi Fields Stephen Fader Nickie Turner Hailey Plemons Shawn Finnerty Jay Perrault

Myers and Stauffer concluded each in-person and virtual interview by compiling the interview notes and requesting any additional data and/or supporting documentation deemed necessary to enhance our understanding of the interview topics. Exit conferences where notable initial findings would have been shared with the plan were not necessary for any of the plan and/or subcontractor interview sessions.

Post-Interviews

After conducting the interviews, Myers and Stauffer identified findings from each interview session. Documentation submitted by AGP and the subcontractors meant to address any follow-up questions or concerns identified during the interview sessions was inspected for relevance. This work was concluded on or before February 28, 2025.

Where appropriate, we noted findings, which are issues of noncompliance with Federal or State guidance. For each finding a recommendation is provided with the expectation that a corrective action will occur as a part of the mitigation process. Observations are potential indicators of risk identified by comparing policy, procedure, and supporting documentation assessments against interview responses. As a result of our comparative analysis, risk levels were assigned to each operational area as low, medium, or high based on the impact to the CMO's operations and/or systems in that area. Observations do not represent specific instances of non-compliance.

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 AGP 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 AGP, Avesis, CarelonRx, and DentaQuest LLC.
6. We assumed data from AGP's information systems operated as described in the documentation supplied by AGP.
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 – Georgia Families®

In this section of the report, we provide an overview of contract compliance for AGP Georgia Families® (GF). Myers and Stauffer assessed the operational areas of behavioral health, call center operations, internal grievance/appeal system, member services, member data maintenance, monitoring and reporting, pharmacy services, provider data maintenance, provider complaints, provider network, provider service, quality management, and utilization management (UM). Key contractual requirements were identified, and a determination was made as to whether AGP's policies and procedures were in compliance with the DCH contract outlined in *Appendix C: Contract Compliance*.

Myers and Stauffer assessed the level of risk identified for each GF operational area within this engagement. The risk levels are defined as follows:

- ***High*** *– An identified concern that will impact the CMO's systems and/or operations.*
- ***Medium*** *– An identified concern that without mitigation, is likely to impact the CMO's systems and/or operations.*
- ***Low*** *– An identified concern that is likely to have low to no impact on the CMO's systems and/or operations.*

Behavioral Health Services

DCH to CMO Contract Language for Behavioral Health Services

Section 4.5.4.3 of the contract requires AGP to provide medically necessary services to correct and/or improve physical and behavioral health disorders, defects, or conditions identified during an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening or preventive visit. Eligible Medicaid members under 21 years of age, regardless of whether those services are included in the State Plan but are otherwise allowed pursuant to 1905 (a) of the Social Security Act.

Overview of Operational Area

AGP's policies and procedures show an integrated approach to the provision of health care services for physical and behavioral health members, as mandated by the contract. AGP is responsible for identifying members in need of behavioral health care management and care coordination. AGP policies and procedures state that when there is concurring physical and behavioral health conditions the members care plan will ensure communications between all necessary teams are in place, to ensure all necessary care is being provided based on the member's needs. AGP has a variety of resources in place to help members in need, such as a comprehensive provider network, behavioral health homes and other resources that can be of assistance to members in need.

Observations: Behavioral Health Services

- *Onsite visits are only conducted by licensed clinicians.*
- *AGP conducts internal and external audits on AGP behavioral health associates, at least 2 internal and 3-4 external audits are done per associate each month.*
    - *Associates are required to score 90 percent or higher.*
- *According to AGP all behavioral health requests are responded to within 48 hours and all inpatient requests are responded to within 24 hours.*
- *New behavioral health associates are required to shadow an experienced team member for 2-3 weeks as part of the training regimen.*
- *Staff members are given ABA standardization tests to keep the staff up to date on new policies and procedures.*
    - *ABA requires associates to score 90 percent or higher to be considered passing.*

Assessment: Behavioral Health

After review of AGP's policies and procedures for Behavioral Health, Myers and Stauffer did not identify sufficient policies or standard operating procedures for contract section 4.8.9.3.

Myers and Stauffer evaluated this contractual area utilizing the submitted policies, procedures and other supporting documentation. A deficiency was identified within the documentation that was not substantive enough to constitute a finding; thus, we determined AGP operations were in accordance with the DCH contract.

Risk Assessment: Behavioral Health Services

There is low risk associated with this operational area.

Call Center Operations

DCH to CMO Contract Language for Member and Provider Call Center Operations

Section 4.3.8.1 of the contract requires AGP 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.

Section 4.9.5.1 of the contract requires AGP to operate a toll-free Call Center to respond to Provider questions, comments and concerns.

Overview of Operational Area

AGP 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. 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

The member and provider call centers utilize quality criteria and protocols to measure and monitor the accuracy of responses and phone etiquette. At minimum, these performance standards shall require that on a calendar month basis AGP must meet metrics for average speed of answer, abandoned call rate, blocked call rate, average hold time, timely response to call center phone inquiries, and accurate response to call center phone inquiries.

Observations: Call Center Operations

- *Call center performance metrics, according to AGP, are currently exceeding the mandated goal measure.*
- *AGP requires that calls should be resolved within a 72-hour period.*
- *All AGP calls are handled within the same call center.*
- *Call center staff take calls from other markets as well.*
    - *Specific metrics for the GA market can be searched and reviewed as a whole, per associate, or per department.*
- *SLAs for average speed of answer, average hold time, and blocked call rate were met for both member and provider call centers for the period analyzed.*

Assessment: Call Center Operations

Myers and Stauffer evaluated this contractual area utilizing the submitted policies, procedures and other supporting documentation. We determined AGP policies and procedures were in accordance with the DCH contract.

Findings: Call Center Operations

AGP provided a live Call Center demonstration, where an AGP member requested assistance locating a provider. The call center agent was able to pull a list from their system. The member asked if the list could be emailed to her. The call center agent responded that she could not, but she could give her the names verbally. Before ending the call, the call center agent referred the member to the AGP website to locate a provider.

Risk Assessment: Call Center Operations

There is low risk associated with this operational area.

Claims Management including Encounter Submissions

DCH to CMO Contract Language for Claims Management including Encounter Submissions

Section 4.16.1 of the contract requires AGP to have adequate staff and a functioning claims management and encounter submission system to ensure that the delivery of services and care are properly accounted for, documented, and reported. Myers and Stauffer reviewed the policies and procedures for claims management and encounter submissions provided by DCH, AGP, and any related subcontractors. In *Appendix C: Contract Compliance*, we identify the key contract requirements and whether AGP has policies and procedures compliant with the contract requirement(s).

Overview of Operational Area

Myers and Stauffer's review of AGP'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 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.

Observations: Claims Management including Encounter Submissions

- *The Claims PO box is checked for paper claims daily. The received claims are scanned into AGP's claim system, Facets, on a daily basis.*
- *Quality audits are conducted on claims entered into Facets to ensure all information is correct.*
- *Analysts are assigned claims through a queue utilizing the tier system referenced below.*
    - *There are 3 tiers of analysts.*
        - *Tier 1 handles inpatient claims; analysts can process claims up to $5,000.*
        - *Tier 2 handles hospital and inpatient claims; analysts can process claims up to $30,000.*
        - *Tier 3 handles all claim types; analysts can process claims up to $105,000.*
- *All claims above $30,000 are automatically subject to an audit by the Quality Team.*

- *The Georgia claims management team consists of 25 associates.*

Assessment: Claims Management including Encounter Submissions

After review of AGP's policies and procedures for Claims Management including Encounter Submissions, Myers and Stauffer did not identify sufficient policies or standard operating procedures for contract section 4.16.1.13, 4.16.2.1, and 4.16.2.2.

Myers and Stauffer evaluated this contractual area utilizing the submitted policies, procedures and other supporting documentation. Deficiencies were identified within the documentation that were not substantive enough to constitute findings; thus, we determined AGP operations were in accordance with the DCH contract.

Risk Assessment: Claims Management including Encounter Submissions

There is low risk associated with this operational area.

Internal Grievances/Appeals System

DCH to CMO Contract Language for Internal Grievances/Appeals System

Section 4.14.1 of the contract requires AGP 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.

Overview of Operational Area

AGP policy and procedures outlines a member's right to express dissatisfaction with administration, operations, or provision of health services. AGP has resources available to members, such as the member handbook, website, and others that will provide instructions on filing grievances. AGP acknowledges that the member has the right to file a grievance or have an authorized representative do so on their behalf. Per AGP policy, the plan shall assist all members that require assistance in any of the steps of filing a grievance if needed.

AGP policy states a member, or their authorized representative can initiate a grievance/appeal orally or in writing. AGP will send written notification to the member within 10 days of receiving the grievance. Once the grievance/appeal process has taken place a resolution letter is mailed to the member explaining how the determination was made. If the member does not agree with the decision, they have the right to appeal the decision. Grievances and appeals are documented, tracked, monitored in a centralized database by the quality management department.

Observations: Internal Grievances/Appeals System

- *AGP analysts have up to 90 days to complete case reviews.*

- *AGP policies and procedures state that all standard appeals must be completed within 30 days and all expedited appeals must be completed within 72 hours.*
- *Monthly regulatory reports are completed and sent to DCH to ensure the plan is complying with contractual obligations.*
- *AGP has three nurses working cases for the state of Georgia.*
- *Grievances can be submitted to AGP via mail, AGP's internal system, and paper claims.*
    - *If a member/provider does not agree with the decision relating to their grievance, the member holds the right to appeal the decision.*

Assessment: Internal Grievances/Appeals System

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Risk Assessment: Internal Grievances/Appeals System

There is low risk associated with this operational area.

Member Data Maintenance

DCH to CMO Contract Language for Member Data Maintenance

Section 4.17 of the contract requires AGP to develop, maintain, and update an information management system for the purpose of integrating all the components required for the delivery of care to its members. The system should be secure and have the capability to store and transmit information; interface with other required systems; and report data as requested by DCH.

Overview of Operational Area

AGP utilizes a comprehensive information management system to securely store all member data. The stored data includes but is not limited to personal information such as names, addresses, data of birth, and health records, as well as other forms of sensitive and private health information. AGP is responsible for making sure member information is transferred and stored securely. AGP receives a daily 834 enrollment file from the state. Once the file is received, the process of loading new members into the system begins. AGP employs a system called Facets to reconcile the 834 files against the states enrollment file, ensuring accuracy and to address any errors they may arise.

Observations: Member Data Maintenance

- *Facets is the internal system used by AGP for the member data maintenance process.*

- *AGP has standard internal SLA's for importing enrollment files, daily files are loaded within 2 days and monthly files are loaded within 3 days.*
- *AGP is producing daily quality reports to ensure the member data processes are being completed properly.*
- *AGP has an internal checklist to ensure the 834 file is being processed properly.*
- *AGP completes a monthly reconciliation to the state's data file but is also doing comparisons daily.*

Assessment: Member Data Maintenance

Upon assessment of AGP's submitted policies and procedures, documentation, and interviews, Myers and Stauffer did not identify complete policies or SOPs for contract Sections 4.17.1.1.1, 4.17.2.3.4, 4.17.2.4.1.1, 4.17.2.4.1.2, 4.17.2.4.1.3, 4.17.2.1.4, 4.17.2.4.1.5, 4.17.2.1.4.1.6, 4.17.2.4.1.8, 4.17.2.4.1.9, and 4.17.2.6.

The policies and procedures in the contract sections listed above have been deemed either non-compliant or partially compliant. Details on the review of these contract sections can be found in *Appendix C: Georgia Families Policy and Procedure Assessment*.

Findings: Member Data Maintenance

Interview responses from AGP staff regarding Member Data Maintenance indicated that there is no mandated timeframe for ensuring that eligible members are loaded in their processing system in an accurate and timely manner. We examined the contract between DCH and AGP to determine if there is a mandate and it does not specify a service level agreement for the processing of member eligibility files.

Risk Assessment: Member Data Maintenance

There is low risk associated with this operational area.

Member Services

DCH to CMO Contract Language for Member Services

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

- *Member rights and responsibilities.*
- *The role of 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 AGP network.*

Overview of Operational Area

The AGP Member Services department is responsible for ensuring that all members are made aware of their rights and have access to the resources provided by the plan. AGP utilizes various communication methods, including phone calls, text messages, email, mail, and social media to reach as many members as possible. These forms of communications are being used to not only inform members of their rights but are also used to convey essential information.

Member Services produces materials that are meant to be used by members to gain knowledge about all the resources that are provided by plan. These materials include Member Handbooks, flyers, messages and many other forms of communication designed to enhance the overall member experience.

Observations: Member Services

- *AGP has 2 data analysts who are specifically assigned to the Georgia Market.*
- *All marketing materials posted on the website undergoes thorough review.*
- *Ombudsman staff conducts monthly meetings with the following government agencies, to discuss complaints and concerns.*
    - *DJJ (Department of Juvenile Justice)*
    - *DFCS (Department of Family and Children's Services)*
- *SharePoint is used to track all Ombudsman related complaints or issues.*
- *Materials that require DCH approval are processed through an internal system called CMAP.*

Assessment: Member Services

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Risk Assessment: Member Services

There is low risk associated with this operational area.

Pharmacy Services

DCH to CMO Contract Language for Pharmacy Services

Section 4.6.6 of the contract requires AGP 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 drugs requiring prior authorization must be available through its website. The Contractor is permitted to establish a Maximum Allowable Cost (MAC) schedule. However, the Contractor must ensure the MAC pricing schedule is evaluated for pricing appropriateness and updated as appropriate no less frequently than every two (2) weeks. The evaluation process ensures the appropriateness of pricing, no limitations on access to medicine, and each medication represented on the MAC schedule has two (2) generic equivalents available to members.

Overview of Operational Area

AGP policy outlines the pharmacy benefit coverage required per the contract with DCH. CarelonRx services have been delegated as the PBM. For pharmacy, the operational areas that have been delegated to CarelonRx are claims processing, call center operations, network development and maintenance, member and provider appeals and utilization management. CVS has been contracted by CarelonRx to provide certain PBM administrative functions such as call center operations and FWA activities.

Oversight of pharmacy services activities are being conducted by AGP utilizing various methods. Methods include regular meetings, reviews of regulatory reporting and various other methods to ensure CarelonRx is fulfilling the contractual requirements agreed upon.

Observations: Pharmacy Services

- *CarelonRx is represented on the Amerigroup Quality Management Committee and the Medical Advisory Committee.*
- *Oversight reporting is utilized by AGP to ensure CarelonRx is meeting their contractual obligations.*
- *At the time of the interviews, there were no corrective action plans (CAPs) for CarelonRx in Georgia.*
- *AGP conducts bi-weekly calls with CarelonRx to ensure all issues and concerns are dealt with in a timely manner.*

- *AGP Pharmacy related Call Center Operations are delegated by CarelonRx to CVS.*

Assessment: Pharmacy Services

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Risk Assessment: Pharmacy Services

There is low risk associated with this operational area.

Provider Complaints

DCH to CMO Contract Language for Provider Complaints

Section 4.9.7 of the contract requires AGP to create a provider complaint system. The provider complaint system allows providers to dispute AGP policies, procedures, or any other aspect of their administrative functions. The policies and procedures for the complaint system should be included in the provider handbook and available for all network providers. Instructions for filing a provider complaint should also be included in the provider handbook.

Overview of Operational Area

AGP policies and procedures state the plan maintains a provider complaint system that allows participating and nonparticipating providers to dispute AGP policies, procedures, and any other administrative function. All provider policy and procedures can be found within the provider handbook. The provider handbook includes instructions on how to contact provider services to file a complaint. Providers have 30 days to file a complaint after an incident or issues has occurred.

AGP policy and procedures state that all providers will receive an acknowledgement letter within 10 days of filing a complaint. Provider complaints will be reviewed by the Complaint Committee and a decision will made within 30 days after receipt the complaint.

Observations: Provider Complaints

- *AGP stores and tracks provider complaints within internal systems called SNOW and SharePoint.*
- *Provider complaints come through the DCH inquiry email inbox among various other methods.*
- *The average number of provider complaints received per month from providers in GA is approximately 75.*
- *AGP has standard reporting in place documenting all provider complaints, allowing them to identify trends and address areas of concern.*
- *Amerigroup maintains internal SLA's relating to provider complaints.*

Assessment: Provider Complaints

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Risk Assessment: Provider Complaints

There is low risk associated with this operational area.

Provider Data Maintenance

DCH to CMO Contract Language for Provider Data Maintenance

Section 4.17 of the contract requires AGP to develop, maintain, and update an information management system capable of integrating all the components required for the delivery of care to its members. The information management system should be secure and have the capability to store and transmit information; interface with other required systems; and report data as requested by DCH. The Contractor shall ensure the system is available and accessible to users at times and in a format that encourages meaningful use by stakeholders.

Overview of Operational Area

AGP maintains an information management system to store provider information including, but not limited to, provider name; designation as a professional group or facility; provider's address and phone number. Additionally, the provider type including any specialty designations and/or credentials will be stored.

AGP policy states that the provider data maintenance process begins with AGP receiving a daily 7400 provider data file from the state. The 7400 file is used to compare against the provider information stored in *Facets*. The 7400 file is loaded and only updates information for existing providers. New providers and their data will not be loaded.

Observations: Provider Data Maintenance

- *AGP receives a full refreshed 7400 file from the state daily, however, the 7400 file is autoloaded into the SPS (Strategic Provider System) system and then Facets on Sundays only.*
- *Fall Out Reports are utilized by AGP to identify missing or inaccurate data on the 7400 files.*
- *Every Monday, AGP also generates a full Provider Report from Facets which is reviewed and compared against the previous weeks 7400 file to ensure that nothing was missed on the Fall Out Report and all data is accurate and complete.*

- *The Provider Data Maintenance team works with the Provider Outreach team to address any issues identified in the 7400 file.*
- *AGP addresses issues identified in the 7400 file within the week they are identified.*
- *AGP is contracted to retain and maintain provider information of up to five (5) years for reporting purposes.*

Assessment: Provider Data Maintenance

After review of AGP's policies and procedures for Provider Data Maintenance, Myers and Stauffer did not identify sufficient policies or standard operating procedures for contract sections 4.17.1.1,1, 4.17.1.2, 4.17.1.3, 4.17.2.1, 4.17.2.3, 4.17.2.3.1, 4.17.2.3.2, 4.17.2.3.4, 4.17.2.4, 4.17.2.4.1.1, 4.17.2.4.1.2, 4.17.2.4.1.3, 4.17.2.4.1.4, 4.17.2.4.1.5, 4.17.2.4.1.6, 4.17.2.4.1.7, 4.17.2.4.1.8, 4.17.2.4.1.9, 4.17.2.5, 4.17.2.6, and 4.17.2.8.

Myers and Stauffer evaluated this contractual area utilizing the submitted policies, procedures and other supporting documentation. Deficiencies were identified within the documentation that were not substantive enough to constitute findings; thus, we determined AGP operations were in accordance with the DCH contract.

Risk Assessment: Provider Data Maintenance

There is low risk associated with this operational area.

Provider Network

DCH to CMO Contract Language for Provider Network

Section 4.8.1 of the contract requires AGP 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 must be available as 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.

Overview of Operational Area

Per the policies laid out in the contract, AGP developed and maintains an adequate network of providers and facilities to deliver covered Medicaid services to its member population. AGP's provider network is designed to reflect, where possible, the diversity of cultural and ethnic backgrounds of its member population, such as, members with limited English proficiency. AGP's providers and facilities must be credentialed by DCH's Credentialing Verification Organization where appropriate. In rural areas, and

when otherwise appropriate, the use of telemedicine should be offered as an option for providing care to members in deficient areas.

The provider network contains physicians, specialists, BH providers, pharmacies, hospitals, physical therapists, occupational therapists, speech therapists, border providers, and other health care professionals. The network does not include any providers that have been excluded from 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. AGP performs monthly checks of the exclusions list to identify and immediately terminate any participating provider found on the list.

Observations: Provider Network

- *AGP maintains a Network Provider Portal, which providers can utilize to virtually submit an enrollment application for the network.*
    - *The enrollment decision is also provided virtually.*
- *AGP Provider Relations team makes any informational updates to the Provider Directory and will inform the Provider Network team when updates are made.*
- *After negotiations are complete between AGP and the Provider, the Configuration team will receive the contract from the Provider Network team and has 30 days to process the Provider into the system from the date of receipt.*
- *AGP mainly utilizes the GeoAccess Deficiency Report to identify and address gaps in the Provider Network. Furthermore, AGP GF and GF 360 reports are compared against each other as further review to identify any potential network gaps.*
- *Single case agreements (SCAs) are negotiated with providers who have chosen not to sign a contract for network participation, to help address identified gaps in the provider network.*

Assessment: Provider Network

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract

Risk Assessment: Provider Network

There is low risk associated with this operational area.

Provider Services

DCH to CMO Contract Language for Provider Services

Section 4.9.1.1 of the contract requires AGP 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.

Overview of Operational Area

AGP maintains a provider services department that utilizes customer care representatives 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 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.

Observations: Provider Services

- *AGP's provider services department consists of eight consultants and four managers.*
- *Consultants are required to perform 30 provider visits per month and are expected to visit providers face-to-face in the community three to four days a week.*
    - *AGP does still offer virtual visits for providers if necessary.*
    - *Virtual visits count towards the thirty visits requirement.*
- *The provider services consultants are assigned across the six GA regions and providers are tiered by county.*
- *The provider services team meets virtually every week to discuss newsletters and team expectations.*
- *AGP documents provider communications and information in the PERM system.*

Assessment: Provider Services

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Risk Assessment: Provider Services

There is low risk associated with this operational area.

Quality Management

DCH to CMO Contract Language for Quality Management

Section 4.12.1 of the contract requires AGP 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 AGP as being at risk of developing serious conditions. AGP is required to partner with members, providers, community resources, and agencies to actively improve the quality of care provided to members.

Overview of Operational Area

AGP has policies and programs in place to ensure their members receive the highest quality of care. AGP's policy and procedures state that the plan will seek input and work with members, providers, community resources to continuously improve the quality of care for members. The Quality Management team is responsible for tracking the overall performance of the plan.

The Quality Management team is responsible for developing new initiatives and outreach programs to help members have the best care. AGP has many member incentive programs with the goal of getting members more to take more initiative in their health. AGP has policies and procedures in place that state the plan develops regulatory reports on a continuous basis to monitor and track areas that need improvement, in addition to looking for areas of possible growth and improvement.

Observations: Quality Management

- *AGP has a member incentive program called Healthy Rewards where incentives are provided based on meeting health care measures, such as health screenings, annual checkups, etc.*
- *All new members receive outreach within 30 days, new members will receive communications via mail, text messages, and phone calls.*
- *A Member Oversight survey is sent out between February and May every year asking members about a variety of topics from quality of care, access to care and other similar questions about member overall experience.*
- *Performance rates are used to track the performance of each individual team and the overall well-being of the plan.*
- *Monthly meetings are conducted with DCH to discuss how the plan is trending and to receive feedback from DCH and to address any issues that may arise.*

Assessment: Quality Management

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Risk Assessment: Quality Management

There is low risk associated with this operational area.

Regulatory Reporting and Monitoring

DCH to CMO Contract Language for Regulatory Reporting and Monitoring

Section 4.18.1 of the contract requires AGP to create and submit ongoing and ad-hoc reports in an effort to track performance and analysis for all activities described in the contract. AGP is responsible for compliance regarding collecting, validating, and reporting required program data to DCH in an accurate and timely manner.

Overview of Operational Area

AGP creates and submits ongoing and ad-hoc reporting to meet the criteria that is referenced within their contract with the state. AGP completes and submits reports based off set guidelines which include specific formatting, instructions, and timetables in which the reports must be submitted.

Regulatory reports are created and reviewed by business owners, business owners are assigned a specific regulatory report or set of reports. Business owners are responsible for ensuring that all contents of the report(s) are correct and are submitted within the timeframe set by DCH. Reports are submitted on a weekly, monthly, quarterly, bi-annual, and annual basis. AGP policies and procedures state that the Chief Executive, Financial Officer, or a designee will attest to the completeness and accuracy of all submitted reports.

Observations: Regulatory Reporting and Monitoring

- *AGP utilizes an internal system called ServiceNow which automatically sends notifications to report business owners 45 days before a report is due to ensure all reports are submitted in a timely manner.*
    - *The system allows AGP to track specific reports and see which business owners are and are not submitting reports within a timely manner.*
- *A scorecard is kept, allowing AGP to track issues with specific reports and business owners to identify any problem areas.*
- *AGP has a Rise Committee where issues can be presented to senior leadership if they continue to persist over time.*

- *AGP has internal standards and procedures for reports to be completed 7 days before state deadlines to allow time for changes to be made if needed.*
- *Business owners sign attestations for all reports and note variances greater than 5 percent.*

Assessment: Regulatory Reporting and Monitoring

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Risk Assessment: Regulatory Reporting and Monitoring

There is low risk associated with this operational area.

Utilization Management

DCH to CMO Contract Language for Utilization Management

Section 4.11.1 of the contract requires AGP to implement effective Utilization Management (UM) processes and procedures to ensure a high quality, clinically appropriate, highly efficient, and cost-effective health care delivery system.

Overview of Operational Area

The Utilization Management department at AGP is responsible for ensuring all members receive appropriate and necessary health care services. AGP is responsible for providing evaluations of the cost and quality and medical services provided to the plans members to identify any over or underutilization by the plan. AGP applies objective, evidence-based criteria that consider individual member circumstances and the local delivery system to make informed determinations regarding medical services.

Provider Authorization requests can be submitted via the GAMMIS Portal. In cases where providers encounter issues with submitting authorizations through the portal, submissions maybe be sent securely via email or fax. AGP processes standard authorization requests within 72 hours and expedited authorization requests within 24 hours.

Observations: Utilization Management

- *A corporate audit team is performing audits of all the UM nurses.*
- *Amerigroup uses InterQual to review clinical data and GAMMIS to check for eligibility.*
- *Anthem Care Management Platform (ACMP) is the platform that is being for by the Utilization Management team on prior authorizations.*

- *Within the plans internal system cases are designated a color determined by the level of importance.*

- *Each UM nurse is typically assigned 10-12 facilities.*
  - *Cases are worked by facility.*
- *For cases that are denied a denial letter is sent to the provider.*
  - *The provider has up to 60 days to appeal a denial that they disagree with.*

Assessment: Utilization Management

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Risk Assessment: Utilization Management

There is low risk associated with this operational area.

Contract Compliance – Georgia Families 360°SM

Georgia Families 360°SM (GF 360) is a specialized managed care program designed to provide services for children, youth, and young adults in foster care, children and youth receiving adoption assistance, and certain youth involved in the juvenile justice system. In this section of the report, we provide an overview of contract compliance for AGP's GF 360 program.

Myers and Stauffer assessed 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). Key contractual requirements were identified, and a determination was made as to whether AGP's policies and procedures were in compliance with the DCH contract outlined in *Appendix C: Contract Compliance*.

Myers and Stauffer assessed the level of risk identified for each GF 360 operational area within this engagement. The risk levels are defined as follows:

- ***High*** *– An identified concern that will impact the CMO's systems and/or operations.*
- ***Medium*** *– An identified concern that without mitigation, is likely to impact the CMO's systems and/or operations.*
- ***Low*** *– An identified concern that is likely to have a low impact on the CMO's systems and/or operations.*

GF 360 - Care Coordination

DCH to CMO Contract Language for GF 360 - Care Coordination

Section 4.11.8.15 of the contract requires AGP to implement an approach to care coordination that employs person-centered strategies, collaboration with DCH and sister agencies, and does not focus solely on the member's immediate health care needs. Further, AGP shall provide care coordination services that are comprehensive and timely. Coordination activities include actively linking the member to providers, medical services, residential, social, and other support services or resources appropriate to the needs and goals identified in their plan of care. Coordination activities tailors care and treatment to each individual.

Overview of Operational Area

AGP policy and procedures indicates that all GF 360 members will have access to care coordination services and an interdisciplinary care coordination team. The care coordination team will include a care coordinator and clinical representatives to meet the individual needs of members. Care coordination representatives are assigned by regions.

Observations: GF 360 - Care Coordination

- *All Care Coordinators are clinically licensed.*
- *GF 360 receives an average of 600-700 newly eligible members monthly. To manage this caseload GF 360 splits the GA regions among their Care Coordinators.*
    - *Each region also has a dedicated Amerigroup point of contact.*
- *Members are assigned a Care Coordinator from the GF 360 Clinical Care Coordination Team and are triaged within 24-48 hours of eligibility.*
    - *The GF 360 scheduling specialist works simultaneously and collaboratively with the assigned Care Coordinator within the first 10 days of member enrollment to schedule initial appointments and compete clinical assessments.*
- *The GF 360 Clinical Care Coordination team consists of 57 members.*

Assessment: GF 360 - Care Coordination

After review of AGP's policies and procedures for GF 360 Care Coordination, Myers and Stauffer did not identify sufficient policies or standard operating procedures for contract section 4.11.8.17.7.1.

The policies and procedures in the contract sections listed above have been deemed either non-compliant or partially compliant. Details on the review of these contract sections can be found in *Appendix C: Georgia Families Policy and Procedure Assessment*.

Risk Assessment: GF 360 - Care Coordination

There is low risk associated with this operational area.

GF 360 - Internal Grievance/Appeal System

DCH to CMO Contract Language for GF 360 - Internal Grievance/Appeals System

Section 4.14.1 of the contract requires AGP to develop written grievance system and appeals process, policies, and procedures that detail the grievance system and appeals process. The system shall include a process to receive, track, resolve, and report on grievances from its members. Further, the appeals process shall include an administrative review process and access to the state's administrative law hearing system.

Overview of Operational Area

The AGP policies and procedures for internal grievances and appeals for GF 360 are consistent with the policies and procedures for internal grievances and appeals for Georgia Families®.

Observations: GF 360 - Internal Grievance/Appeals System

- *Appeals and grievances are received by email, letter, customer service line, or the PEGA Next Gen system.*
- *Adverse Benefit Determination letters are mailed to members and providers notifying them of their right to appeal.*
    - *The appeal can be filed based on the information contained within the letter.*
- *Monthly and quarterly reports are provided to AGP by an internal team.*
- *The Appeals team has 30 days to provide a resolution or a decision regarding the appeal or grievance.*
- *During the appeal process, AGP provides the opportunity to present evidence, written comments, documents or other information and allegations of fact or law in person, as well as in writing, at any time.*

Assessment: GF 360 - Internal Grievance/Appeals System

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Risk Assessment: GF 360 - Internal Grievance/Appeals System

There is low risk associated with this operational area.

GF 360 - Member Call Center Operations

DCH to CMO Contract Language for GF 360 - Member Call Center Operations

Section 4.3.8 of the Contract requires AGP to provide a twenty-four (24) hour call center staffed with experienced staff familiar with GF 360, Georgia child-serving agencies, and the Georgia provider community.

Overview of Operational Area

AGP's call center is staffed and trained to accurately assist members with general inquiries, identify the need for crisis intervention, and provide referrals to Georgia crisis and access line and/or other resources for crisis and emergent needs. Additionally, the call center 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. The call center shall

achieve performance standards and monitor call center performance by recording calls and employing other monitoring activities.

AGP policies and procedures indicated that a call center team staffed 24/7 with Anthem personal guides serving the members, child-serving agencies, and the Georgia provider community. The policies outline the standard operating procedures for compliance with the contractual metrics, call handling, and daily operations.

Observations: GF 360 - Member Call Center Operations

- *An interactive voice response system is utilized to document calls, and a repository documentation system enables AGP to access accounts on calls.*
- *The member call center is staffed with four associates and one manager.*
- *The call center has a 24/7 crisis line.*
- *Call center representatives' performance is reviewed through their associate scorecards.*
- *Associates' lunches and breaks are staggered to account for heightened call times.*
- *Each associate receives two quality assurance audits per month.*

Assessment: GF 360 - Member Call Center Operations

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Risk Assessment: GF 360 - Member Call Center Operations

There is low risk associated with this operational area.

GF 360 - Member Enrollment and Disenrollment

DCH to CMO Contract Language for GF 360 - Member Enrollment and Disenrollment

Section 4.1.1.1 of the contract requires AGP to be responsible for enrolling and disenrolling its members, educating them on enrollment options, and developing and implementing outreach activities. AGP shall not discriminate against individuals on any basis, including but not limited to religion, gender, race, color, or national origin, or based on health, health status, pre-existing condition, sexual orientation, or need for health care services.

Overview of Operational Area

AGP policy indicates that the plan is responsible for the enrollment and disenrollment of its members. Policies are in place that layout guidelines for members' rights regarding enrollment and disenrollment. The policies and procedures emphasize the availability of education options on enrollment and disenrollment topics, alongside various outreach initiatives designed to keep the community well informed and educated. In addition, AGP policies are designed with the goal of ensuring that all enrollment and disenrollment requests are processed efficiently and in a timely manner. AGP policies and procedures state all members will be provided care coordination upon enrollment and will provide all members with access to a PCP.

Observations: GF 360 - Member Enrollment and Disenrollment

- *The 834 file is compared to the state's enrollment file for accuracy.*
- *Temporary IDs are provided to members during the enrollment process which allows the member to have access to the plan's resources immediately.*
- *All members enrolled in the Department of Juvenile Justice or Foster Care programs may request disenrollment within the first 90 days without cause.*
- *AGP's clinical triage team will complete risk assessment, care coordination, and individual care plans within 30 days of assignment.*
- *AGP completes all disenrollment paperwork for members seeking to disenroll.*

Assessment: GF 360 - Member Enrollment and Disenrollment

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Risk Assessment: GF 360 - Member Enrollment and Disenrollment

There is low risk associated with this operational area.

GF 360 - Provider Network

DCH to CMO Contract Language for GF 360 - Provider Network

Section 4.8.1.1 of the contract states 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 which may include the use of telemedicine when appropriate to the condition and needs of the member.

Overview of Operational Area

AGP is solely responsible for providing a robust network of physicians, pharmacies, hospitals, physical therapists, occupational therapists, speech therapists, border providers, and other health care providers able to provide the items and services included in covered services. AGP is required to expand upon its GF 360 provider network to meet the unique needs of the members. AGP employs innovative solutions for providing access in underserved areas. For example, the contractor may consider the provision of physical health and behavioral health telemedicine services in local schools.

AGP maintains, at a minimum, a provider network of primary care and specialist providers who are trained or experienced in trauma-informed care and in treating individuals with complex special needs. This care includes the population, which comprises the members; providers who have knowledge and experience in identifying child abuse and neglect; providers who render core services and Intensive Family Intervention (IFI) services; and providers recommended by DCH to ensure network access for members, including independent behavioral health providers and non-traditional providers. AGP must ensure that all providers meet the State's credentialing requirements. The MCO is encouraged to contract with the community service boards to provide core services and such providers must meet the GF 360 state credentialing requirements.

Observations: GF 360 - Provider Network

- *For Georgia, AGP GF 360 establishes contracts with behavioral health providers in a different manner than with AGP GF behavioral health providers.*
- *AGP maintains a Network Provider Portal, which providers can utilize to virtually submit an enrollment application for the GF 360 network. The enrollment decision is also provided virtually.*
- *AGP provider contract specialists conduct outreach to providers to fill potential gaps when current providers terminate their contract.*
- *AGP utilizes a system called Contraxx to manage and track current provider contracts as well as provider contracts in the process of being evaluated.*
- *AGP mainly utilizes the GeoAccess Deficiency Report to identify and address gaps in the provider network.*

Assessment: GF 360 - Provider Network

After review of AGP's policies and procedures for GF 360 Provider Network, Myers and Stauffer did not identify sufficient policies or standard operating procedures for contract sections 4.8.1.4.1, 4.8.1.4.2, 4.8.2.2.1, 4.8.3.2, and 4.8.3.3.

Myers and Stauffer evaluated this contractual area utilizing the submitted policies, procedures and other supporting documentation. Deficiencies were identified within the documentation that were not substantive enough to constitute findings; thus, we determined AGP operations were in accordance with the DCH contract.

Risk Assessment: GF 360 - Provider Network

There is low risk associated with this operational area.

GF 360 - Quality Improvement

DCH to CMO Contract Language for GF 360 - Quality Improvement

Section 4.12.1 of the contract requires AGP to 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 and maintain the member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status.

Overview of Operational Area

AGP's policies and procedures are designed to improve the quality of care rendered to all Amerigroup and Georgia Families® 360 members. The plan is required to be NCQA certified per contract requirements. AGP, as mandated by the contract, must have a Quality Improvement Committee containing members of executive and management staff. This committee contains a senior health plan leader from Quality Management and Utilization Management, a senior health plan Medical Director, and Senior Corporate leaders of Quality, Case, Disease, and Utilization Management, Behavioral Health, Network, National Call Center, Long Term Care Services and Pharmacy. The Quality Improvement Committee is tasked with providing leadership and guidance for the plan to ensure the highest standard of care.

AGP policies and procedures state the Quality Management team reports to the Medical Advisory Committee, Quality Management Committee, Quality Improvement Council and the Georgia Board of Directors. AGP has implemented oversight and regulatory reporting to ensure that the plan is providing the highest quality of care possible to its members.

Observations: GF 360 - Quality Improvement

- *The Quality Improvement department has 3 clinical program managers, 2 of which are nurses and the third oversees HEDIS and clinical aspects of the program.*
- *The plan has reporting in place to see how the team is trending on a monthly and yearly basis.*
- *AGP has internal benchmarks for all HEDIS measures with a goal of 66.7% or higher for all measures unless the state requires a higher percentage.*
- *An annual survey is sent out to all members to engage members to provide feedback on the quality of care they are receiving.*
- *AGP conducts a monthly meeting with DCH to discuss how the plan is trending and to intake any feedback from DCH.*

Assessment: GF 360 - Quality Improvement

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Risk Assessment: GF 360 - Quality Improvement

There is low risk associated with this operational area.

GF 360 - Required Assessments and Screenings

DCH to CMO Contract Language for GF 360 - Required Assessments and Screenings

Section 4.7.7.3 of the contract requires that AGP must conduct, and report required assessments and screenings upon GF 360 member enrollment. AGP must be able to determine the need to complete a new screening each time a member moves to a new placement or based on the change in the member's medical or behavioral health as identified by providers.

Overview of Operational Area

The required assessments and screenings that AGP must have the ability to conduct, include Comprehensive Child and Family Assessment (CCFAs), Medical Assessments for Foster Care (FC) members, Trauma Assessment Screenings, Health Risk Screenings, and Medical Assessments for Juvenile Justice (JJ) Members. The assessments and screenings listed above are then used to identify the immediate needs of members transitioning into and out of the GF 360 program. The assessments and screenings that members receive may vary depending on the member's population type.

Observations: GF 360 - Required Assessments and Screenings

- *AGP conducts the following required assessments and screenings for the relevant members: the Comprehensive Child and Family Assessment (CCFAs), Medical Assessments, Trauma Assessment Screenings, and Health Risk Screenings.*
- *AGP has 12 staff members scheduling, monitoring, and recording the assessments and screenings being conducted.*
    - *The assessments and screenings are usually scheduled within 10 days of outreach to the member.*
- *AGP conducts outreach via phone and text reminders to members who miss their scheduled appointment as these assessments and screenings are necessary to coordinate care.*
- *AGP staff maintain an accurate tracking/case management system to provide the highest quality reporting to the state.*

- *The system is regularly reviewed and updated to maintain and accurate and complete records.*

Assessment: GF 360 - Required Assessments and Screenings

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Risk Assessment: GF 360 - Required Assessments and Screenings

There is low risk associated with this operational area.

GF 360 - Utilization Management

DCH to CMO Contract Language for GF 360 - Utilization Management

Section 4.11.1 of the GF 360 contract requires AGP to implement effective Utilization Management (UM) processes and procedures to ensure a high quality, clinically appropriate, highly efficient, and cost-effective health care delivery system. AGP 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.

Overview of Operational Area

The Utilization Management department is one of the entities AGP GF 360 uses to administer a health care system designed to provide members with access to quality resources and appropriate care. AGP ensures that healthcare services are delivered efficiently while utilizing resources effectively. AGP is responsible for ensuring all members are provided with the proper assistance while ensuring appropriate utilization of resources.

The Utilization Management department is responsible for overseeing authorizations for medical, dental, and behavioral health services. The UM department ensures all member authorizations will be evaluated for medical necessity, level of care, clinical appropriateness, and site of appropriateness of health care services. The purpose of the AGP Utilization Management department is to optimize the use of available resources thereby ensuring the highest quality care of members.

Observations: GF 360 - Utilization Management

- *Providers prior authorization letters and denial letters are sent directly to DFCS, and inpatient denials go directly to the CM team for referral.*
- *Providers are allowed up to 60 days to request an appeal if they disagree with a decision.*
- *All single case agreements must be approved by the medical director.*

- *The internal system used by AGP for processing cases is called ACMP- Anthem Care Management Platform.*
- *All cases are assigned by facility, each nurse is assigned about 10-12 facilities for which they will work cases on.*
- *Cases are assigned a color code within AGP's internal system categorized by the level of urgency per case.*

Assessment: GF 360 - Utilization Management

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Risk Assessment: GF 360 - Utilization Management

There is low risk associated with this operational area.

Program Integrity Oversight

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

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

DCH to CMO Contract Language for Program Integrity Oversight

Section 4.13.1.1 of the contract requires that AGP sustain a PI program, which includes a required compliance plan aimed at preventing fraud, waste, and abuse (FWA). This PI program must encompass policies, procedures, and standards of conduct to prevent, detect, report, and take corrective action for both confirmed and suspected instances of fraud, waste, and abuse in the administration and delivery of services under the contract.

Overview of Operational Area

The contract requires the appointment of a compliance officer who is accountable to AGP's senior management and is responsible for ensuring effective communication between AGP and DCH staff. The compliance officer is also responsible for ensuring the implementation and ongoing operation of the compliance program, including the monitoring and oversight of the adherence with Medicaid, legal, regulatory, and contractual requirements. The role also includes the assessment, identification, and remediation of compliance risks, such as FWA health care services.

AGP maintains a PI program to document how the detect, report, prevent, and apply corrective actions to suspected FWA cases. The policies, procedures, and standards of conduct are documented and include corrective action of suspected cases of fraud and abuse.

Additionally, AGP sustains a mandatory compliance program and a pharmacy lock-in program as required by the contract. AGP supplies monthly reports regarding members enrolled in the pharmacy lock-in program to DCH.

Observations: Program Integrity Oversight

- *AGP's Medicaid Compliance Director serves as the local Plan Compliance Officer (PCO).*
- *The Special Investigations Unit (SIU) is comprised of six Georgia dedicated investigators.*
- *AGP maintains a Program Integrity and Investigations Committee.*
- *The Medicaid Compliance Department maintains and houses policies and procedures regarding compliance with all applicable and federal and state requirements.*

- *Members and providers are given information regarding Fraud, Waste, and Abuse reporting via the member and provider websites.*
- *The AGP Compliance Officer meets quarterly with DCH.*
- *AGP informs DCH about known or suspected fraud cases.*
- *AGP receives FWA leads through members, internal associates, DCH, other CMOs, and The Fight Fraud Website (www.fighthealcarefraud.com).*
- *Data analysis is another tool to identify potential FWA cases.*

Assessment: Program Integrity Oversight

Myers and Stauffer evaluated this contractual area utilizing the submitted policies, procedures and other supporting documentation. We determined AGP policies and procedures were in accordance with the DCH contract.

Risk Assessment: Program Integrity Oversight

There is low risk associated with this operational area.

Fraud, Waste, and Abuse Reporting

AGP is contractually required to submit a quarterly Fraud, Waste, and Abuse 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 least 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 utilization management, claims management, post-processing review of claims, and provider profiling.*

Myers and Stauffer examined four quarterly Fraud and Abuse reports submitted by AGP for the first quarter of state fiscal year 2024 through the fourth quarter of state fiscal year 2024. These reports comprised 291 FWA cases. We assessed the history of these cases in terms of the CMO's Special

Investigative Unit (SIU) productivity, case mix, case outcomes, completeness, and consistency of reporting.

SIU Productivity

During the state fiscal year (July 2023 through June 2024), AGP began with a backlog of 145 FWA cases, opened 146 additional cases, closed 95 cases, and ended with a backlog of 196 FWA cases. It appears the FWA case backlog increased steadily during the twelve months of the review period. The typical turn-around-time (from open to close) for all cases closed during the review period was approximately 14 months.

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

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

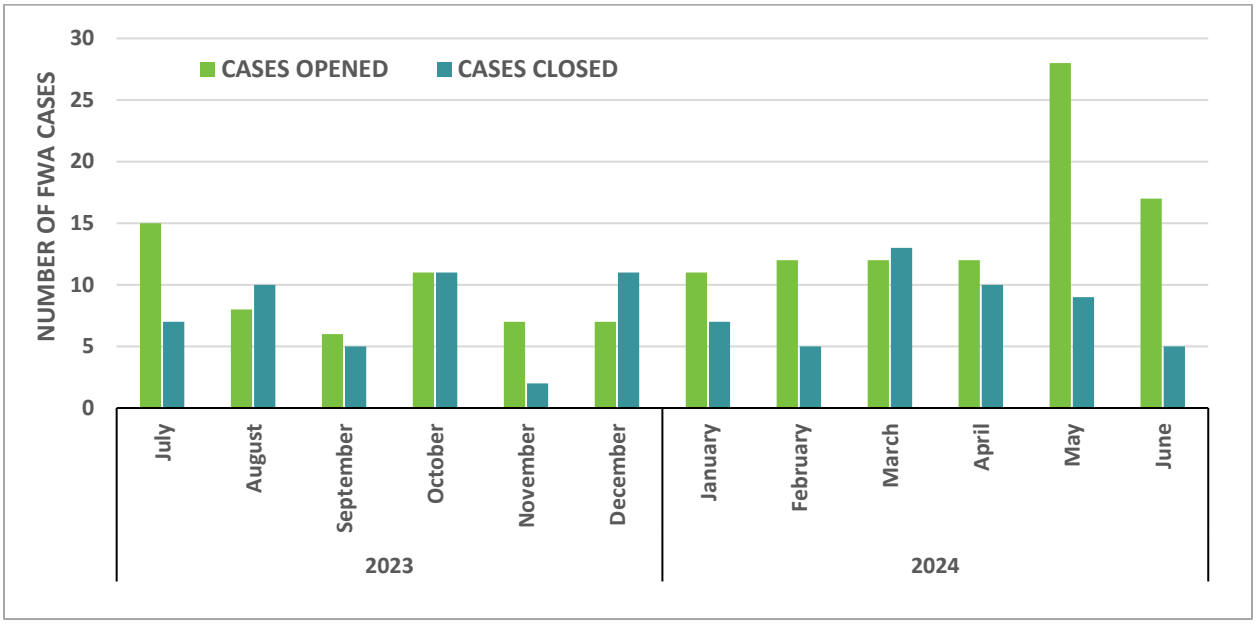
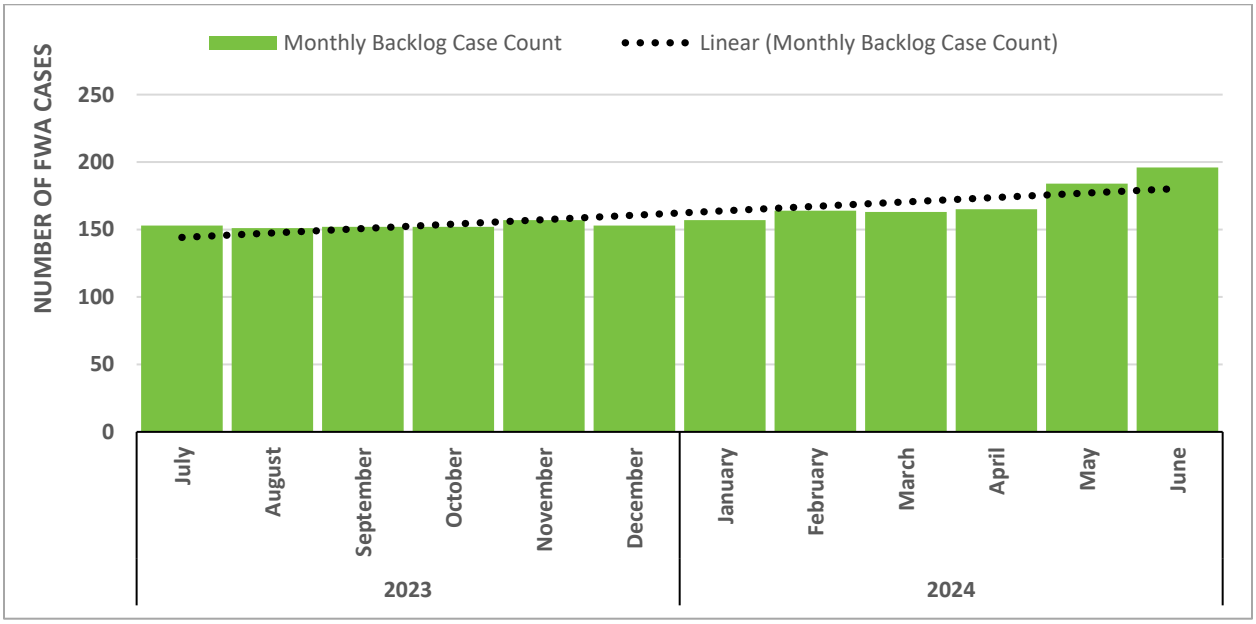


Figure 2: Number of Backlogged FWA Cases by Month



Additionally, it appeared that there was a delay in reporting some new cases, as they did not appear until after the report period of the case's date of complaint. Of the 146 new cases during the review period, 23 cases were not documented until after the report period in which the date of complaint occurred. We could not verify when the investigation of these cases began and are unable to determine if these reporting delays indicate a delay in the start of case investigation. *Table 2* indicates the reporting delay during the review period. To calculate this delay, we assumed that the date of complaint field refers to the calendar date of the report to the Special Investigation Unit.

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**
SFY 2024 Q1					0
SFY 2024 Q2	2	3	5		10
SFY 2024 Q3					0
SFY 2024 Q4	2	3	1	7	13
Total	**4**	**6**	**6**	**7**	**23**

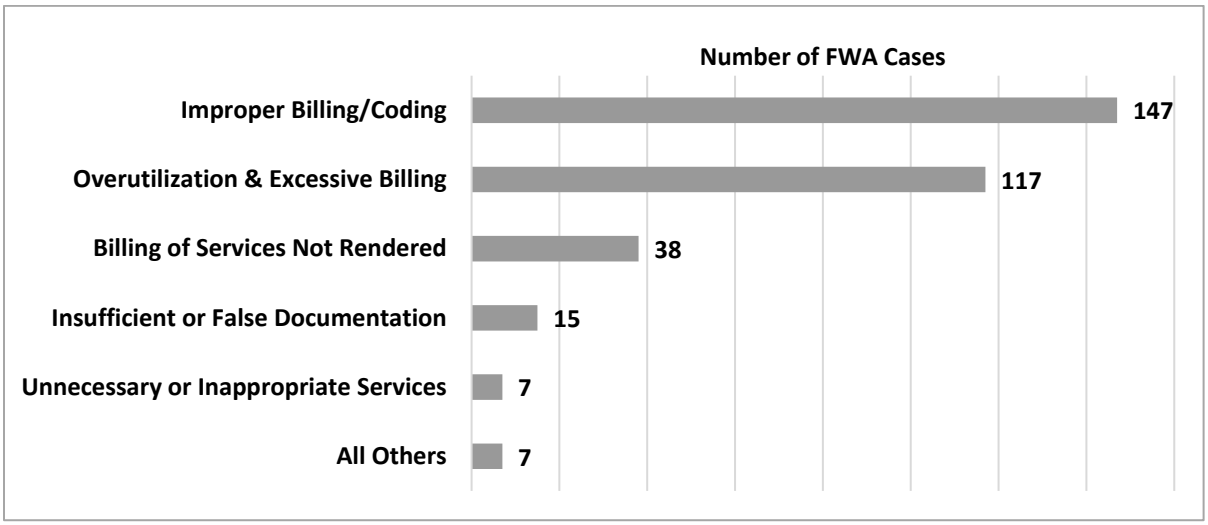
The time gap was calculated based on the first date of the quarter during which the case was first reported.

FWA Case Mix

Myers and Stauffer examined the FWA case mix within the 291 active cases during the review 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 two most common identified schemes were improper billing and coding, and overutilization and excessive billing. There were many instances of multiple schemes identified per case. As a result, Figure 3 contains a total case count greater than 291.

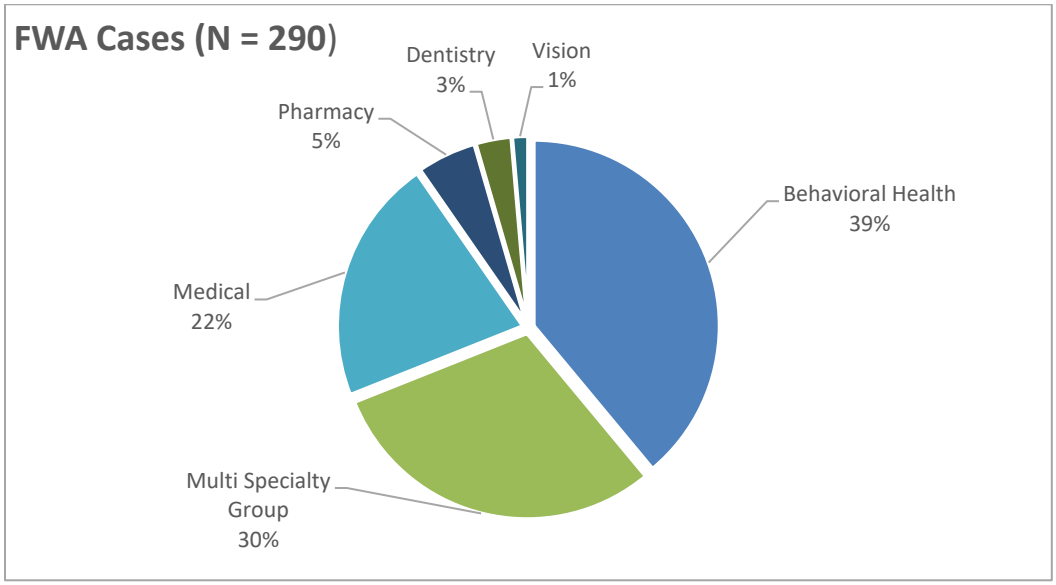
Figure 3: Nature of Complaints Documented for FWA Cases



There was one instance of member fraud which appeared in the FWA reports during the review period. The most common types of providers alleged to be engaging in FWA were behavioral health, multiple specialty groups, and medical providers, as shown in Figure 4. Note that the member fraud case is not included in Figure 4.

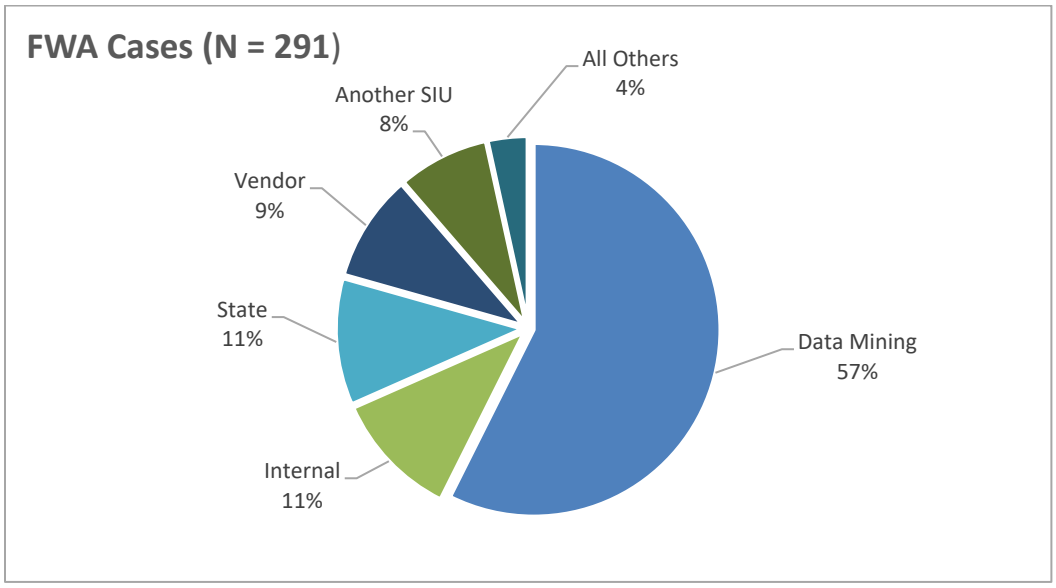
It appears that multiple specialty groups and behavioral health providers had the most cases opened within the review period and had the lowest percentage of case closure when comparing the number of opened and closed cases by provider type.

Figure 4: Provider Types Involved in FWA Cases



The FWA cases reported during this twelve-month period were sourced from multiple entities. The most common complaint sources being data mining, internal AGP sources, and state sources as shown in Figure 5. The "Internal" category is comprised of associates from within and outside of the SIU as well as the health plan itself, determined by the source of complaint data. The "All Others" category contains member sources as well as former SIU associates.

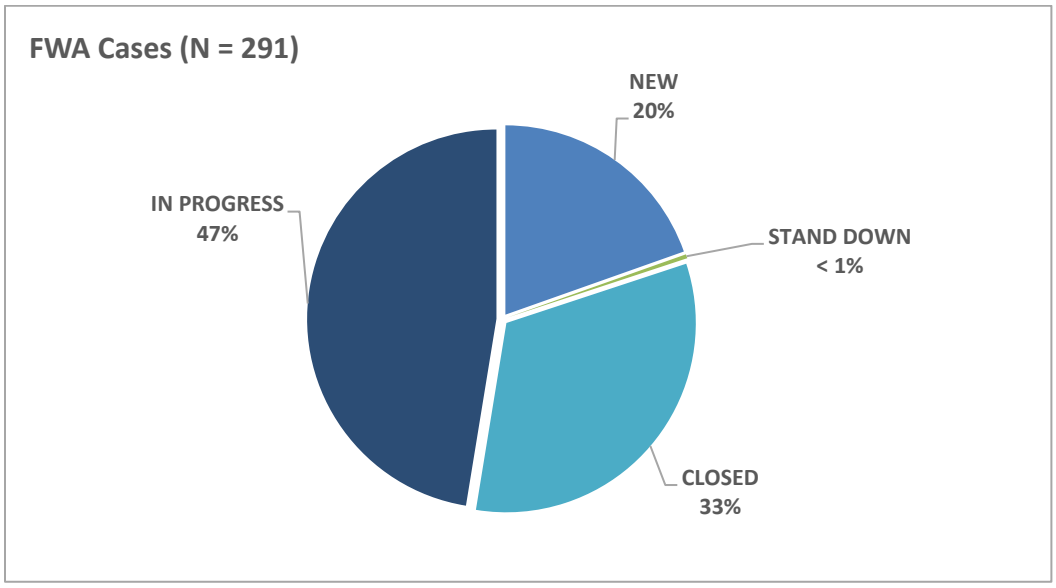
Figure 5: FWA Source of Complaint



FWA Case Outcomes

Myers and Stauffer examined the actions and outcomes AGP reported for the 291 FWA cases active during the review period. We categorized each case's final status as new, stand down, in progress, or closed as shown in Figure 6.

Figure 6: Final Status of FWA Cases



Actions taken by AGP SIU as observed in the case records submitted included: education; prepay review; overpayment determination; recoupment; and notification to the provider of termination without cause. Of the 95 FWA cases closed during the review period (July 2023 through June 2024), 61 had multiple actions reported per case throughout the review period. The most common combination of disciplinary action was overpayment determination followed by education, prepay review, and recoupment. For some cases, the FWA reports indicated that the investigation yielded no findings, but a disciplinary action, most frequently education or overpayment determination, was described.

Figure 7: Actions Taken Towards Closed FWA Cases by Number of Cases

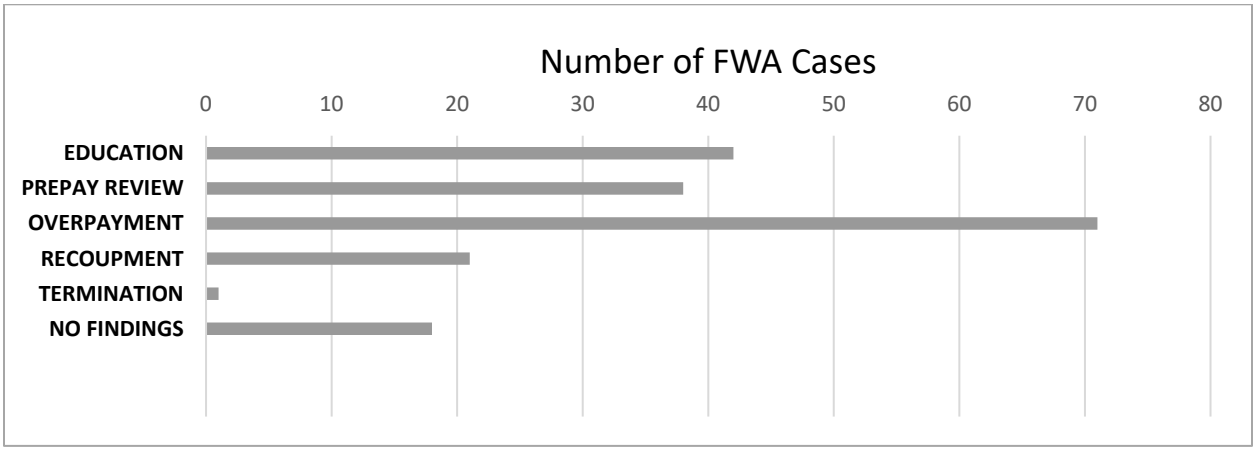
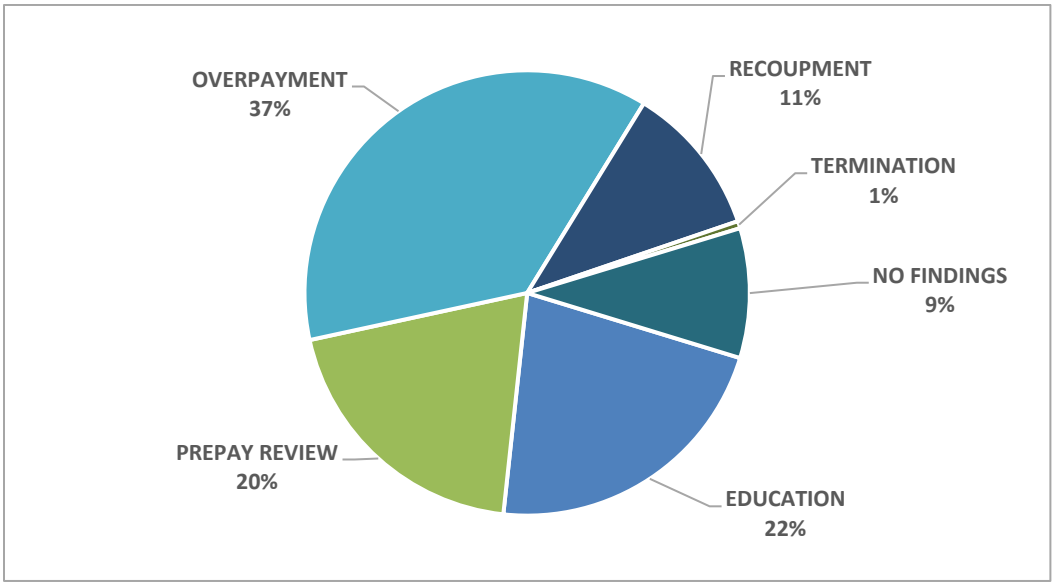


Figure 8: Actions Taken Towards Closed FWA Cases by Percentage of Total Actions



AGP SIU reported an estimate of dollars involved through two methods: dollars identified and dollars potentially exposed. The identified amounts were recorded for 51 closed cases and cases in progress. The potentially exposed amounts were recorded for all case statuses and had much larger values than the identified dollars. AGP did not provide explicit overpayment, or recoupment amounts in the FWA reports. The total amount identified during the twelve-month review period was approximately $830,334.36, and the total amount potentially exposed was approximately $104,059,408.25 as shown in *Table 3*.

Table 3: Approximate Dollar Amounts Documented in Quarterly Reports

FWA Financial Outcomes – Approximate Dollar Amounts Documented in Quarterly Reports				
Final Case Status	**Estimated Dollars Identified**		**Estimated Dollars Potentially Exposed**	
Closed	51 cases	$109,410.63	39 cases	$21,808,218.56
In Progress	93 cases	$720,923.73	89 cases	$66,121,854.98
New	0 cases	n/a	41 cases	$15,431,230.28
Stand-Down	0 cases	n/a	1 case	$698,104.43
Totals	**144 cases**	**$830,334.36**	**170 cases**	**$104,059,408.25**

Reviewing the financial outcomes for closed cases in more detail, during the twelve-month review period July 2023, March 2024, and May 2024 had the largest identified totals. These three months had a combined identified amount of approximately $61,500 for closed cases. March 2024, April 2024, and June 2024 had the largest potentially exposed totals. These three months had a combined potentially exposed amount of approximately $11,900,000 for closed cases.

Figure 9: Approximate Identified Dollars of Closed Cases

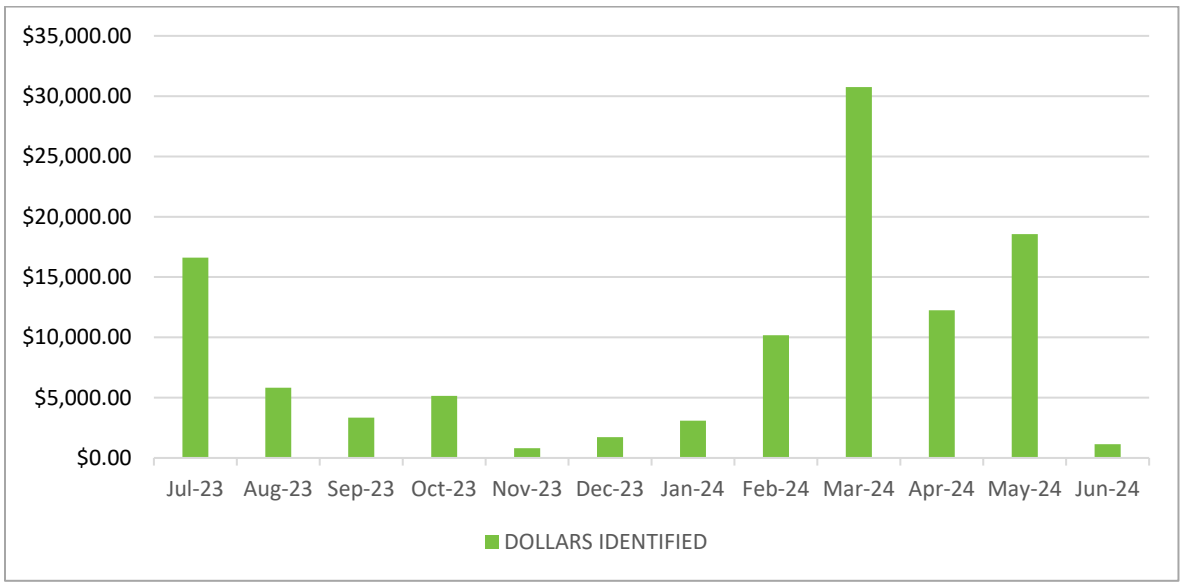
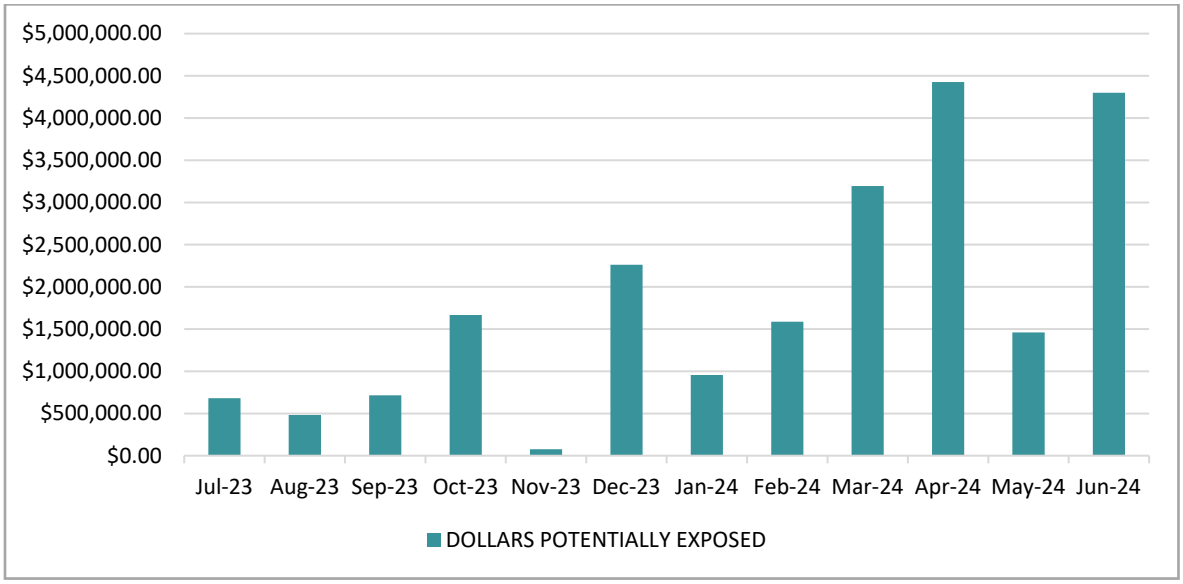


Figure 10: Approximate Potentially Exposed Dollars of Closed Cases



Observations: Fraud, Waste, and Abuse Reporting

- *Myers and Stauffer observed backlog of FWA cases during our examination of AGP's FWA reporting activity.*
- *Myers and Stauffer observed that fields on the quarterly FWA reports related to estimates of dollars involved are not being fully utilized or populated with data.*

Assessment: GF - Fraud, Waste, and Abuse Reporting

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, reports, and interviews. We determined AGP operations were in accordance with the DCH contract.

Risk Assessment: GF - Fraud, Waste, and Abuse Reporting

There is low risk associated with this operational area. DCH is currently working with Amerigroup to address reporting of cases.

Subcontractor Oversight

This section of the report provides an overview of AGP's subcontractor oversight. We performed an assessment of AGP's policies and procedures for subcontractor oversight. We identified the key contractual requirements, then determined whether AGP's policies and procedures were in compliance with the DCH contract language as 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. AGP's subcontractors with their corresponding delegated functions are represented in *Table 4* below.

Table 4: Subcontractor Functions

Delegated Function	CarelonRx (PBM)	DentaQuest (Dental)	Avesis (Vision)
Claims Processing	X	X	X
Utilization Management	X	X	X
Call Center Operations	X	X	X
Network Development and Maintenance	X	X	X
Member/Provider Appeals	X	X	X

Observations: Subcontractor Oversight

- *Vendors are monitored via meetings and regulatory reporting; regulatory reporting occurs on a regular basis through monthly and quarterly reporting.*
- *AGP currently has two open CAPs for DentaQuest for network management and claims processing.*
- *Decisions to select a vendor are a combined function of the corporate office and the local plan.*
- *AGP's Health Plan Operations and Vendor Oversight teams are responsible for overseeing and monitoring vendor performance.*

Assessment: Subcontractor Oversight

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Risk Assessment: Subcontractor Oversight

There is low risk associated with this operational area.

Avesis

DCH to CMO Contract Language for Avesis

Section 4.7.4.5 of the contract requires AGP to provide medical and routine vision services to its members. Avesis is contracted by AGP to provide vision services to its members. The specific activities and responsibilities delegated to Avesis are outlined in the contract with AGP.

Overview of Operational Area

AGP is required to establish vision services for its members and has subcontracted with Avesis to fill this contractual obligation. AGP and Avesis shall evaluate Avesis' performance on a regular basis to identify deficiencies or issues within vision services. The specific activities and responsibilities delegated to Avesis are outlined within the AGP contract. Avesis is delegated by AGP to provide the following functions: Utilization Management, Claims Processing, Member/Provider Appeals, Network Development and Maintenance, and Call Center Operations. Avesis does delegate some functions out to another vendor.

Avesis meets monthly with AGP to discuss operations. Every week Avesis and AGP exchange an Excel tracker document that outlines any open items that displays the status of projects. They also have quarterly operations meetings to review activities over the last three months.

Observations: Avesis

- *Avesis is delegated to perform FWA, claims and encounters, provider network, reporting, UM, and customer service.*
- *Avesis, at the time of interview, had three active CAPs for their member and provider call centers.*
    - *Avesis underperformed in metrics for the GF360 provider call center average speed of answer, GF360 provider call center average wait time, and the AGP member call center percentage of calls answered within 30 seconds.*
- *There are monthly delegation oversight meetings between Avesis and AGP to discuss the previous month's performance*
- *Avesis has no internal audit process, instead, they track quality metrics and discuss deficiencies across departments.*
- *Avesis utilizes two data clearing houses for AMG GA – TriZetto and Office Ally.*

Assessment: Avesis

Myers and Stauffer evaluated Avesis' operations utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Risk Assessment: Avesis

There is low risk associated with this operational area.

CarelonRx

DCH to CMO Contract Language for CarelonRx

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

Overview of Operational Area

CarelonRx is contracted by AGP to provide pharmacy services to its members. The specific activities and responsibilities delegated to CarelonRx are outlined within the contract with AGP. CarelonRx has been delegated many areas of operations as the PBM by AGP. The areas delegated by AGP include Claims Processing, Utilization Management, Call Center Operations, Network Development and Maintenance, and Member/Provider Appeals. CarelonRx delegated certain administrative services to CVS including but not limited to call center operations and FWA operations.

Call Center Operations are handled by CVS utilizing a staff of over 1,000 associates across all markets. CVS staff answer all calls related to Pharmacy and are trained to assist with claims transactions, pharmacy, and claims related inquiries. The call center is responsible for fulfilling the contractual obligations outlined in the DCH contract with Amerigroup. CarelonRx is responsible for providing all pharmacy services listed out in the contract between AGP and DCH.

Observations: CarelonRx

- *CarelonRx has a team responsible for updating policies and procedures.*
- *The CarelonRx Quality Team conducts internal audits on areas of operations.*
- *All authorizations (standard and expedited) are processed within 24 hours.*
- *Each CarelonRx Utilization Management associate has 10 of their cases reviewed per month in non-peak season and 6 per month during peak season.*
- *Quality assurance is performed on claims by taking adjudicated claims and ensuring all claims meet the requirements and specifications within the contract.*

Assessment: CarelonRx

Myers and Stauffer evaluated CarelonRx's policies and procedures, documentation, and interview responses for pharmacy services and determined their compliance with the DCH contract, with the exception of the finding below.

Findings: CarelonRx

During the interview of CarelonRx Encounters staff, Myers and Stauffer asked if there are any claims excluded from the encounter data files. CarelonRx responded that they do not exclude any claims from their encounter files. Myers and Stauffer assessed the encounter data submitted for this engagement and determined that most denied claims and a large number of previous adjudication sequences were missing from the encounter data.

Risk Assessment: CarelonRx

There is low risk associated with this operational area.

DentaQuest

DCH to CMO Contract Language for DentaQuest

Section 4.7.4.5.2 of the DCH contract requires AGP to provide dental diagnostic care and treatment services to its members.

Overview of Operational Area

DentaQuest is contracted by AGP to provide dental services to the plan's members**.** Basic 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.

DentaQuest is delegated the functions of Claims Processing, Utilization Management, Call Center Operations, Network Development and Maintenance, and Member/Provider Appeals. AGP has monthly meetings and reports in place to ensure DentaQuest is meeting the requirements listed in the contract. The specific activities and responsibilities delegated to Envolve Dental are outlined in their contract with AGP.

Observations: DentaQuest

- *DentaQuest and Amerigroup share a dashboard to upload reports and track issues that may arise.*
- *DentaQuest has four provider representatives for the state of Georgia, two in the south and two in the north.*

- *Geoaccess reports are used to identify and to help fill gaps within the DentaQuest network.*
- *DentaQuest uses data analytics to identify potential cases of fraud to refer to AGP.*
- *DentaQuest has a FWA hotline and email box in place to report potential cases of Fraud. Internal tips and other forms of communications are used to identify fraud as well.*

Assessment: DentaQuest

Myers and Stauffer evaluated DentaQuest's policies and procedures, documentation, and interview responses for dental services and determined their compliance with the DCH contract, with the exception of the findings below.

Findings: DentaQuest

Based on interview responses from the discussions of inbound claims and encounter submissions, it appears that no oversight or trend reviews are being conducted on encounter information or encounter edits. It appears that encounter response files are handled by an automated system and no reports or output encounter edits are reviewed by staff. The lack of oversight could lead to inaccuracies within the data.

Additionally, there are also inaccuracies within the encounter data due to adjustments to original claims not accepted into encounters and adjusted claims being processed as new day encounters, while the original claims are being bypassed.

Risk Assessment: DentaQuest

There is low risk associated with this operational area.

Encounter Submissions and Payment Systems

Approach and Methodology

Overview

Myers and Stauffer's examination of AGP'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 the CMO and its subcontractors is to accept and adjudicate claims payments for beneficiaries participating in the Georgia Families® and Georgia Families 360°SM programs. 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 claims adjudicated under its purview, regardless of their outcome. Encounters are records of these adjudications, and each CMO is contractually required to submit complete, accurate, and timely encounters, including any subcontractor paid 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 this engagement, Myers and Stauffer examined the organizational teams and systems responsible for handling the claims life cycle. This examination began with the receipt of provider billings, their adjudication, and their eventual submission to the State as encounters. One objective of the engagement was to identify any gaps that had the potential to impact the processing, information, completeness, timeliness, or accuracy of claims and encounters. Our examination 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 AGP having a service date during April 2024 or a paid date in May 2024. The CMO and its subcontractors were requested to provide all claims satisfying these 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), currently Gainwell Technologies. This data extract contains paid and denied CMO institutional, medical, dental, vision, and pharmacy encounters that were submitted by the CMO to the FAC and are subsequently loaded into the MMIS. Unless otherwise noted, we accept the encounter data as complete and accurate.

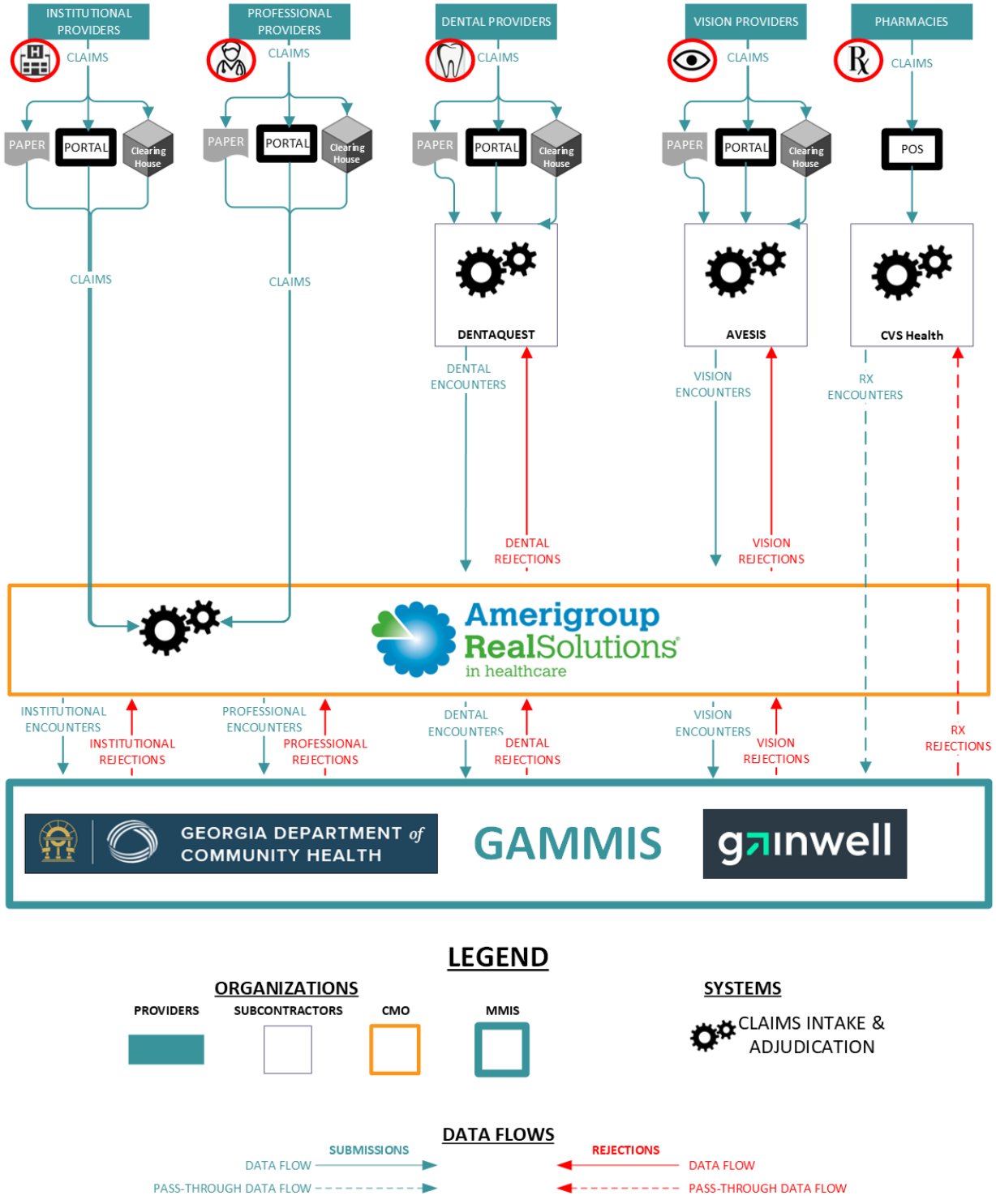
Myers and Stauffer mapped the claim/encounter data flow from subcontractor to the CMO and into the MMIS by linking related claim lines at the different processing points in the claim life cycle. Claim lines

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

Myers and Stauffer classifies MMIS encounters under Georgia Families® and Georgia Families 360°SM based on monthly member eligibility information received from Gainwell. Due to timing differences between the Gainwell member eligibility data and member program designation maintained by AGP and its subcontractors, the classification of the MMIS encounters may not always match the member's program designation in AGP and its subcontractor's systems. To avoid complications caused by potential mismatching program designation, Myers and Stauffer reviewed claim lines for Georgia Families® and Georgia Families 360°SM in a combined data set. The results reported in this section and in Exhibit II represent the combined detail lines for Georgia Families® and Georgia Families 360°SM during the review period.

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

Figure 11: Claims and Encounters Data Flow Diagram



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 examined a sample of claims from the CMO and each of its subcontractors' claims processing systems. We compared individual claim lines in these claims to 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. 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 its 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 inspected 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 inspected 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 investigation 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 inspected 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

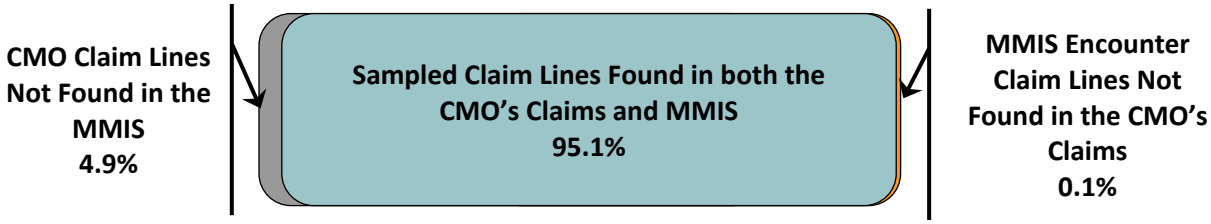
Myers and Stauffer compared data elements in the CMO, and subcontractor claims to related encounter data within the claim/encounter life cycle to determine if the information in the originating system ultimately matched the information reported in the MMIS. We evaluated and documented differences in claim element values, including missing values. Results were broken out by vendor, claim type, and data element then tallied for percent of matching values. 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 – AGP

Encounter Submission Completeness

Myers and Stauffer inspected approximately 2.6 million claim lines adjudicated by AGP for institutional and professional 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%.



Encounter Submission Completeness	
95.1%†	**Percentage of sampled lines appearing in both the CMO's claims and the State's MMIS encounters.**
4.9%	**Percentage of sampled lines appearing only in the CMO's claims.**
	• ***Other (2.6%)*** *– A claim line with insufficient information available to explain their absence as an encounter.* • ***Alternative Found (2.3%)*** *– Claim lines that did not appear to exist as encounters for which a different version or adjustment was found.*
0.1%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**
	• ***Other (0.1%)*** *– An encounter line with insufficient information available to explain its absence from the subcontractor's claims.*

† 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 68,500 (2.6%) AGP 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 6,200; 0.2%) were flagged as rejected by the MMIS, implying encounter submission was attempted but unsuccessful. There was no additional information present to explain the absence of these claim lines from the MMIS.*
- ***Alternative Found.*** *Approximately 59,800 (2.3%) AGP FFS claim lines in the CMO'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. Many of these claim lines (approximately 28,000; 1.1%) appeared to have alternate versions with matching line payment amounts when compared to the associated version identified in the MMIS. Approximately 11,000 (0.4%) additional claim lines appeared to have been adjudicated within seven days of the associated version identified in the MMIS. These*

claim lines may have been adjusted within the CMO's weekly cycle for encounter submissions and AGP may have only submitted the most recent claim adjustment to the MMIS.

Encounter Submission Accuracy

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

- ***Date Claim Submitted to AGP 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.*
- ***Interest Paid*** *(Institutional and Professional Encounters). The occurrence of interest reported in the AGP claims extracts was rare and appeared to be reported on approximately 0.6% of claim detail lines; however, a large portion of MMIS encounters for claim detail lines reporting interest in the AGP claims extracts appeared to be missing the interest paid amount or did not appear to have interest separately reported (approximately 78% of claim lines reporting interest in the AGP claims extracts, or approximately 0.5% of all claim detail lines).*
- ***Payee Provider Tax ID*** *(Professional Encounters Only). Approximately 6.8% of professional claim lines in the AGP 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*** *(Institutional and Professional Encounters). For approximately 3.7% of detail lines in the AGP encounters, the rendering provider's NPI did not match the value found in the claims' extracts submitted by AGP. For most of these claim lines, the rendering provider NPI did not appear to be reported in the AGP claims extracts, but did appear to match the payee provider NPI reported in the AGP claims extracts.*
- ***Referring Provider NPI*** *(Institutional and Professional Encounters). For approximately 45.7% of the detail lines in the MMIS encounters for AGP, the referring provider NPI appeared to be reported in the claims extracts but appeared to be missing in the MMIS encounters.*
- ***Attending Provider NPI*** *(Institutional Encounters Only). For approximately 73.2% of institutional detail lines in the MMIS encounters for AGP, the attending provider NPI appeared to be reported in the claims extracts but appeared to be missing in the MMIS encounters.*

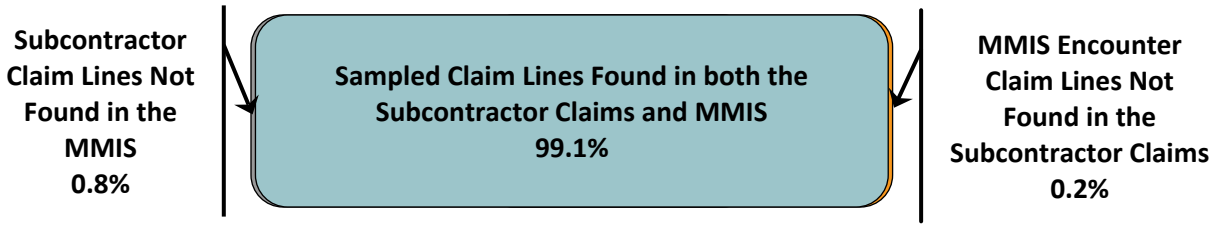
- ***Claim Detail Line International Classification of Diseases (ICD) Diagnosis Codes*** *(professional encounters only). For approximately 4.4% of professional claim lines in the AGP encounters, the claim detail line diagnosis codes did not match the values in the AGP extracts.*
- ***Place of Service*** *(Professional Encounters Only). For approximately 1.6% of professional claim lines in the AGP encounters, the claim detail line place of service code did not match the values in the AGP extracts.*

Exhibit II comprises additional detail concerning the accuracy of all data elements inspected for institutional encounters (*Table 16*) and professional encounters (*Table 17*).

Dental Claims – DentaQuest

Encounter Submission Completeness

Myers and Stauffer examined approximately 376,700 claim lines adjudicated by DentaQuest 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. 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%.



Encounter Submission Completeness	
99.1%†	**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.**
	• ***Denied (0.5%)*** *– A claim line denied for payment by the subcontractor during their claim adjudication process due to authorization, eligibility, limits issues, or other reasons.* • ***Other (0.2%)*** *– A claim line with insufficient information available to explain its absence as an encounter*

	• ***Alternative Version Found (0.1%)*** *– Claim lines that did not appear to exist as encounters for which a different version or adjustment was found.*
0.2%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**
	• ***Alternative Found (0.1%)*** *– Encounter lines that did not appear to exist as claim lines for which a different version or adjustment was found.* • ***Other (0.1%)*** *– An encounter line with insufficient information available to explain its absence from the subcontractor's claims.*

† 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%.

DentaQuest claims not found in the MMIS encounters:

- ***Denied****. Approximately 1,800 (0.5%) DentaQuest claim lines appeared to be denied in the subcontractor's claims but did not appear to exist in the MMIS. It appears that AGP may not be submitting all denied dental claim lines to the MMIS.*
- ***Other.*** *Approximately 720 (0.2%) DentaQuest claim lines in the subcontractor's claims did not appear to exist as encounter claim lines in the MMIS. There was no additional information present to explain the absence of these claim lines from the MMIS.*

Encounter Submission Accuracy

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

- ***Date Claim Submitted to DentaQuest 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.*
- ***Procedure Code****. For approximately 1.9% of detail lines in the DentaQuest encounters, the procedure code did not match the value found in the claims extracts submitted by DentaQuest.*
- ***Payee Provider Tax ID****. Approximately 5.6% of the detail lines in the DentaQuest 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.*
- ***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 DentaQuest.*

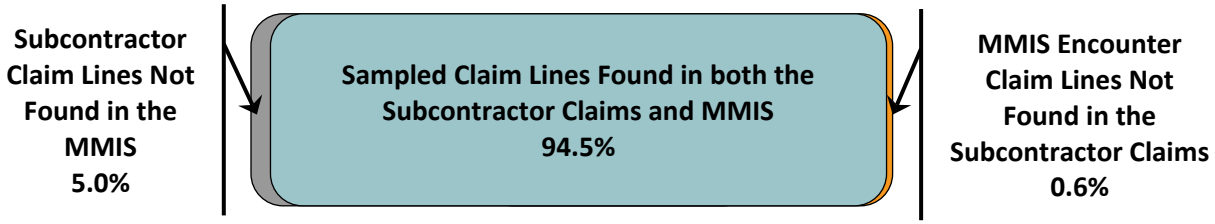
- ***Tooth Number**. For approximately 6.6% of the detail lines in the MMIS encounters for DentaQuest, the tooth number appeared to be reported in the claims extracts, but missing in the MMIS encounters.*
- ***Place of Service**. For approximately 1.8% of detail lines in the DentaQuest encounters, the place of service did not match the value found in the claims extracts submitted by DentaQuest.*

Exhibit II, Table 18 comprises additional detail concerning the accuracy of all dental data elements inspected.

Vision Claims – Avesis Vision

Encounter Submission Completeness

Myers and Stauffer examined approximately 43,900 claim lines adjudicated by Avesis 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%.



Encounter Submission Completeness	
94.5%†	**Percentage of sampled lines appearing in both the subcontractor's claims and the State's MMIS encounters.**
5.0%	**Percentage of sampled lines appearing only in the subcontractor's claims.**
	• ***Alternative Version Found (4.0%)** – Claim lines that did not appear to exist as encounters for which a different version or adjustment was found.* • ***Denied (0.6%)** – A claim line denied for payment by the subcontractor during their claim adjudication process due to authorization, eligibility, limits issues, or other reasons.* • ***Other (0.4%)** – A claim line with insufficient information available to explain its absence as an encounter.*

0.6%	**Percentage of sampled lines appearing only in the State's MMIS encounters.** • ***Alternative Found (0.5%)*** *– Encounter lines that did not appear to exist as claim lines for which a different version or adjustment was found.* • ***Other (0.1%)*** *– An encounter line with insufficient information available to explain its absence from the subcontractor's claims.*

† 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%.

Avesis Vision claims not found in the MMIS encounters:

- ***Alternative Found.*** *Approximately 1,760 (4.0%) Avesis 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 490 (1.1%) of these claim lines appeared to have alternate versions with matching line payment amounts when compared to the associated version identified in the MMIS. Approximately 1,050 (2.4%) additional claim lines appeared to have been adjudicated within seven days of the associated version identified in the MMIS. These claim lines may have been adjusted within the subcontractor's weekly cycle for encounter submissions and AGP may have only submitted the most recent claim adjustment to the MMIS.*
- ***Denied****. Approximately 270 (0.6%) Avesis Vision claim lines appeared to be denied in the subcontractor's claims but did not appear to exist in the MMIS. It appears that Avesis Vision may not be submitting all denied vision claim lines to the MMIS.*
- ***Other.*** *Approximately 150 (0.4%) Avesis Vision claim lines in the subcontractor's claims did not appear to exist as encounter claim lines in the MMIS. There was no additional information present to explain the absence of these claim lines from the MMIS.*

MMIS encounters not found in the Avesis Vision claims:

- ***Alternative Found.*** *Approximately 230 (0.5%) Avesis Vision 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.*

Encounter Submission Accuracy

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

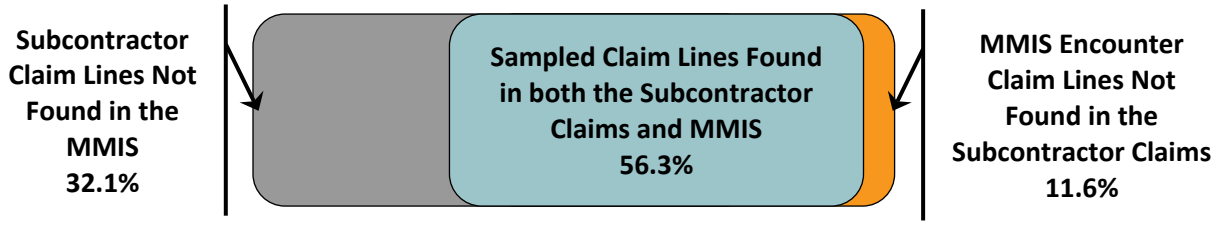
- ***Date Claim Submitted to Avesis Vision by the Provider****. The claim receipt date in the MMIS encounters appeared to have been consistently misreported to be the same as the claim's paid date.*
- ***Interest Paid****. The occurrence of interest reported in the Avesis Vision claims extracts was rare and appeared to be reported on approximately 0.3% of claim detail lines; however, many of the MMIS encounters for claim detail lines reporting interest in the Avesis Vision claims extracts appeared to be missing the interest paid amount or did not appear to have interest separately reported (approximately 43% of claim lines reporting interest in the Avesis Vision claims extracts, or approximately 0.1% of all claim detail lines).*
- ***Payee Provider Tax ID****. Approximately 6.2% of the detail lines in the Avesis 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.*
- ***Claim Detail Line ICD Diagnosis Codes****. Line diagnosis code pointers for Avesis Vision encounters appear to have been hard coded to values "1," "2," and "3" for all Avesis Vision encounters. The line ICD diagnosis codes reported in the MMIS encounters may not accurately reflect the relevant diagnosis codes for the detail line service provided.*
- ***Referring Provider NPI****. The referring provider NPI did not appear to be reported in the MMIS for Avesis Vision encounters.*

Exhibit II, Table 19 comprises additional detail concerning the accuracy of all vision data elements inspected.

Pharmaceutical Claims – CVS Health

Encounter Submission Completeness

Myers and Stauffer examined approximately 1,036,900 claim lines adjudicated by CVS Health 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%.



Encounter Submission Completeness	
56.3%†	**Percentage of sampled lines appearing in both the subcontractor's claims and the State's MMIS encounters.**
32.1%	**Percentage of sampled lines appearing only in the subcontractor's claims.**
	• ***Rejected or Denied (22.9%)*** *– 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 (9.2%)*** *– Claim lines that did not appear to exist as encounters for which a different version or adjustment was found.* • ***Other (0.1%)*** *– A claim line with insufficient information available to explain its absence as an encounter.*
11.6%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**
	• ***Alternative Found (5.0%)*** *– Encounter lines that did not appear to exist as claim lines for which a different version or adjustment was found.* • ***Other (3.9%)*** *– An encounter line with insufficient information available to explain its absence from the subcontractor's claims.* • ***Denied (2.8%)*** *– An encounter line 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%.

CVS Health claims not found in the MMIS encounters:

- ***Rejected or Denied.*** *Approximately 237,400 (22.9%) CVS Health pharmaceutical claim lines appeared to be rejected or denied in the subcontractor's claims but did not appear to exist in the MMIS. It appears that CVS Health may not be submitting all rejected or denied encounter claim lines to the MMIS.*
- ***Alternative Found.*** *Approximately 95,300 (9.2%) CVS Health 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 appeared to be denied or rejected, and a later version of the claim line appeared to be paid and reported in the MMIS. Alternatively, approximately 30,400 (2.9%) claim lines appeared to have alternate versions with matching line payment amounts when compared to the associated version identified in the MMIS.

MMIS encounters not found in the CVS Health claims:

- ***Alternative Found.*** *Approximately 51,400 (5.0%) CVS Health 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. Many of these encounter claim lines (approximately 23,500; 2.3%) appear to have alternate versions with matching line payment amounts and matching paid dates compared to the associated version identified in the subcontractor's claims.*
- ***Other.*** *Approximately 40,000 (3.9%) CVS Health 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.*
- ***Denied.*** *Approximately 28,600 (2.8%) CVS Health pharmaceutical encounter claim lines in the MMIS appeared to be denied but did not appear to exist in the subcontractor's claims.*

Encounter Submission Accuracy

Myers and Stauffer examined 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 CVS Health data elements whose inaccuracy could have a concerning impact on the use of encounters for program management, PI, and regulatory reporting.

- ***Date Claim Submitted to CVS Health by the Provider****. For approximately 2.0% of the MMIS encounters for CVS Health, the claim receipt date did not match the value found in the claims extracts submitted by CVS Health.*
- ***Payee Provider Tax ID****. Approximately 5.0% of the MMIS encounters for CVS Health 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.*
- ***Dispensing Provider NPI****. For approximately 1.3% of the MMIS encounters for CVS Health, the dispensing provider NPI did not match the value found in the claims extracts submitted by CVS Health. For most of these cases, it appears the dispensing provider NPI in the MMIS encounters reflect an older NPI associated with the Medicaid provider ID reported on the encounter.*

- ***Ingredient Cost Submitted****. For approximately 99.5% of the MMIS encounters for CVS Health, the ingredient cost submitted reported did not appear to match the value found in the claims extracts submitted by CVS Health.*
- ***Amount Billed****. For approximately 96.2% of the MMIS encounters for CVS Health, the billed amount reported did not appear to match the value found in the claims extracts submitted by CVS Health. The billed amount reported in the MMIS encounters appears to represent the sum of the ingredient cost submitted and the dispensing fee.*
- ***Gross Amount Due****. For approximately 93.9% of the MMIS encounters for CVS Health, the gross amount due reported did not appear to match the value found in the claims extracts submitted by CVS Health. The gross amount due reported in the MMIS encounters appears to represent the ingredient cost submitted and the dispensing fee.*

Exhibit II, Table 20 comprises additional detail concerning the accuracy of all CVS Health pharmaceutical data elements inspected.

Myers and Stauffer observed potentially missing data in the MMIS, in particular denied claim lines missing from the encounters submitted to the MMIS by AGP and its subcontractors. Myer and Stauffer recommends AGP communicate its concerns and provide additional specific examples to DCH and Gainwell of encounter claims where denied lines are known or expected to cause issues with the submission of complete and accurate encounter records. We also recommend AGP support DCH in implementing updates to Gainwell's systems to ensure denied encounter claim lines can be submitting to the MMIS without causing duplicate rejection issues.

Myers and Stauffer observed mismatching claim data elements between the AGP FFS claims, subcontractor encounters extracts, and the MMIS encounters. AGP and its subcontractors should review their processes and policies for the reporting of encounters to the MMIS and adjust their processes to ensure reliable reporting of claim data elements.

Cash Disbursement Journal Verification

Introduction

DCH requires that each of their contracted CMOs submit encounter data to the FAC, currently Gainwell Technologies. To assess the compliance with contractual provisions related to encounter submissions, DCH engages Myers and Stauffer to perform bi-monthly encounter data validations to ensure each CMO meets contractual requirements. As part of this process, Myers and Stauffer analyzes Medicaid encounter data that has been submitted by the CMOs to Gainwell and performs a reconciliation of the encounters to Cash Disbursement Journals (CDJs) provided by each CMO.

As part of that engagement, Myers and Stauffer receives a journal of payments, referred to as CDJ files, from AGP and their subcontractors monthly. These CDJ files are a mirror of the payment transactions from their financial payment system made by AGP and their subcontractors to providers during the month. We utilize this information to calculate the denominator in the completeness calculation of encounter data for the Georgia Families® and Georgia Families 360® programs. The encounter reconciliation process uses CDJ files as an independent primary source document to compare against related period encounter data submitted to the Georgia MMIS system. In this review, we are comparing the period specific CDJ files for a sample month to an alternative, and when possible, 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

To verify the CDJ data, Myers and Stauffer requested an additional accounting source (e.g., check register, bank statement, or general ledger), separately provided from the CDJ data submissions, for payments and recoupments made during May 2024 (the sample month) from AGP and their subcontractors for Georgia Families® and Georgia Families 360®.

Myers and Stauffer sent the request below to AGP in July 2024:

- *"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 Amerigroup Georgia Medicaid members (Georgia Families® and Georgia Families 360°SM) in the month of May 2024. 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 Amerigroup as well as its delegated vendors Carelon Behavioral Health,

DentaQuest, Avesis, and CarelonRx. Please provide the requested data to Myers and Stauffer by August 30, 2024, via secure FTP."

Analysis and Recommendations

The validation documentation received from AGP, and its subcontractors was compared to their CDJ submissions for the sample month of May 2024. 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 AGP and their subcontractors indicates that the sample month CDJ file submissions for AGP medical and behavioral health services show a variance when compared to the provided documentation. We observed instances of potential over-reporting of payments in the AGP CDJ for some adjustment claims.

In addition to the verification review summarized in this section, Myers and Stauffer performed an interview session with AGP staff who perform CDJ activities. During this interview, AGP staff communicated that CDJ data is only being reconciled against encounter data. Myers and Stauffer recommends that AGP update their procedures for the reconciliation of CDJ data to include a financial component to ensure that all data is accurate.

We recommend AGP include all payments and recoupments for a specific provider on the payment date and identify potential improvements to its financial reconciliation procedures for continuously monitoring the completeness and accuracy of AGP and subcontractor CDJ file submissions against independent financial sources.

Fee-for-Service Claims, Institutional and Professional – Amerigroup Community Care

AGP submitted an excerpt from their May 2024 bank statement(s) for this review. The supplied documentation included check register detail information reporting the check number, issue date, paid date, and amount for all transactions in a specific AGP bank account. The check register detail appeared to include checks for provider claim payments, subcontractor capitation payments, and provider capitation payments.

We performed a detailed comparison of the supplied check register information to AGP CDJ medical and behavioral health files previously supplied to Myers and Stauffer. During our review, we identified differences in the two data sources which limited our review, including the following:

- ***Timing Differences**. The supplied check register detail was limited to transactions having a paid date in May 2024. The CDJ files only include a transaction date, which is analogous to the posting date. Although the CDJ transaction date and check register paid date are highly*

correlated, the delay between the CDJ transaction date and the check register paid date is inconsistent. For checks identified in both sources, we observed delay between the CDJ transaction date and check register paid date ranging from one (1) day up to 241 days, with an average delay of five (5) days. Due to the differences between the CDJ transaction date and the check register paid date, we were unable to precisely filter CDJ transactions to those with a corresponding paid date in May 2024.

- ***Negative Balances**. Negative balances, voids, and recoupments (henceforth, "negative balances") present a more specific case of timing differences between the AGP CDJs and the supplied check register detail. Negative balances appear to be reported in the AGP CDJ with a transaction date based on when the transaction occurs (e.g. when a claim was voided) and often are not associated with a specific check number in the AGP CDJ. Based on our review of a sample of AGP explanation of payment (EOP) documents supplied by AGP, it appears these negative balances are often applied to subsequent check transactions having a later paid date. The method for reporting negative balances in each data source appears reasonable and appropriate. Differences in how negative balances are reported in each data source may result in a variance between the check payment amount derived from the AGP CDJ and the check amount reported in the AGP check register, but this variance does not represent an issue or concern.*

Timing differences and negative balances are common when comparing CDJs to independent accounting sources. These differences do not represent a particular issue or concern but do limit our ability to fully reconcile the May 2024 AGP CDJ to the supplied check register detail. Given this limitation, we took a two-part approach to our review of the May 2024 AGP CDJ as summarized in the bullets below and further detailed in the following sections.

- ***Existence of Check Numbers**. Evaluate the existence of AGP check register check numbers in the AGP CDJ File.*
- ***Payment Comparison**. For check numbers identified in both the AGP check register and the AGP CDJ, evaluate any variances between payment amounts reported in each source.*

Existence of Check Numbers

We reviewed the supplied AGP check register detail against the AGP CDJ to evaluate the existence of check register check numbers in the CDJ. The results of this comparison are summarized in *Table 5* below.

Table 5: AGP FFS CDJ to Verification Documentation Check Number Comparison

AGP FFS CDJ to Verification Documentation Check Number Comparison				
Existence of Check Numbers in CDJ	**Check Count**	**Check Register Paid Amount**	**Matched CDJ Transaction Amount**	**Variance**
AGP Check Numbers Identified in the AGP CDJ	30,027	$111,844,180	$112,491,515	$647,336
AGP Check Numbers not Identified in the AGP CDJ	2,116	$8,899,327	$0	($8,899,327)
TOTAL	**32,143**	**$120,743,506**	**$112,491,515**	**($8,251,991)**

For check numbers reported in the AGP check register but not identified in the AGP CDJ, we sampled five (5) check numbers and requested additional documentation from AGP, including EOP documentation and an explanation for the apparent missing check numbers in the CDJ. Feedback from AGP is paraphrased below:

- *Four (4) of the five (5) sampled check numbers were for payments associated with a different line of business and were not for services covered under Amerigroup Georgia Medicaid. Amerigroup staff acknowledged it was not a best practice to make payments for different lines of business out of the bank account for the Amerigroup Georgia Medicaid line of business, but that it may happen on manual claims. We would not expect to see these payments reported in the CDJ, so their absence appears appropriate.*
- *One (1) of the five (5) sampled check numbers was for a large capitation payment to Avesis Vision. Based on additional information provided by AGP, this check number appears to be a reissued check for a capitation payment already reported in the AGP CDJ with an earlier transaction date. We would not expect to see reissued checks in the CDJ, so the absence of this sampled check number from the CDJ appears appropriate.*

Based on our review of the sample of check numbers not identified in the AGP CDJ, we did not observe any instances of potential missing checks in the AGP CDJ. We were not able review all check numbers not identified in the AGP CDJ and we were not able to verify that the AGP CDJ for May 2024 includes all check payments for the Amerigroup Georgia Medicaid line of business.

Payment Comparison

We performed a more detailed comparison of check numbers identified in both the AGP check register and the AGP CDJ. The results of this comparison are summarized in *Table* 6 below.

Table 6: AGP FFS CDJ to Verification Documentation Comparison for Check Numbers Identified in Both Sources

AGP FFS CDJ to Verification Documentation Comparison Check Numbers Identified in Both Sources						
Verification Documentation		**CDJ Submissions**			**Comparison**	
Date Paid	**Paid Amount**	**First Transaction Date**	**Last Transaction Date**	**Transaction Amount**	**Variance^**	**Verification Percentage**
5/1/2024	$10,940,013	3/1/2024	4/30/2024	$11,011,918	$71,904	100.66%
5/2/2024	$1,178,640	1/9/2024	4/30/2024	$1,180,826	$2,186	100.19%
5/3/2024	$9,034,571	1/9/2024	4/30/2024	$9,182,376	$147,805	101.64%
5/4/2024	$3,352	4/16/2024	4/26/2024	$3,352	$0	100.00%
5/5/2024	$89	4/16/2024	4/16/2024	$89	$0	100.00%
5/6/2024	$160,363	9/8/2023	5/3/2024	$171,705	$11,343	107.07%
5/7/2024	$603,148	3/1/2024	5/3/2024	$608,305	$5,158	100.86%
5/8/2024	$10,756,481	3/22/2024	5/7/2024	$10,834,844	$78,363	100.73%
5/9/2024	$1,086,319	2/2/2024	5/7/2024	$1,086,762	$443	100.04%
5/10/2024	$10,500,818	3/22/2024	5/7/2024	$10,524,565	$23,747	100.23%
5/11/2024	$2,431	4/19/2024	4/30/2024	$2,431	$0	100.00%
5/13/2024	$110,339	2/16/2024	5/10/2024	$110,360	$20	100.02%
5/14/2024	$907,585	3/19/2024	5/10/2024	$909,004	$1,419	100.16%
5/15/2024	$12,934,776	3/26/2024	5/14/2024	$13,014,831	$80,056	100.62%
5/16/2024	$1,075,992	3/29/2024	5/14/2024	$1,076,924	$932	100.09%
5/17/2024	$9,140,484	3/12/2024	5/14/2024	$9,199,641	$59,156	100.65%
5/18/2024	$504	4/9/2024	4/12/2024	$504	$0	100.00%
5/19/2024	$84	4/19/2024	5/7/2024	$84	-1.42E-14	100.00%
5/20/2024	$371,292	3/22/2024	5/17/2024	$374,488	$3,197	100.86%
5/21/2024	$704,753	4/2/2024	5/17/2024	$705,627	$874	100.12%
5/22/2024	$11,750,514	2/27/2024	5/21/2024	$11,782,743	$32,229	100.27%
5/23/2024	$626,254	4/19/2024	5/21/2024	$626,800	$546	100.09%
5/24/2024	$11,327,310	2/23/2024	5/21/2024	$11,314,895	($12,415)	99.89%
5/25/2024	$311	5/10/2024	5/10/2024	$311	$0	100.00%
5/27/2024	$1,757	5/7/2024	5/10/2024	$1,757	$0	100.00%
5/28/2024	$213,234	1/23/2024	5/24/2024	$217,648	$4,414	102.07%
5/29/2024	$808,328	4/12/2024	5/24/2024	$807,717	($611)	99.92%
5/30/2024	$11,869,594	3/29/2024	5/28/2024	$11,989,993	$120,399	101.01%
5/31/2024	$5,734,846	4/19/2024	5/28/2024	$5,751,017	$16,171	100.28%
TOTAL	**$111,844,180**			**$112,491,515**	**$647,336**	**100.58%**

^The variance calculation is the difference between the CDJ transaction amount, and the verification documentation paid amount.

Overall, the verification data reported approximately $647,300 less in payments when compared to the CDJ files, representing a potential over-reporting of payments in the CDJ. We performed an additional review of check numbers where the sum of the CDJ transaction amounts did not match the AGP check register paid amount. We identified a sample of five (5) check numbers with mismatching paid amounts between the AGP check register and the CDJ. We requested additional EOP documentation and

explanation from AGP for the five sampled check numbers. Based on our review of the additional AGP supplied documentation and detailed CDJ transactions, we identified two (2) reporting differences and two (2) potential reporting issues, which appear to explain a portion of the observed variance. Due to limitations of the available information, we were unable to quantify the total contribution for each identified reporting difference and potential reporting issue. Furthermore, additional, unidentified reporting differences or issues may contribute to the observed variances.

An explanation for each identified reporting difference and potential reporting issue is provided below.

- ***Reporting Differences**:*
  - ***Reporting Interest**. Upon review of sample EOPs, it appears the AGP CDJ for May 2024 does not include interest in any of the reported payment fields (transaction amount, transaction interest amount, or total check amount). The AGP check register amounts do appear to include interest payments. The apparent exclusion of interest in the AGP CDJ results in a lower payment variance in the table above. Myers and Stauffer excludes interest from our encounter data validation (EDV) review, so the apparent exclusion of interest from the AGP CDJ is not likely to impact our use of the CDJ for EDV review. Please note that historical AGP CDJs appear to have included interest. Based on a review of historical CDJs, the AGP CDJ reporting process may have been updated to exclude interest for CDJs with a reporting period on or after January 2022.*
  - ***Reporting Negative Balances**. A large portion of the observed variance appears to be due to differences in how negative balances are reported in the AGP CDJ, when compared to the AGP check register. We were able to tie many negative balances to subsequent check payments using an empirical approach, but we were not able to tie all negative balances in this way. Negative balances missed in our approach result in a higher payment variance in the table above; however, variances due to differences in how negative balances do not represent an issue or concern.*
- ***Potential Reporting Issues**:*
  - ***Missing CDJ Transactions for Increasing Adjustments**. When reviewing the five (5) sampled check numbers, we observed one instance where payment for an increasing adjustment claim (the adjustment claim paid more than the prior claim sequence) appeared to be overstated in the CDJ. For this instance, a transaction was reported for the full amount of the original claim payment and a second transaction was reported for the full amount of the adjusted claim payment, but no reversal transaction was reported in the CDJ to offset the original paid amount. As a result, the CDJ appears to overstate the payment amount for the claim. Of note, we observed a different provider number reported on the second transaction when compared to the first transaction. This*

potential issue may be related to the way AGP's CDJ reporting process handles updated provider numbers on adjustment claims.

- ***Redundant CDJ Transactions for Decreasing Adjustments**. When reviewing the five (5) sampled check numbers, we observed one instance where payment for a decreasing adjustment claim (the adjustment claim paid less than the prior claim sequence) appeared to be overstated in the CDJ. For this instance, a transaction was reported for the full amount of the original claim payment. A second negative balance transaction was reported to offset the original payment amount and sum to the adjusted claim's lower payment amount. However, a third transaction was also reported for the full amount of the adjustment claim. As a result, the CDJ appears to overstate the payment amount for the claim. Of note, we observed a different provider number reported on the third transaction when compared to the first two transactions. This potential issue may be related to the way AGP's CDJ reporting process handles updated provider numbers on adjustment claims.*

Dental Claims – DentaQuest

DentaQuest submitted May 2024 check register details as their verification documentation. We summarized the check register payments by the supplied payment cycle and the CDJ files by transaction date in *Table 7*.

Table 7: DentaQuest CDJ to Verification Documentation Comparison

DentaQuest CDJ to Verification Documentation Comparison					
Verification Documentation		**CDJ Submissions**		**Comparison**	
Payment Cycle #	**Check Register Paid Amount**	**Transaction Dates**	**Transaction Amount**	**Variance**	**Verification Percentage**
359855	$1,706,966	05/04/2024	$1,706,966	$0	100.00%
360535	$1,775,752	05/11/2024	$1,775,752	$0	100.00%
361268	$1,631,290	05/18/2024	$1,631,290	$0	100.00%
361938	$1,546,187	05/18/2024 - 05/25/2024	$1,546,187	$0	100.00%
TOTAL	**$6,660,195**		**$6,660,195**	**$0**	**100.00%**

Overall, the verification data reconciled to the CDJ data with no variances. However, the check register information supplied by DentaQuest consisted of screenshots and did not appear to include sufficient detail to tie the check transactions to an external source. Myers and Stauffer did not receive an independent verification source from DentaQuest in a timely manner, and therefore, we were unable to perform additional testing to ensure that the summary of check payments corresponded to a bank statement from a financial institution.

Vision Claims – Avesis Vision

Avesis Vision submitted check register details for May 2024 and May 2024 and June 2024 bank statements as its verification documentation. We summarized the check register payments by the supplied paid date and the CDJ files by transaction date in *Table* 8.

Table 8: Avesis Vision CDJ to Verification Documentation Comparison

Avesis Vision CDJ to Verification Documentation Comparison					
Verification Documentation		**CDJ Submissions**		**Comparison**	
Paid Date	**Paid Amount**	**Transaction Date**	**Transaction Amount**	**Variance**	**Verification Percentage**
5/1/2024	$183,712	5/1/2024	$183,712	$0	100.00%
5/2/2024	$6,040	5/2/2024	$6,040	$0	100.00%
5/8/2024	$101,465	5/8/2024	$101,465	$0	100.00%
5/9/2024	$4,836	5/9/2024	$4,836	$0	100.00%
5/15/2024	$73,175	5/15/2024	$73,175	$0	100.00%
5/16/2024	$3,395	5/16/2024	$3,395	$0	100.00%
5/22/2024	$83,017	5/22/2024	$83,017	$0	100.00%
5/23/2024	$4,130	5/23/2024	$4,130	$0	100.00%
5/29/2024	$65,546	5/29/2024	$65,546	$0	100.00%
5/30/2024	$26,512	5/30/2024	$26,512	$0	100.00%
TOTAL	**$551,828**		**$551,828**	**$0**	**100.00%**

Overall, the verification data reconciled to the CDJ data with no variances.

Pharmaceutical Claims – CVS Health

CVS Health submitted check register details and an extract of payment information from an encounter system for May 2024 as its verification documentation. We summarized the check register payments by payment type (i.e., EFT or check) and estimated payment date and the CDJ files by transaction date in *Table 9* and *Table 10*.

Table 9: CVS Health Verification Documentation to CDJ Comparison – Payments by Check

CVS Verification Documentation to CDJ Comparison – Payments by Check					
Verification Documentation		CDJ Submissions		Comparison	
Estimated Payment Date	Paid Amount	Transaction Date	Transaction Amount	Variance	Verification Percentage
5/1/2024	$2,312,429	5/1/2024	$2,312,429	$0	100.00%
5/2/2024	$159,421	5/2/2024	$159,421	$0	100.00%
5/3/2024	$157,901	5/3/2024	$157,901	$0	100.00%
5/4/2024	$190,971	5/4/2024	$190,971	$0	100.00%
5/5/2024	$16,953	5/5/2024	$16,953	$0	100.00%
5/6/2024	$76,237	5/6/2024	$76,237	$0	100.00%
5/7/2024	$405,448	5/7/2024	$405,448	$0	100.00%
5/8/2024	$2,331,172	5/8/2024	$2,331,172	$0	100.00%
5/9/2024	$219,271	5/9/2024	$219,271	$0	100.00%
5/10/2024	$269,930	5/10/2024	$269,930	$0	100.00%
5/11/2024	$190,606	5/11/2024	$190,606	$0	100.00%
5/12/2024	$39,609	5/12/2024	$39,609	$0	100.00%
5/13/2024	$59,164	5/13/2024	$59,164	$0	100.00%
5/14/2024	$300,094	5/14/2024	$300,094	$0	100.00%
5/15/2024	$2,656,359	5/15/2024	$2,656,359	$0	100.00%
5/16/2024	$187,567	5/16/2024	$187,567	$0	100.00%
5/17/2024	$113,439	5/17/2024	$113,439	$0	100.00%
5/18/2024	$297,012	5/18/2024	$297,012	$0	100.00%
5/19/2024	$5,642	5/19/2024	$5,642	$0	100.00%
5/20/2024	$4,360	5/20/2024	$4,360	$0	100.00%
5/21/2024	$199,540	5/21/2024	$199,540	$0	100.00%
5/22/2024	$2,109,068	5/22/2024	$2,109,068	$0	100.00%
5/23/2024	$187,171	5/23/2024	$187,171	$0	100.00%
5/24/2024	$251,991	5/24/2024	$251,991	$0	100.00%
5/25/2024	$186,646	5/25/2024	$186,646	$0	100.00%
5/26/2024	$50,407	5/26/2024	$50,407	$0	100.00%
5/27/2024	$60,081	5/27/2024	$60,081	$0	100.00%
5/28/2024	$79,483	5/28/2024	$79,483	$0	100.00%
5/29/2024	$2,141,978	5/29/2024	$2,141,978	$0	100.00%
5/30/2024	$271,467	5/30/2024	$271,467	$0	100.00%
5/31/2024	$232,265	5/31/2024	$232,265	$0	100.00%
TOTAL	**$15,763,683**		**$15,763,683**	**$0**	**100.00%**

Table 10: CVS Health Verification Documentation to CDJ Comparison – Payments by EFT

CVS Verification Documentation to CDJ Comparison – Payments by EFT					
Verification Documentation		**CDJ Submissions**		**Comparison**	
Estimated Payment Date	**Paid Amount**	**Transaction Date**	**Transaction Amount**	**Variance**	**Verification Percentage**
05/01/2024	$11,830	05/01/2024	($12,874)		
05/08/2024		05/08/2024	$7,916		
05/15/2024		05/15/2024	$4,317		
05/22/2024		05/22/2024	$11,508		
05/29/2024		05/29/2024	$961		
TOTAL	**$11,830**		**$11,830**	**$0**	**100.00%**

Overall, the verification data reconciled to the CDJ data with no variances. However, the check register information supplied by CVS consisted of screenshots and did not appear to include sufficient detail to tie the check transactions to an external source. Myers and Stauffer did not receive an independent verification source from CVS in a timely manner, and therefore, we were unable to perform additional testing to ensure that the summary of check payments corresponded to a bank statement from a financial institution.

Findings and Recommendations

Table 11 summarizes the findings and recommendations identified during this engagement and are based on the data and documentation provided by AGP and the information obtained during interviews. We assessed each finding and classified them by the following risk levels:

- ***High*** *– An identified concern that will impact the CMO's systems and/or operations.*
- ***Medium*** *– An identified concern that without mitigation, is likely to impact the CMO's systems and/or operations.*
- ***Low*** *– An identified concern that is likely have low to no impact on the CMO's systems and/or operations.*

Table 11: Findings and Recommendations

Findings and Recommendations					
Entity	**Operational Area**	**Risk Level**	**Finding Page Number**	**Findings**	**Recommendation**
DCH	Member Data Maintenance	**High**	Pg. 17	During the Member Data Maintenance interview session, we found that AGP adheres to standard operating procedure for processing eligibility/enrollment data files. The standard is two (2) business days for daily files and three (3) business days for monthly files. After reviewing the DCH contract, it was determined that DCH does not have a mandated timeframe for the processing of eligibility/enrollment data files.	DCH should include a provision in their contract with the CMOs that requires the CMO to ensure member eligibility/enrollment data files are loaded within a specified timeframe. As an example, the Florida Medicaid Managed Care Contract includes the following requirements: 1. The Manage Care Plan shall receive process and update enrollment files sent daily by the Agency or its agent(s); and 2. The Manage Care Plan shall update its eligibility/enrollment database within twenty-four (24) hours after receipt of said files.

Findings and Recommendations					
Entity	**Operational Area**	**Risk Level**	**Finding Page Number**	**Findings**	**Recommendation**
AGP - Corp	CDJ/Subcontractor Revenue	**Low**	Pg. 70	During the interview with the AGP staff who performs CDJ activities, Myers and Stauffer found that CDJ data is only being reconciled against encounter data.	Myers and Stauffer recommends that AGP update their procedures for the reconciliation of CDJ data to include a financial component. The CDJ is used as a source of truth of details on all payments/recoupments made to providers and requires accuracy.
AGP - Corp	CDJ Verification	**Low**	Pg. 73	Myers and Stauffer observed instances of potential over-reporting of payments in the AGP CDJ for some adjustment claims.	Myers and Stauffer recommends AGP identify potential improvements to its financial reconciliation procedures for continuously monitoring the completeness and accuracy of AGP and subcontractor CDJ file submissions against independent financial sources and ensure AGP and its subcontractors are meeting contractual requirements.
AGP - Corp	Encounter Submissions	**Medium**	Pg. 68	Myers and Stauffer observed potentially missing data in the MMIS, specifically, denied claim lines missing from the encounters submitted to the MMIS by AGP and its subcontractors.	Myer and Stauffer recommends AGP provide specific examples to DCH and Gainwell of encounter claims where denied lines are known or expected to cause issues with the submission of complete and accurate encounter records. We also recommend AGP support DCH in implementing updates to Gainwell's systems to ensure denied encounter claim lines can be submitted to the MMIS without causing duplicate rejection issues.

Findings and Recommendations					
Entity	**Operational Area**	**Risk Level**	**Finding Page Number**	**Findings**	**Recommendation**
AGP - Corp	Encounter Submissions	**Medium**	Pg. 68	Myers and Stauffer observed mismatching claim data elements between the AGP FFS claims, subcontractor encounters extracts, and the MMIS encounters.	AGP and its subcontractors should review their processes and policies for the reporting of encounters to the MMIS and adjust their processes to ensure reliable reporting of claim data elements.
AGP - Local	Member Call Center Operations	**Low**	Pg. 13	During the Call Center demonstration, an AGP member was attempting to locate a provider. The call center agent was able to retrieve a list from their system. The member asked if the list could be emailed to her. The call center agent responded that she could not, but she could give her the names. Before ending the call, the call center agent referred the member to the AGP website to locate a provider.	Myers and Stauffer recommends that AGP establish a customer service email box that is restricted to outgoing emails for member outreach. This email box would be used by call center staff to submit member communications such as a custom provider list.
CarelonRx (PBM)	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration	**Low**	Pg. 52	Myers and Stauffer assessed CarelonRx's encounter files as a response to interview responses that indicated that they do not exclude any claims from the encounter files. We found that most denied claims and many previous claim adjudication sequences were missing from the encounter data.	Myers and Stauffer recommends that CarelonRx review and update their existing policies and procedures to require the inclusion of all adjudicated claims into its encounter submissions, resulting in complete and accurate encounter data sets per contractual requirements. We also recommend AGP support DCH in implementing updates to Gainwell's systems, if required, to ensure denied

Findings and Recommendations					
Entity	**Operational Area**	**Risk Level**	**Finding Page Number**	**Findings**	**Recommendation**
					encounter claims can be submitted to the MMIS without causing rejection issues.
DentaQuest	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration	**Low**	Pg. 53	Myers and Stauffer assessed DentaQuest's claims data and it appears that if a claim is adjusted and the original claim is not accepted into the encounters, the adjustment would be sent as a new-day encounter then the original claim would be passed.	Myers and Stauffer recommends that DentaQuest review and update their existing procedures for how adjusted claims are accepted into the encounters so that the original claims is not excluded from submissions and ensure all claims are submitted as encounters.
DentaQuest	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration	**Low**	Pg. 53	Interviews of DentaQuest noted that the results from the automated processing of encounter response files are not reported to or reviewed by staff. There does not appear to be oversight or trend reviews of the encounter informational/educational edits.	Myers and Stauffer recommends DentaQuest review and revise their current procedures for reviewing encounter information/educational edits to include oversight and/or trend reviews to ensure encounter completeness and accuracy issues can be identified as they occur.

Exhibit I: Interview Schedules

Interviews with AGP

In order to gain a better understanding of AGP's policies and procedures for contract compliance, PI, encounter submissions, and subcontractor oversight, Myers and Stauffer interviewed the individuals listed in *Table 12* on the dates and at the locations indicated.

Table 12: AGP Interviews

Date	Location	Interviewees	Title	Operational Area
9/30/2024	Local	Leticia Mayfield	Director II Compliance	Contract Compliance/ Compliance Plan
9/30/2024	Local	Paige Greenwell	Compliance Manager	Contract Compliance/ Compliance Plan
9/30/2024	Local	Bhavini Solanki	Director Foster Care Program	Georgia Families 360° Program Overview including Operations/ Required Assessments and Screenings/ Member Enrollment and Disenrollment
9/30/2024	Local	Ryan Thorsbakken	State Operations Director Sr	Georgia Families 360° Program Overview including Operations/ Required Assessments and Screenings/ Member Enrollment and Disenrollment
9/30/2024	Local	Heather Macgregor	(GF360) - Quality Evaluator Lead	Georgia Families 360° Program Overview including Operations/ Required Assessments and Screenings/ Member Enrollment and Disenrollment
9/30/2024	Local	Vanessa Rutledge	Manager I Customer Care	Georgia Families 360° Program Overview including Operations/ Required Assessments and Screenings/ Member Enrollment and Disenrollment
9/30/2024	Local	Alana Arnold	Manager I GBD Special Programs	Georgia Families 360° Program Overview including Operations/ Required Assessments and Screenings/ Member Enrollment and Disenrollment
9/30/2024	Local	Corey Charles	Scheduling Lead GF360	Georgia Families 360° Program Overview including Operations/ Required Assessments and Screenings/ Member Enrollment and Disenrollment

Date	Location	Interviewees	Title	Operational Area
9/30/2024	Local	Anneshia Boxley-Jones	(GF 360) Manager II Customer Care	Georgia Families 360° Program Overview including Operations/ Required Assessments and Screenings/ Member Enrollment and Disenrollment
9/30/2024	Local	Joyce LeTourneau	Manager II Enrollment Data	Georgia Families 360° Program Overview including Operations/ Required Assessments and Screenings/ Member Enrollment and Disenrollment
9/30/2024	Local	Lisa Ridley	Compliance Analyst Sr.	Georgia Families 360° Program Overview including Operations/ Required Assessments and Screenings/ Member Enrollment and Disenrollment
9/30/2024	Local	Bhavini Solanki	Director Foster Care Program	Georgia Families 360° - Case Management/ Care Coordination
9/30/2024	Local	Abby Boldin	Business Change Manager	Georgia Families 360° - Case Management/ Care Coordination
9/30/2024	Local	Jennifer Williams	(Frontline Associate) - Special Programs Case Manager II	Georgia Families 360° - Case Management/ Care Coordination
9/30/2024	Local	Heather Macgregor	(GF360) - Quality Evaluator Lead	Georgia Families 360° - Case Management/ Care Coordination
9/30/2024	Local	Bhavini Solanki	Director Foster Care Program	Georgia Families 360° - Case Management/ Care Coordination
9/30/2024	Local	Alana Arnold	GBD Special Programs	Georgia Families 360° - Case Management/ Care Coordination
9/30/2024	Local	Sarah Pedraza	Marketing Coordinator	Georgia Families 360° and Georgia Families- Community Relations
9/30/2024	Local	Maria Henriquez	Director Medicaid Plan Marketing	Georgia Families 360° and Georgia Families- Community Relations
9/30/2024	Local	Heather Macgregor	(GF360) - Quality Evaluator Lead	Georgia Families 360° and Georgia Families- Community Relations
9/30/2024	Local	Bhavini Solanki	Director Foster Care Program	Georgia Families 360° and Georgia Families- Community Relations
9/30/2024	Local	Marcus Linen	Manager II GBD Special Programs	Georgia Families 360° and Georgia Families- Community Relations
9/30/2024	Local	Bhavini Solanki	Director Foster Care Program	Georgia Families 360° - Provider Network
9/30/2024	Local	Monica Lester	Network Management	Georgia Families 360° - Provider Network

Date	Location	Interviewees	Title	Operational Area
9/30/2024	Local	Sabrina Brinson	Provider Network Manager Sr.	Georgia Families 360° - Provider Network
9/30/2024	Local	Anneshia Boxley-Jones	(GF 360) Manager II Customer Care	Member Call Center Operations - to include Georgia Families 360° Demonstration: (Three Live Calls)
9/30/2024	Local	Felicia Bryant (GF)	Manager II Customer Care	Member Call Center Operations - to include Georgia Families 360° Demonstration: (Three Live Calls)
9/30/2024	Local	Kenya Watts	(Frontline Associate) Customer Care Representative II	Member Call Center Operations - to include Georgia Families 360° Demonstration: (Three Live Calls)
10/1/2024	Local	Trina Tatum	OP UM – Nurse Medical Management II	Utilization Management/Prior Authorizations to include Georgia Families 360°
9/30/2024	Local	Bhavini Solanki	Director Foster Care Program	Utilization Management/Prior Authorizations to include Georgia Families 360°
10/1/2024	Local	Tuyen Tran	IP UM – Nurse Medical Management Senior	Utilization Management/Prior Authorizations to include Georgia Families 360°
10/1/2024	Local	Heather Macgregor	(GF360) - Quality Evaluator Lead	Quality Improvement to include Georgia Families 360°
10/1/2024	Local	Danielle Lower	(GF) - GB QM Health Plan Director	Quality Improvement to include Georgia Families 360°
10/1/2024	Local	Altavese Dickens	Clinical Quality Program Administrator	Quality Improvement to include Georgia Families 360°
10/1/2024	Local	Anneshia Boxley-Jones	(GF 360) Manager II Customer Care	Quality Improvement to include Georgia Families 360°
10/1/2024	Local	Bhavini Solanki	Director Foster Care Program	Quality Improvement to include Georgia Families 360°
10/1/2024	Local	Darlene McGraw	Clinical Quality Program Administrator	Quality Improvement to include Georgia Families 360°
10/1/2024	Local	Rhonda Allen	Clinical Quality Program Manager	Quality Improvement to include Georgia Families 360°
10/1/2024	Local	Thandi Gil	Clinical Quality Program Administrator	Quality Improvement to include Georgia Families 360°
10/1/2024	Local	Heather Taylor	Program Manager	Quality Improvement to include Georgia Families 360°
10/1/2024	Local	Riichi Torre	Corporate Quality and Accreditation Team	Quality Improvement to include Georgia Families 360°
10/1/2024	Local	Andre'a Brown	Clinical Quality Program Manager	Quality Improvement to include Georgia Families 360°
10/1/2024	Local	Monica Lester	Director Network Management	Provider Complaints

Date	Location	Interviewees	Title	Operational Area
10/1/2024	Local	Bhavini Solanki	Director Foster Care Program	Provider Complaints
10/1/2024	Local	Heather Macgregor	(GF360) - Quality Evaluator Lead	Provider Complaints
10/1/2024	Local	Lisa Ridley	Compliance Analyst Sr.	Provider Complaints
10/1/2024	Local	Roslyn Phillips	Manager Provider Relationship Account Management	Provider Complaints
10/1/2024	Local	Kendra Avery	Provider Relations Account Director	Provider Complaints
10/1/2024	Local	Monica Lester	Director Network Management	Provider Services/Relations including Field Staff
10/1/2024	Local	Bhavini Solanki	Director Foster Care Program	Provider Services/Relations including Field Staff
10/1/2024	Local	Heather Macgregor	(GF360) - Quality Evaluator Lead	Provider Services/Relations including Field Staff
10/1/2024	Local	Roslyn Phillips	Manager Provider Relationship Account Management	Provider Services/Relations including Field Staff
10/1/2024	Local	Kendra Avery	Provider Relations Account Director	Provider Services/Relations including Field Staff
10/1/2024	Local	Michelle Howell	Provider Relations Acct Manager	Provider Services/Relations including Field Staff
10/1/2024	Local	Monica Lester	Director Network Management	Provider Network and Contracting – not to include Georgia Families 360°
10/1/2024	Local	Bhavini Solanki	Director Foster Care Program	Provider Network and Contracting – not to include Georgia Families 360°
10/1/2024	Local	Heather Macgregor	(GF360) - Quality Evaluator Lead	Provider Network and Contracting – not to include Georgia Families 360°
10/1/2024	Local	Sabrina Brinson	Provider Network Manager Sr.	Provider Network and Contracting – not to include Georgia Families 360°
10/1/2024	Local	Maria Henriquez	Director Medicaid Plan Marketing	Member Services - to include Ombudsman, Enrollment and Marketing and Communications
10/1/2024	Local	Bhavini Solanki	Director Foster Care Program	Member Services - to include Ombudsman, Enrollment and Marketing and Communications
10/1/2024	Local	Heather Macgregor	(GF360) - Quality Evaluator Lead	Member Services - to include Ombudsman, Enrollment and Marketing and Communications
10/1/2024	Local	Abby Boldin	Business Change Manager	Member Services - to include Ombudsman, Enrollment and Marketing and Communications

Date	Location	Interviewees	Title	Operational Area
10/1/2024	Local	Felicia Bryant (GF)	Manager II Customer Care	Member Services - to include Ombudsman, Enrollment and Marketing and Communications
10/1/2024	Local	Joyce LeTourneau	Manager II Enrollment Data	Member Services - to include Ombudsman, Enrollment and Marketing and Communications
10/2/2024	Local	LaKeisha Williams	UM 360 - Director Behavioral Health Services	Behavioral Health - to include Georgia Families 360°
10/2/2024	Local	Cherrice Smith	Team Lead	Behavioral Health - to include Georgia Families 360°
10/2/2024	Local	Bhavini Solanki	Director Foster Care Program	Behavioral Health - to include Georgia Families 360°
10/2/2024	Local	Pamela Gilmore	Team Lead	Behavioral Health - to include Georgia Families 360°
10/2/2024	Local	Christine Bailey	Behavioral Health Manager	Behavioral Health - to include Georgia Families 360°
10/2/2024	Local	Minsu Kim	Nurse	Carelon Medical Benefits Management – Utilization Management
10/2/2024	Local	Ekaterina Kosinskaya	Medical Director	Carelon Medical Benefits Management – Utilization Management
10/2/2024	Local	Suzanne Jesucat	Compliance Manager	Carelon Medical Benefits Management – Utilization Management
10/2/2024	Local	Virginia Nuttleman	Referral Specialist	Carelon Medical Benefits Management – Call Center
10/2/2024	Local	Suzanne Jesucat	Compliance Manager	Carelon Medical Benefits Management – Call Center
10/2/2024	Local	Nancy Gifford	Client Executive	Carelon Medical Benefits Management – Call Center
10/2/2024	Local	Danielle Florence	Manager II	Carelon Medical Benefits Management – Call Center
10/2/2024	Local	Jacqueline Pendleton	(PI) - Carelon Payment Integrity Manager	Program Integrity
10/2/2024	Local	JP Joyce	(PI) - Director I Compliance	Program Integrity
10/2/2024	Local	Haley Everson	(SIU) - Manager I Investigations	Program Integrity
10/2/2024	Local	Kim Wright	(SIU) – Regulatory Compliance Consultant	Program Integrity

Date	Location	Interviewees	Title	Operational Area
10/2/2024	Local	Cassandra Tancil	Pharmacy Account Manager	Pharmacy Services and Operations–to include Subcontractor Oversight
10/2/2024	Local	Jermaine Gipson	PBM Compliance Manager	Pharmacy Services and Operations–to include Subcontractor Oversight
10/8/2024	Corporate	Sally Dietrich	Director I Claims Operations	Claims Management Inbound Claims Processing and Inbound Subcontractor
10/8/2024	Corporate	Angela Blocker-Beaty	Manager New Day Claims Operations	Claims Management Inbound Claims Processing and Inbound Subcontractor
10/8/2024	Corporate	Florence Arauz	New Day Claims Representative III	Claims Management Inbound Claims Processing and Inbound Subcontractor
10/8/2024	Corporate	Twanya Cooper	Manager New Day Claims Operations	Claims Management Inbound Claims Processing and Inbound Subcontractor
10/8/2024	Corporate	Jami Sove	Grievance/Appeals Analyst Lead	Appeals and Grievances
10/8/2024	Corporate	Alisa Murphy	Manager II Appeals	Appeals and Grievances
10/8/2024	Corporate	Cheryl Shipp	Nurse Appeals Sr.	Appeals and Grievances
10/8/2024	Corporate	Rachel Rogers	Nurse Appeals Lead	Appeals and Grievances
10/8/2024	Corporate	Beth Mull	Compliance Consultant Sr	Regulatory Reporting
10/8/2024	Corporate	Mark Gornitzka	Director II	Regulatory Reporting
10/8/2024	Corporate	Rodney Mack	Director Strategic Vendor Management	Subcontractor Oversight
10/8/2024	Corporate	Caitlyn Marshall	Clinical Compliance Consult	Subcontractor Oversight
10/8/2024	Corporate	Rebekah Hensley-Martin	Manager Delegation Oversight	Subcontractor Oversight
10/8/2024	Corporate	Selwyn Shannon	Business Change Advisor	Subcontractor Oversight
10/8/2024	Corporate	Leshon Dean	Strategic Vendor Management	Subcontractor Oversight
10/8/2024	Corporate	Todd Kogut	GBD Finance Director	Payment Processing, Cash Disbursement Journal (CDJ) Reporting and Subcontractor Revenue
10/8/2024	Corporate	Manuel Gonzalez	Business Info Consultant	Payment Processing, Cash Disbursement Journal (CDJ) Reporting and Subcontractor Revenue
10/9/2024	Corporate	Bijuga Rajkumar	Developer	Payment Processing, Cash Disbursement Journal (CDJ)

Date	Location	Interviewees	Title	Operational Area
				Reporting and Subcontractor Revenue
10/8/2024	Corporate	Harish Venkatesh	Claims Payment Manager	Payment Processing, Cash Disbursement Journal (CDJ) Reporting and Subcontractor Revenue
10/8/2024	Corporate	James Connor	Actuarial Business Consultant	Payment Processing, Cash Disbursement Journal (CDJ) Reporting and Subcontractor Revenue
10/8/2024	Corporate	Julie Pierce	Director Finance Accounting/Reporting/Analysis	Payment Processing, Cash Disbursement Journal (CDJ) Reporting and Subcontractor Revenue
10/9/2024	Corporate	Elizabeth Eller	Director Internal Audit	Internal Audit
10/8/2024	Corporate	Tanner Hodges	Director of Reporting & Analytics	CDJs/Encounters II
10/9/2024	Corporate	Joyce LeTourneau	Manager II Enrollment Data	Member Data Maintenance
10/9/2024	Corporate	Geneva Massenburg	Enrollment Data Analyst III	Member Data Maintenance
10/9/2024	Corporate	Garry Williams	Business Information Analyst Sr	Provider Data Maintenance
10/9/2024	Corporate	Bashkor Biswas	Manager II Systems Support & Programs	Provider Data Maintenance
10/9/2024	Corporate	Ryan Thorsbakken	State Operations Director Sr	Provider Data Maintenance
10/9/2024	Corporate	Peter Bolen	Manager II Engineering	Provider Data Maintenance
10/9/2024	Corporate	Gina Bingham	Process Improvement Manager	Provider Data Maintenance
10/9/2024	Corporate	Peter Bolen	Manager II Engineering	EDW Claims and Data Warehouse Management and Reporting
10/9/2024	Corporate	Heather Brummer	Manager II Engineering	EDW Claims and Data Warehouse Management and Reporting
10/9/2024	Corporate	Das Supratik	Manager Business Information	Encounters Submissions and Reconciliation Encounter Processing (EDI) Demonstration: Encounters System
10/9/2024	Corporate	Pankaj Saraswat	Manager Business Information	Encounters Submissions and Reconciliation Encounter Processing (EDI) Demonstration: Encounters System
10/9/2024	Corporate	Jennifer Hobson	Manager II Engineering	Encounters Submissions and Reconciliation Encounter Processing (EDI)

Date	Location	Interviewees	Title	Operational Area
				Demonstration: Encounters System
10/9/2024	Corporate	Nimeshkumar Patel	Encounter Manager	Encounters Submissions and Reconciliation Encounter Processing (EDI) Demonstration: Encounters System
10/9/2024	Corporate	Tammy Tate	Business Info Analyst Sr.	Encounters Submissions and Reconciliation Encounter Processing (EDI) Demonstration: Encounters System
10/9/2024	Corporate	Manuel Gonzalez	Business Info Consultant	Data Analytics (CDJs)
10/9/2024	Corporate	Harish Venkatesh	Claims Payment Manager	Data Analytics (CDJs)
10/9/2024	Corporate	Bijuga Rajkumar	Developer	Data Analytics (CDJs)
10/9/2024	Corporate	Todd Kogut	GBD Finance Director	Data Analytics (CDJs)
10/9/2024	Corporate	Patrcia Coogan	Manager of Reimbursement System Analysis	Data Analytics (CDJs)
10/9/2024	Corporate	Cassie Evans	Director	Data Analytics (CDJs)
10/9/2024	Corporate	Roger Balducci	Regional Vice President Government Finance	Data Analytics (CDJs)
10/9/2024	Corporate	Felicia Bryant (GF)	Manager II Customer Care	Provider Call Center
10/9/2024	Corporate	Kenya Watts	(Frontline Associate) Customer Care Representative II	Provider Call Center
10/10/2024	Corporate	Tanner Hodges	Director of Reporting & Analytics	CDJs/Encounters II
10/10/2024	Corporate	Cheryl Bright	Compliance Director	Policies and Procedures
10/10/2024	Corporate	Shaune Gregg	Compliance Manager	Policies and Procedures
10/10/2024	Corporate	Sally Dietrich	Director I Claims Operations	Claims Payment Processing

Interviews with Subcontractors

Avesis

Avesis provides vision services for AGP members. Myers and Stauffer met virtually with Avesis staff on October 22, 2024, through October 23, 2024. The interviewees are referenced in *Table 13* shown below.

Table 13: Avesis

Date	Interviewees	Title	Operational Area
10/22/2024	Darwyn Young	Vendor Implementation Manager	Account Management Contract Compliance Regulatory Reporting Internal Audit
10/22/2024	Cassaundra Nichelson	Strategic Client Partner	Account Management Contract Compliance Regulatory Reporting Internal Audit
10/22/2024	Octavia Woodard	Account Coordinator	Account Management Contract Compliance Regulatory Reporting Internal Audit
10/22/2024	Josh Martell	Sr. Compliance Analyst	Account Management Contract Compliance Regulatory Reporting Internal Audit
10/22/2024	Sheila Schaefer	Compliance Director	Account Management Contract Compliance Regulatory Reporting Internal Audit
10/22/2024	Michelle Rush	Director of Account Management	Account Management Contract Compliance Regulatory Reporting Internal Audit
10/22/2024	Diana Schneider	Manager, Customer Service	Call Center Operations
10/22/2024	Garett Bird	Director, Provider Recruitment and Network Development	Provider Services - Provider Network and Maintenance
10/22/2024	Bill Wright	Vision Recruitment Manager	Provider Services - Provider Network and Maintenance
10/22/2024	Chuck Labora	Sr Manager, Provider Relations	Provider Services - Provider Network and Maintenance
10/22/2024	Meranda Sandlin	Vision Provider Relations Manager	Provider Services - Provider Network and Maintenance
10/22/2024	Angie Hatch	Director, Provider Credentialing	Provider Services - Provider Network and Maintenance
10/22/2024	Marian Gutierrez	Manager, NPID	Provider Services - Provider Network and Maintenance
10/22/2024	Lauren Dillard	A&G Supervisor	Provider Appeals
10/22/2024	Deb Gephart	Director, Utilization Management	Utilization Management
10/22/2024	Ciara Thomas	Manager, Utilization Management	Utilization Management

Date	Interviewees	Title	Operational Area
10/22/2024	Tara Gagnon	Manager, Utilization Management	Utilization Management
10/22/2024	Shaista Janif	Sr. Clinical Audit Coordinator	Utilization Management
10/22/2024	David Worth	VP Vision Services	Utilization Management
10/22/2024	Liz Mayer	Director, Program Integrity	Program Integrity (SIU, FWA)
10/22/2024	Kristyl Thompson	Chief Compliance Officer	Program Integrity (SIU, FWA)
10/22/2024	Cassaundra Nichelson	Strategic Client Partner	Program Integrity (SIU, FWA)
10/22/2024	Diane Perry	Program Integrity Team	Program Integrity (SIU, FWA)
10/23/2024	Darwyn Young	Vendor Implementation Manager	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration
10/23/2024	Cassaundra Nichelson	Strategic Client Partner	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration
10/23/2024	Sharon Tate	EDI Systems Administration Manager	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration
10/23/2024	Adriana Hinjosa	Director of Claims Department	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration
10/23/2024	Lori Peterson	Senior Dr. of Operations of EDI, Encounters, and Eligibility	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration
10/23/2024	Jerri Embry	Supervisor or Vendor Relations	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration
10/23/2024	Alethea London	Claims Manager of Claims Department	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration
10/23/2024	Brian Leake	Senior Audit Coordinator	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration
10/23/2024	Darwyn Young	Vendor Implementation Manager	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration
10/23/2024	Cassaundra Nichelson	Strategic Client Partner	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration

Date	Interviewees	Title	Operational Area
10/23/2024	Darwyn Young	Vendor Implementation Manager	IT Department
10/23/2024	Cassaundra Nichelson	Strategic Client Partner	IT Department

CarelonRx

CarelonRx provides PBM services for AGP members. Myers and Stauffer met virtually with CarelonRx staff on October 29, 2024, through October 30, 2024. On November 5, 2024, additional virtual interviews were conducted with CVS to discuss functions delegated to them by CarelonRx. The interviewees are referenced in *Table 14* were interviewed.

Table 14: CarelonRx

Date	Interviewees	Title	Operational Area
10/29/2024	Cassandra Tancil	Pharmacy Account Manager	Account Management Contract Compliance Regulatory Reporting Internal Audit
10/29/2024	Jermaine Gipson	PBM Compliance Manager	Account Management Contract Compliance Regulatory Reporting Internal Audit
10/29/2024	Cassandra Tancil	Pharmacy Account Manager	Call Center Operations
10/29/2024	Jermaine Gipson	PBM Compliance Manager	Call Center Operations
10/29/2024	Kia Morrison	Program Director – Member Services	Call Center Operations
10/29/2024	Nichole Weickert Bevis	Director- Carelon	Call Center Operations
10/29/2024	Jenna Bishop	Business Analyst	Call Center Operations
10/29/2024	Cassandra Tancil	Pharmacy Account Manager	Provider Services - Provider Network and Maintenance
10/29/2024	Jermaine Gipson	PBM Compliance Manager	Provider Services - Provider Network and Maintenance
10/29/2024	Meredith Fleming	Pharmacy Network Director	Provider Services - Provider Network and Maintenance
10/29/2024	Nichole Weickert Bevis	Director- Carelon	Provider Services - Provider Network and Maintenance
10/29/2024	Cassandra Tancil	Pharmacy Account Manager	Utilization Management
10/29/2024	Jermaine Gipson	PBM Compliance Manager	Utilization Management
10/29/2024	Amanda Cecere	Business Analyst	Utilization Management
10/29/2024	Jenna Bishop	Business Analyst	Utilization Management
10/29/2024	Cassandra Tancil	Pharmacy Account Manager	Program Integrity (SIU, FWA)

Date	Interviewees	Title	Operational Area
10/29/2024	Jermaine Gipson	PBM Compliance Manager	Program Integrity (SIU, FWA)
10/29/2024	Jonathan Plata	Senior Business Account Manager	Program Integrity (SIU, FWA)
10/29/2024	Amy Matthews	Director of Pharmacy Management	Program Integrity (SIU, FWA)
10/29/2024	Rod Granlund	Lock-In Team	Program Integrity (SIU, FWA)
10/29/2024	Amy Matthews	Director of Pharmacy Management	Pharmacy Network
10/30/2024	Jonathan Plata	Business Account Manager Sr.	Program Integrity (SIU, FWA)
10/30/2024	Leonor Newby	Manager Investigations SIU	Program Integrity (SIU, FWA)
10/30/2024	Cassandra Tancil	Pharmacy Account Manager	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration
10/30/2024	Jermaine Gipson	PBM Compliance Manager	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration
10/30/2024	Cassandra Tancil	Pharmacy Account Manager	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration
10/30/2024	Jermaine Gipson	PBM Compliance Manager	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration
10/30/2024	Behnaz Esmailzadeh	Manager II Systems Support & Programs	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration
10/30/2024	Chanda Cromwell	Process Expert Sr	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration
10/30/2024	Krunal Goswami	Data Management	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration
10/30/2024	Cassandra Tancil	Pharmacy Account Manager	IT Department
10/30/2024	Jermaine Gipson	PBM Compliance Manager	IT Department
11/5/2024	Ashley Marken	Manager, Client Operations (CVS)	Call Center Operations
11/5/2024	Jasmyne Greenhill	Manager Prior Authorization	Utilization Management
11/5/2024	Rachel Blanco	Manager Clinical Operations (Clinical Processing)	Utilization Management
11/5/2024	Tanya Hovis	Quality Manager	Utilization Management

Date	Interviewees	Title	Operational Area
11/5/2024	Nichole Weickert-Bevis	Director Clinical Quality Management	Utilization Management
11/5/2024	Jenna Bishop	Business Analyst	Utilization Management
11/5/2024	Sasha Kondratyeva	Quality Manager	Utilization Management
11/5/2024	Janet Choi	Clinical Quality Manager	Utilization Management
11/5/2024	Matt Bunting	Compliance Consultant	Regulatory Reporting
11/5/2024	Kristina Berry	Director Compliance	Regulatory Reporting
11/5/2024	Jonathan Plata	Business Account Manager Sr.	Program Integrity (SIU, FWA)
11/5/2024	Amy Matthews	Director Pharmacy Network	Program Integrity (SIU, FWA)
11/5/2024	Wendy Clements	Senior Manager, Pharmacy Operations (CVS)	Program Integrity (SIU, FWA)
11/5/2024	Sabrina Hormann	Senior Manager, Pharmacy Operations (CVS)	Program Integrity (SIU, FWA)
11/5/2024	Elizabeth Testa	Senior Manager- Audit Teams	Program Integrity (SIU, FWA)
11/5/2024	Cassandra Tancil	Pharmacy Account Manager	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration
11/5/2024	Jermaine Gipson	PBM Compliance Manager	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration
11/5/2024	Juan Kamulo N. Bondad	Lead Director, Client Services (CVS)	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration
11/5/2024	Delvin Taylor	Client Audit Manager (CVS)	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration
11/5/2024	Behnaz Esmailizadeh	Encounters Manager	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration
11/5/2024	Chanda Cromwell	Process Expert Sr	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration
11/5/2024	Krunal Goswami	Data Management	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration
11/5/2024	James Kelly	Manager, Finance Operations (CVS)	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration
11/5/2024	Karl Reed	Senior Manager, Finance Operations (CVS)	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration

Date	Interviewees	Title	Operational Area
11/5/2024	Britta Berney	Lead Director, Finance Operations (CVS)	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration
11/5/2024	Shay Collins	Account MGMT Executive advisor	IT Department
11/5/2024	Marcie Young	Director System Support and Programs	IT Department
11/5/2024	Lori Trexler- Flowers	Business Analyst	IT Department
11/5/2024	Cassandra Tancil	Pharmacy Account Manager	IT Department
11/5/2024	Jermaine Gipson	PBM Compliance Manager	IT Department

DentaQuest LLC

DentaQuest LLC provides dental services to AGP members. Myers and Stauffer met virtually with DentaQuest on October 15, 2024, through October 16, 2024. The interviewees are referenced in *Table 15* shown below.

Table 15: DentaQuest

Date	Interviewees	Title	Operational Area
11/1/2024	Christina Medina	Associate Director AGP	Account Management Contract Compliance Regulatory Reporting Internal Audit
11/1/2024	Vonnie Harris	Client Partner	Account Management Contract Compliance Regulatory Reporting Internal Audit
11/1/2024	Michele Welch	Vendor Implementation Manager	Call Center Operations
11/1/2024	Kelly Reid	Vice President of Customer Service	Call Center Operations
11/1/2024	Sheila Schmidt	Sr. Manager Customer Service	Call Center Operations
11/1/2024	Christina Medina	Associate Director AGP	Call Center Operations
11/1/2024	Michele Welch	Vendor Implementation Manager	Provider Services - Provider Network and Maintenance
11/1/2024	Vonnie Harris	Client Partner	Provider Services - Provider Network and Maintenance
11/1/2024	Stephanie Tate	Network Provider Partner Manager	Provider Services - Provider Network and Maintenance
11/1/2024	Michele Welch	Associate Director Utilization Management	Member/Provider Appeals
11/1/2024	Christina Medina	Associate Director AGP	Member/Provider Appeals

Date	Interviewees	Title	Operational Area
11/1/2024	Adrianna Dykstra	Complaints and Grievances Senior Manager	Member/Provider Appeals
11/1/2024	Michele Welch	Vendor Implementation Manager	Utilization Management
11/1/2024	Thomas Yang	Audit Specialist	Utilization Management
11/1/2024	Nicole Braun	Associated Director for UM Dept	Utilization Management
11/1/2024	Emily Knezic	Audit Specialist	Utilization Management
11/1/2024	Carolyn Clark	Associate Director Utilization Management	Utilization Management
11/1/2024	Michele Welch	Vendor Implementation Manager	Program Integrity (SIU, FWA)
11/1/2024	Nicholad Messuri	Assistant Vice President SIU	Program Integrity (SIU, FWA)
11/1/2024	Kathlene Gruettner	Associate Director Utilization Management	Program Integrity (SIU, FWA)
11/1/2024	Michele Welch	Vendor Implementation Manager	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration
11/1/2024	Jessica Ratzlow	Director of Vision and Dental Claim Operations	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration
11/1/2024	Marina Pyatkes	Claims Audit Analyst	Inbound Claims Processing (EDI), Claims Adjudication and Claim System Demonstration
11/2/2024	Michele Welch	Vendor Implementation Manager	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration
11/2/2024	Christina Medina	Associate Director AGP	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration
11/2/2024	Raul Cruz Jr.	Business Analyst	Encounter Submissions, Encounter Data Oversight, and Encounter System Demonstration
11/2/2024	Michele Welch	Vendor Implementation Manager	IT Department
11/2/2024	Ben Cole	Member Enrollment Analyst	IT Department
11/2/2024	Dylan Normandant	Business Systems Analyst	IT Department
11/2/2024	Christina Medina	Associate Director AGP	IT Department
11/2/2024	Liza Morris	Associate Director of Provider Operations	IT Department

Date	Interviewees	Title	Operational Area
11/2/2024	Michael Duhamel	Dir of Member Enrollment	IT Department

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 examination. 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:

- *Amerigroup.*
  - *Table 16 – Institutional (837I/UB04).*
  - *Table 17 – Professional (837P/CMS-1500).*
- *DentaQuest Dental.*
  - *Table 18 – Dental (837D/ADA).*
- *Avesis Vision.*
  - *Table 19 – Vision (837P/CMS-1500).*
- *CVS Health.*
  - *Table 20 – Pharmaceutical (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% and less than 100% were truncated to 99.9%. Percentages below 99% were examined 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 16: AGP FFS - Institutional (837I/UB04)

AGP FFS – Institutional (837I/UB04) Claim Lines Examined = 584,700			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Plan by Provider	0.0	The claim receipt date reported in the AGP FFS extracts for institutional claim lines did not match the claim receipt date reported in the MMIS encounters. In most cases (99.7%), the claim receipt date reported in the MMIS encounters may represent the date AGP paid the claim, since the claim receipt date appeared to be the same date as the encounter paid date.
2	Date Paid	99.8	
3	Amount Paid - Claim Header	99.9	
4	Amount Paid - Claim Detail Lines	99.6	
5	Interest Paid - Claim Header	99.2	The occurrence of interest on AGP institutional claims was rare (less than 1%). We observed approximately 5,300 claim lines in the AGP institutional extracts having a non-zero header interest paid amount; however, approximately 4,600 of these claim lines included interest amounts that did not appear to be reported in the MMIS encounters (0.8% of reviewed institutional claim lines).
6	Denial Indicator - Claim Header	99.6	
7	Member Medicaid ID	99.8	
8	Payee Provider Tax ID	99.9	
9	Rendering Provider NPI	91.0	We observed approximately 51,400 institutional claim lines (8.8%) where the rendering provider NPI reported in the MMIS encounters did not appear to match the rendering provider NPI in the AGP claims extracts but did appear to match the payee provider NPI reported in the AGP extracts.
10	Referring Provider NPI	N/A	The referring provider NPI did not appear to be reported in the MMIS for AGP institutional encounters. We observed the referring provider NPI reported on approximately 14,000 institutional claim lines in the AGP FFS claims extracts (2.4%).

AGP FFS – Institutional (837I/UB04) Claim Lines Examined = 584,700			
	Claim Data Element	**% Match**	**Notes**
11	Attending Provider NPI	26.7	The attending provider NPI supplied on approximately 428,300 institutional claim lines (73.2%) in the AGP claims extracts did not appear to be reported in the MMIS encounters.
12	Operating Provider NPI	99.3	
13	DRG Code	99.2	
14	Claim ICD Diagnosis Codes	99.5	Most 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.
15	Claim ICD Surgical Procedure Codes	99.9	
16	Type of Bill	99.9	
17	Medical Record Number	98.7	Myers and Stauffer requested AGP include the medical record number when preparing the claims extracts; however, it appeared the medical record number was not included in the AGP claims extracts for approximately 7,600 institutional claim lines (1.3%)
18	Amount Billed - Claim Header	99.6	
19	Amount Billed - Claim Detail Lines	97.8	Approximately 7,900 AGP institutional claim lines (1.3%) appeared to have been bundled into fewer claim lines in the MMIS encounters. The sum of bundled line billed amounts in the AGP institutional extracts appeared to match the line billed amount reported in the MMIS encounters. Please note that AGP may be required to bundle some claim lines by Gainwell to facilitate acceptance of claim lines into the MMIS encounters.
20	Admission Date	99.8	
21	Discharge Date	99.0	
22	First Date of Service – Claim Header	99.9	
23	Last Date of Service – Claim Header	99.9	
24	First Date of Service – Claim Detail Lines	99.9	
25	Last Date of Service – Claim Detail Lines	99.9	

AGP FFS – Institutional (837I/UB04) Claim Lines Examined = 584,700			
	Claim Data Element	**% Match**	**Notes**
26	Claim Detail Line Number	93.1	Approximately 7,900 institutional claim lines (1.3%) appeared to have been bundled into fewer claim lines in the MMIS institutional encounters for AGP. Additional claims were observed where one or more claim lines in the AGP claims extracts did not appear to be reported in the MMIS encounters. As a result of potential claim line bundling and potential missing claim lines, the line number on approximately 39,900 AGP institutional claim lines (6.8%) appeared to have been either renumbered or reordered in the MMIS encounters. Please note that AGP may be required to bundle some claim lines by Gainwell to facilitate acceptance of claim lines into the MMIS encounters.
27	Units Billed	97.5	Approximately 7,900 AGP institutional claim lines (1.3%) appeared to have been bundled into fewer claim lines in the MMIS encounters. The sum of bundled line billed units in the AGP institutional extracts appeared to match the line billed units reported in the MMIS encounters. Additionally, Myers and Stauffer requested AGP include the units billed when preparing the claims extracts; however, it appeared the units billed were not included in the AGP claims extracts for approximately 1,500 institutional claim lines (0.2%). We were unable to verify the units billed reported in the MMIS encounters for these claims. Please note that AGP may be required to bundle some claim lines by Gainwell to facilitate acceptance of claim lines into the MMIS encounters.
28	Revenue Code	100	
29	Procedure Code	99.9	
30	Procedure Code Modifier 1	99.9	
31	Procedure Code Modifier 2	99.9	
32	Procedure Code Modifier 3	99.9	
33	Procedure Code Modifier 4	100.0	
34	NDC	99.2	

Table 17: AGP FFS - Professional (837P/CMS-1500)

AGP FFS – Professional (837P/CMS-1500) Claim Lines Examined = 1,887,300			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Plan by Provider	0.0	The claim receipt date reported in the AGP FFS extracts for professional claim lines did not match the claim receipt date reported in the MMIS encounters. In most cases (99.7%), the claim receipt date reported in the MMIS encounters may represent the date AGP paid the claim, since the claim receipt date appeared to be the same date as the encounter paid date.
2	Date Paid	99.8	
3	Amount Paid – Claim Header	99.9	
4	Amount Paid – Claim Detail Lines	99.8	
5	Interest Paid - Claim Header	99.6	The occurrence of interest on AGP professional claims was rare (less than 0.5%). We observed approximately 9,800 claim lines in the AGP professional extracts having a non-zero header interest paid amount; however, approximately 7,300 of these claim lines included interest amounts that did not appear to be reported in the MMIS encounters (0.4% of reviewed professional claim lines).
6	Denial Indicator - Claim Header	99.7	
7	Member Medicaid ID	99.8	
8	Payee Provider Tax ID	92.8	For approximately 128,300 professional claim lines (6.8%) it appeared the Payee Provider Tax ID in the MMIS encounters for AGP 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	98.0	We observed approximately 37,000 professional claim lines (1.9%) where the rendering provider NPI reported in the MMIS encounters did not appear to match the rendering provider NPI in the AGP claims extracts but did appear to match the payee provider NPI reported in the AGP extracts.

AGP FFS – Professional (837P/CMS-1500) Claim Lines Examined = 1,887,300			
	Claim Data Element	**% Match**	**Notes**
10	Referring Provider NPI	40.9	The referring provider NPI supplied on approximately 1,115,400 professional claim lines (59.1%) in the AGP claims extracts did not appear to be reported in the MMIS encounters. This field may not be required for submission to the MMIS.
11	Claim ICD Diagnosis Codes	99.6	Most 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.
12	Amount Billed – Claim Header	99.8	
13	Amount Billed - Claim Detail Lines	99.3	
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	98.4	Approximately 7,000 professional claim lines (0.4%) appeared to have been bundled into fewer claim lines in the MMIS professional encounters for AGP. Additional claims were observed where one or more claim lines in the AGP claims extracts did not appear to be reported in the MMIS encounters. As a result of potential claim line bundling and potential missing claim lines, the line number on approximately 30,100 AGP professional claim lines (1.6%) appeared to have been either renumbered or reordered in the MMIS encounters. Please note that AGP may be required to bundle some claim lines by Gainwell to facilitate acceptance of claim lines into the MMIS encounters.
19	Units Billed	99.0	

AGP FFS – Professional (837P/CMS-1500) Claim Lines Examined = 1,887,300			
	Claim Data Element	**% Match**	**Notes**
20	Place of Service	98.9	For approximately 20,600 professional claim lines (1.1%) the place of service in the AGP FFS claims extracts did not appear to match the value in the corresponding MMIS AGP professional encounters. For approximately 9,500 of these claim lines (0.5%), 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	99.7	
23	Procedure Code Modifier 2	99.9	
24	Procedure Code Modifier 3	99.9	
25	Procedure Code Modifier 4	99.9	
26	NDC	99.9	
27	Claim Detail Line ICD Diagnosis 1	95.6	We observed approximately 82,600 professional claim lines (4.4%) in the AGP 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	97.4	We observed approximately 49,400 professional claim lines (2.6%) in the AGP 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.

AGP FFS – Professional (837P/CMS-1500) Claim Lines Examined = 1,887,300			
	Claim Data Element	**% Match**	**Notes**
29	Claim Detail Line ICD Diagnosis 3	98.4	We observed approximately 30,300 professional claim lines (1.6%) in the AGP 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.
30	Claim Detail Line ICD Diagnosis 4	99.0	

Table 18: DentaQuest Dental (837D/ADA)

DentaQuest Dental (837D/ADA) Claim Lines Examined = 373,200			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Subcontractor by Provider	0.0	The claim receipt date reported in the DentaQuest extracts for dental claim lines did not match the claim receipt date reported in the MMIS encounters. In most cases (99.3%), the claim receipt date reported in the MMIS encounters may represent the date DentaQuest paid the claim, since the claim receipt date appeared to be the same date as the encounter paid date.
2	Date Paid	99.7	
3	Subcontractor Amount Paid – Claim Header	99.2	
4	Subcontractor Amount Paid – Claim Detail Lines	98.2	Approximately 4,800 dental claim lines (1.3%) appeared to have been bundled into fewer claim lines in the MMIS encounters for DentaQuest. The sum of bundled line paid amounts in the DentaQuest extracts appeared to match the line paid amount reported in the MMIS encounters. Please note that AGP may be required to bundle some claim lines by Gainwell to facilitate acceptance of claim lines into the MMIS encounters.

DentaQuest Dental (837D/ADA) Claim Lines Examined = 373,200			
	Claim Data Element	**% Match**	**Notes**
5	Interest Paid - Claim Header	100.0	Interest appeared to be reported as $0 for all records in the DentaQuest claims extracts and the MMIS encounter data for DentaQuest.
6	Denial Indicator - Claim Header	99.8	
7	Member Medicaid ID	99.2	
8	Payee Provider Tax ID	94.2	For approximately 21,100 dental claim lines (5.6%) it appeared the Payee Provider Tax ID in the MMIS encounters for DentaQuest 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	99.8	
10	Referring Provider NPI	N/A	The referring provider NPI did not appear to be reported in either the DentaQuest claims extracts or the MMIS encounters for DentaQuest.
11	Claim ICD Diagnosis Codes	99.9	The occurrence of ICD diagnosis codes on DentaQuest claims was rare (less than 0.1%). We observed approximately 560 claims in the DentaQuest extracts having an ICD diagnosis code, and all values reported in the DentaQuest claims extracts appeared to match values reported in the MMIS encounters.
12	Amount Billed - Claim Header	99.9	
13	Amount Billed - Claim Detail Lines	94.5	Approximately 15,200 DentaQuest dental claim lines (4.0%) appeared to have been bundled into fewer claim lines in the MMIS encounters. The sum of bundled line billed amounts in the DentaQuest extracts appeared to match the line billed amount reported in the MMIS encounters. Please note that AGP may be required to bundle some claim lines by Gainwell to facilitate acceptance of claim lines into the MMIS encounters.
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	

DentaQuest Dental (837D/ADA) Claim Lines Examined = 373,200			
	Claim Data Element	**% Match**	**Notes**
18	Claim Detail Line Number	92.4	Approximately 15,200 dental claim lines (4.0%) appeared to have been bundled into fewer claim lines in the MMIS dental encounters for DentaQuest. Additional claims were observed where one or more claim lines in the DentaQuest claims extracts did not appear to be reported in the MMIS encounters. As a result of potential claim line bundling and potential missing claim lines, the line number on approximately 28,200 DentaQuest dental claim lines (7.6%) appeared to have been either renumbered or reordered in the MMIS encounters. Please note that AGP may be required to bundle some claim lines by Gainwell to facilitate acceptance of claim lines into the MMIS encounters.
19	Units Billed	93.9	Approximately 15,200 DentaQuest dental claim lines (4.0%) appeared to have been bundled into fewer claim lines in the MMIS encounters. The sum of bundled line billed units in the DentaQuest extracts appeared to match the line billed units reported in the MMIS encounters. Additionally, Myers and Stauffer requested DentaQuest include the units billed when preparing the claims extracts; however, it appeared the units billed were not included in the DentaQuest claims extracts for approximately 2,700 dental claim lines (0.7%). We were unable to verify the units billed reported in the MMIS encounters for these claims. Please note that AGP may be required to bundle some claim lines by Gainwell to facilitate acceptance of claim lines into the MMIS encounters.

DentaQuest Dental (837D/ADA) Claim Lines Examined = 373,200			
	Claim Data Element	**% Match**	**Notes**
20	Place of Service	98.2	The place of service reported in the DentaQuest extracts for approximately 6,600 dental claim lines (1.8%) did not match the place of service reported in the MMIS encounters. Myers and Stauffer was not able to identify a potential cause for this difference; however, we did observe more variety in the place of service codes reported in the DentaQuest extracts (19 unique code values) when compared to the MMIS encounters (5 unique code values). The place of service reported in the MMIS encounters for DentaQuest claim lines may not accurately represent the place of service billed on the claim.
21	Procedure Code	98.1	The procedure code reported in the DentaQuest extracts for approximately 7,100 dental claim lines (1.9%) did not match the procedure code reported in the MMIS encounters. Myers and Stauffer was not able to identify a potential cause for this difference; however, we did observe almost all of these mismatched claim lines appeared to be reported in the MMIS encounters as "D0210" (Intraoral - complete series of radiographic images).
22	Procedure Code Modifier 1	99.9	
23	Procedure Code Modifier 2	N/A	Procedure Code Modifier 2 through 4 did not appear to be populated in either the DentaQuest claims extracts or the MMIS encounters for DentaQuest. The sample review period may not include any dental claim lines with more than one procedure code modifier, which may explain the absence of values.
24	Procedure Code Modifier 3	N/A	
25	Procedure Code Modifier 4	N/A	
26	Tooth Number	93.4	For approximately 24,700 DentaQuest dental claim lines (6.6%) 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	

DentaQuest Dental (837D/ADA) Claim Lines Examined = 373,200			
	Claim Data Element	**% Match**	**Notes**
30	Tooth Surface Code 4	99.9	
31	Tooth Surface Code 5	99.9	
32	Claim Detail Line ICD Diagnosis 1	99.9	The occurrence of ICD diagnosis codes on DentaQuest claims was rare (less than 0.1%). We observed approximately 560 claims in the DentaQuest extracts having an ICD diagnosis code, and all values reported in the DentaQuest claims extracts appeared to match values reported in the MMIS encounters.
33	Claim Detail Line ICD Diagnosis 2	N/A	Claim detail line ICD diagnosis code 2 did not appear to be present in the DentaQuest claims extract or in the MMIS encounter data.
34	Claim Detail Line ICD Diagnosis 3	N/A	Claim detail line ICD diagnosis code 3 did not appear to be present in the DentaQuest claims extract or in the MMIS encounter data.
35	Claim Detail Line ICD Diagnosis 4	N/A	Claim detail line ICD diagnosis code 4 did not appear to be present in the DentaQuest claims extract or in the MMIS encounter data.

Table 19: Avesis Vision (837P/CMS-1500)

Avesis Vision (837P/CMS-1500) Claim Lines Examined = 41,500			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Subcontractor by Provider	1.9	The claim receipt date reported in the Avesis Vision extracts for vision claim lines did not match the claim receipt date reported in the MMIS encounters. In most cases (97.2%), the claim receipt date reported in the MMIS encounters may represent the date Avesis paid the claim, since the claim receipt date appeared to be the same date as the encounter paid date.
2	Date Paid	99.9	
3	Subcontractor Amount Paid – Claim Header	99.1	
4	Subcontractor Amount Paid – Claim Detail Lines	99.7	

Avesis Vision (837P/CMS-1500) Claim Lines Examined = 41,500			
	Claim Data Element	**% Match**	**Notes**
5	Interest Paid - Claim Header	99.9	The occurrence of interest on Avesis Vision claims was rare (less than 0.4%). We observed approximately 130 claim lines in the Avesis Vision extracts having a non-zero header interest paid amount; however, approximately 50 of these claim lines included interest amounts that did not appear to be reported in the MMIS encounters (0.1% of reviewed vision claim lines).
6	Denial Indicator - Claim Header	99.6	
7	Member Medicaid ID	100.0	
8	Payee Provider Tax ID	93.8	For approximately 2,500 vision claim lines (6.2%) it appeared the Payee Provider Tax ID in the MMIS encounters for Avesis 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 submission.
9	Rendering Provider NPI	98.5	We observed approximately 290 vision claim lines (0.7%) where the rendering provider NPI reported in the MMIS encounters did not appear to match the rendering provider NPI in the Avesis Vision claims extracts but did appear to match the payee provider NPI in the Avesis Vision extracts.
10	Referring Provider NPI	N/A	The occurrence of a referring provider NPI on Avesis Vision claims was very rare (less than 0.1%). We observed approximately 40 claim lines in the Avesis Vision extracts having a referring provider NPI; however, the referring provider NPI did not appear to be reported in the MMIS encounters for these claim lines.
11	Claim ICD Diagnosis Codes	99.2	
12	Amount Billed - Claim Header	99.9	

Avesis Vision (837P/CMS-1500) Claim Lines Examined = 41,500			
	Claim Data Element	**% Match**	**Notes**
13	Amount Billed - Claim Detail Lines	97.4	Approximately 1,000 Avesis Vision claim lines (2.5%) appeared to have been bundled into fewer claim lines in the MMIS encounters. The sum of bundled line billed amount in the Avesis Vision extracts appeared to match the line billed amount reported in the MMIS encounters. Please note that AGP may be required to bundle some claim lines by Gainwell to facilitate acceptance of claim lines into the MMIS encounters.
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	97.2	Approximately 1,000 Avesis vision claim lines (2.5%) appeared to have been bundled into fewer claim lines in the MMIS vision encounters for Avesis Vision. Additional claims were observed where one or more claim lines in the Avesis Vision claims extracts did not appear to be reported in the MMIS encounters. As a result of potential claim line bundling and potential missing claim lines, the line number on approximately 1,100 Avesis Vision claim lines (2.8%) appeared to have been either renumbered or reordered in the MMIS encounters. Please note that AGP may be required to bundle some claim lines by Gainwell to facilitate acceptance of claim lines into the MMIS encounters.
19	Units Billed	96.5	Approximately 1,000 Avesis Vision claim lines (2.5%) appeared to have been bundled into fewer claim lines in the MMIS encounters. The sum of bundled line billed units in the Avesis Vision extracts appeared to match the line billed units reported in the MMIS encounters. Please note that AGP may be required to bundle some claim lines by Gainwell to facilitate acceptance of claim lines into the MMIS encounters.
20	Place of Service	99.9	

Avesis Vision (837P/CMS-1500) Claim Lines Examined = 41,500			
	Claim Data Element	**% Match**	**Notes**
21	Procedure Code	100.0	
22	Procedure Code Modifier 1	99.9	
23	Procedure Code Modifier 2	99.9	
24	Procedure Code Modifier 3	100.0	
25	Procedure Code Modifier 4	99.9	
26	NDC	99.9	
27	Claim Detail Line ICD Diagnosis 1	97.3	Line diagnosis code pointers for Avesis Vision claims in the MMIS encounters appear to be explicitly set to values "1", "1,2" or "1,2,3"; Line diagnosis codes reported in the MMIS encounters may not accurately represent the line diagnosis codes billed on the claim.
28	Claim Detail Line ICD Diagnosis 2	89.5	
29	Claim Detail Line ICD Diagnosis 3	97.1	
30	Claim Detail Line ICD Diagnosis 4	99.5	

Table 20: CVS Health (NCPDP)

CVS Health (NCPDP) Claim Lines Examined = 583,500			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Subcontractor by Provider	98.0	The claim receipt date reported in the CVS Health extracts for approximately 11,500 pharmacy claims (2.0%) did not match the claim receipt date reported in the MMIS encounters. Myers and Stauffer was not able to identify a potential cause for this difference; however, we did observe the claim receipt date reported in the MMIS encounters appeared to occur after the claim adjudication date for most instances of mismatched values.
2	Date Paid	100.0	
3	Subcontractor Amount Paid	99.9	
4	Denial Indicator	99.9	
5	Member Medicaid ID	99.9	
6	Payee Provider Tax ID	94.9	For approximately 29,600 pharmacy claim lines (5.0%) it appeared the Payee Provider Tax ID in the MMIS encounters for CVS Health 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.

CVS Health (NCPDP) Claim Lines Examined = 583,500			
	Claim Data Element	**% Match**	**Notes**
7	Dispensing Provider NPI	98.6	We observed approximately 7,500 pharmacy claim lines (1.3%) in the CVS Health 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	99.8	
9	Claim ICD Diagnosis Codes	N/A	ICD Diagnosis codes do not appear to be reported in the MMIS encounter data for pharmacy claims. We observed approximately 106,900 pharmacy claim lines (18.3%) where one or more ICD diagnosis codes appeared to be reported in the CVS Health pharmacy 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	99.9	
11	Amount Billed	3.8	We observed approximately 561,100 pharmacy claim lines (96.2%) where the amount billed reported in the CVS Health claims extracts did not match the amount billed reported in the MMIS encounters. The amount billed reported in approximately 548,300 of the MMIS encounters (93.9%) appeared to represent the sum of the ingredient cost submitted and the dispensing fee.
12	Date Filled	100.0	
13	Dispensed Units	99.3	
14	NDC	100.0	
15	Days' Supply	98.9	We observed approximately 6,500 pharmacy claim lines (1.1%) where the days' supply reported in the CVS Health claims extracts did not match the days' supply reported 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 mismatched claim adjustment sequences between the claims extracts and MMIS encounters due to limitations of our claim matching logic.

CVS Health (NCPDP) Claim Lines Examined = 583,500			
	Claim Data Element	**% Match**	**Notes**
16	Refill Number	99.9	
17	Dispensing Fee	98.8	We observed approximately 6,800 pharmacy claim lines (1.2%) where the provider dispensing fee reported in the CVS Health claims extracts did not match the provider dispensing fee reported 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 mismatched claim adjustment sequences between the claims extracts and MMIS encounters due to limitations of our claim matching logic.
18	Ingredient Cost Submitted	0.5	For approximately 580,500 pharmacy claim lines (99.5%), it appeared that the ingredient cost submitted reported in the CVS Health 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	3.8	We observed approximately 548,100 pharmacy claim lines (93.9%) where the gross amount due reported in the CVS Health claims extracts did not match the gross amount due reported in the MMIS encounters. The gross amount due reported in the MMIS encounters appeared to represent the sum of the ingredient cost submitted and the dispensing fee.
22	Provider Fee Amount	N/A	This provider fee amount was not populated in the supplied claims extracts or in MMIS encounters.
23	Patient Paid Amount	81.0	Myers and Stauffer requested CVS Health include the patient paid amount when preparing the claims extracts; however, it appeared the patient paid amount was not included in the CVS Health claims extracts for approximately 107,600 pharmacy claim lines (18.5%).

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).*
- ***Amerigroup Community Care (Amerigroup or AGP)*** *– 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).*
- ***Avesis*** *– The AGP subcontractor responsible for managing vision services.*
- ***Behavioral Health*** *– The discipline or treatment focused on the care and oversight of individuals with mental disorders and/or substance abuse disorders as classified in the Diagnostic and Statistical Manual of Mental Disorders-Five published by the American Psychiatric Association. Those meeting the medical necessity requirements for services in behavioral health usually have symptoms, behaviors, and/or skill deficits which impede their functional abilities and affect their quality of life.*
- ***Behavioral Health Home*** *– A behavioral health home is responsible for the integration and coordination of the individual's health care (physical as well as behavioral health care services). Behavioral health home providers do not need to provide all the services themselves but must ensure the full array of primary and behavioral health care services is available, integrated, and coordinated.*
- ***Behavioral Health Services*** *– Covered services for the treatment of mental, emotional, or chemical dependency disorders.*
- ***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.*
- ***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 (CHIP)*** *– 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 (COB)*** *– 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®.*
- ***CarelonRx (Carelon)*** *– The AGP subcontractor responsible for pharmacy benefit management (PBM) services.*
- ***CVS Health (CVS)*** *– Provides certain PBM administrative functions for CarelonRx, since 2019.*
- ***DentaQuest LLC (DQ)*** *– The AGP subcontractor responsible for managing dental services.*
- ***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.*
- ***Department of Juvenile Justice (DJJ)*** *– The multi-faceted agency serving the state of Georgia's youth, up to age 21, involved in the Juvenile Justice system.*
- ***Department of Family and Children Services (DFCS)*** *- Investigates allegations of child abuse, supports foster and adoptive families, and advocates for the welfare of abused and neglected children. Additionally, the department administers programs such as SNAP, Medicaid, and TANF.*

It also assists unemployed parents in regaining financial stability and offers various support services and resources to families in need.

- ***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 fiscal agent contractor is 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.*
- ***Georgia Families 360°SM*** *– The risk-based Medicaid managed care delivery program for children, youth, and young adults in foster care, children and youth receiving adoption assistance, and certain youth involved in the juvenile justice system. AGP is the Care Management Organization managing this program.*

- ***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.*
- ***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.*

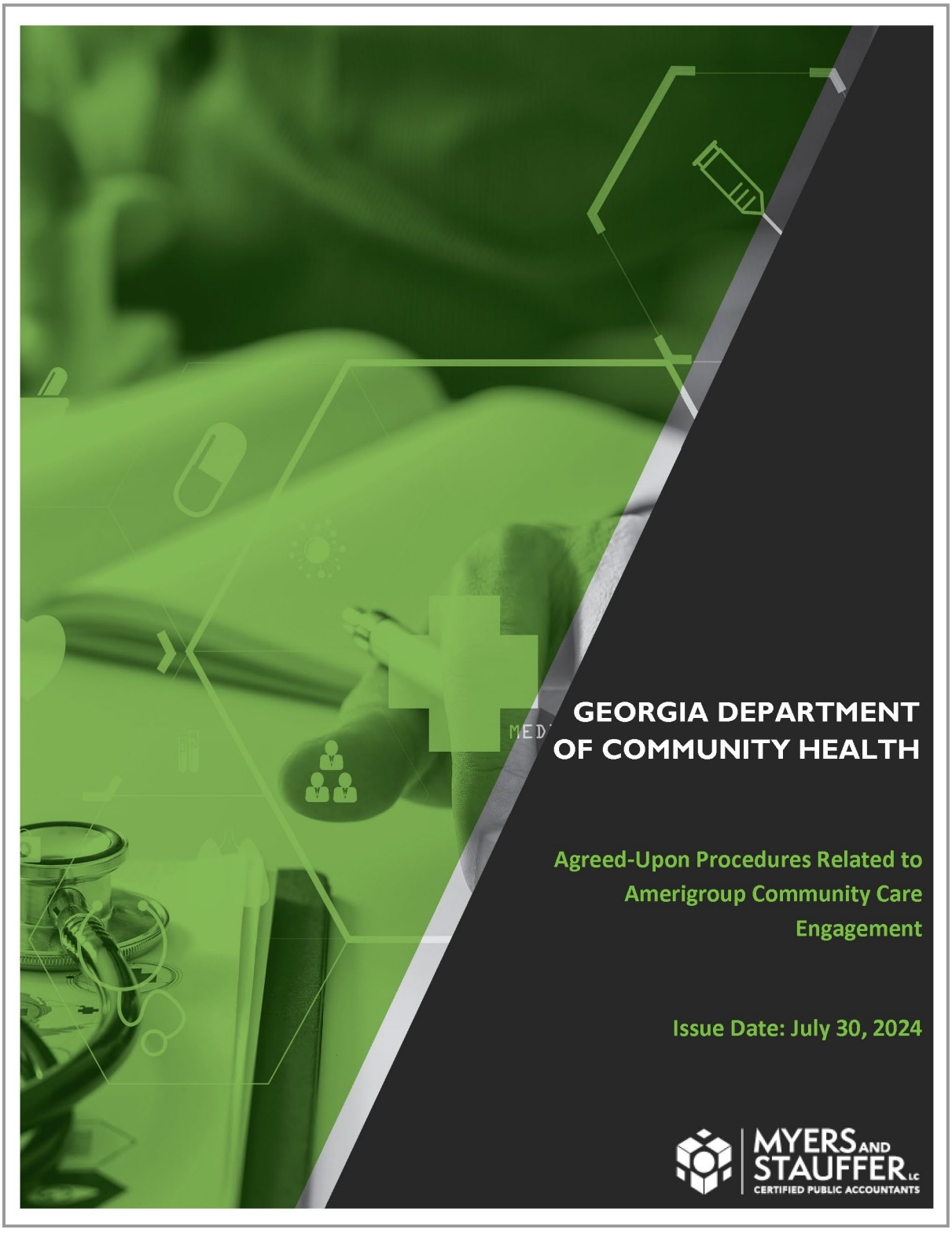
- ***Ombudsman*** *– AGP employees responsible for coordinating services with local community organizations and working with local advocacy organizations to ensure members have access to covered and non-covered services and collaborating with DCH to identify and resolve issues such as access to health 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 (PA)*** *– 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°SM.*
- ***Special Investigations Unit (SIU)*** *– AGP/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 described below will be applied to AGP and its subcontractors regarding Contract Compliance, Claims Management including Encounter Submissions, Program Integrity, and Subcontractor Oversight as it relates to the Georgia Families® program.


GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Agreed-Upon Procedures Related to Amerigroup Community Care Engagement
Issue Date: July 30, 2024
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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Introduction

This document provides a summary, methodology, and agreed-upon procedures to be used to assess Amerigroup's business practices as it relates to the Georgia Families and Georgia Families 360° programs. Amerigroup is a Georgia Families and Georgia Families 360° 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.
- ***Amerigroup*** – Amerigroup is a Care Management organization contracted by the Department of Community Health to deliver health care services to Georgia Families and Georgia Families 360°enrollees.
- ***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).
- ***Behavioral Health*** – The discipline or treatment focused on the care and oversight of individuals with mental disorders and/or substance abuse disorders as classified in the Diagnostic and Statistical Manual of Mental Disorders-Five [DSM 5] published by the American Psychiatric Association. Those meeting the medical necessity requirements for services in Behavioral Health usually have symptoms, behaviors, and/or skill deficits that impede their functional abilities and affect their quality of life.
- ***Care Coordination*** – The process of deliberately organizing member care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of healthcare services. Services from providers, medical services, residential, social, and other support services or resources are organized as appropriate to meet the needs and goals identified for the member.

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- ***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.
- ***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.
- ***Community Based Services*** – Services provided to Medicaid members with disabilities and/or chronic health conditions in the community setting.
- ***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.

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- ***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.
- ***Georgia Families 360°*** – A managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, and select youth involved in the juvenile justice system. Amerigroup is the Care Management Organization managing this program.
- ***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.
- ***Home Based Services –*** Services provided to Medicaid members with disabilities and/or chronic health conditions in the home setting.
- ***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.

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- ***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.
- ***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 (PI) Oversight*** – As mandated in section 4.13 of the contract between DCH and Amerigroup, 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.

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- ***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.
- ***Required Assessments and Screenings*** – Assessments and screenings used as tools to identify immediate needs for members transitioning into and out of Georgia Families 360°.
- ***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.
- ***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.

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 mangers and senior and staff 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 Amerigroup's business practices as it relates to the Georgia Families and Georgia Families 360° programs. Specifically, this engagement will focus on the internal controls and processes related to:

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

Scope of Activities

The scope of the engagement will include the following activities, which, along with the agreed upon procedures herein, may be modified at the request of the Department:

- **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 Amerigroup along with contracts between Amerigroup and its subcontractors. We will submit to Amerigroup the *Amerigroup and Subcontractors P&P Documentation Request and GA Families 360° P&P Documentation Request* in order to gain insight into Amerigroup's policies and procedures. We will use the obtained responses to develop specific focus topics, interview questions, and a general template for the Amerigroup staff interview procedures.
- **Amerigroup Staff Interviews, and Document Analysis** – The engagement team will meet both in person and virtually with selected staff from Amerigroup 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 Amerigroup or subcontractor procedures. A high-level overview of the findings will be conducted during an exit conference on the last day of interview activities, if necessary.
- **Synthesis, Clarification, and Additional Procedures** – The engagement team may request any additional documents that may be necessary. Additional virtual meetings with Amerigroup and its subcontractor(s) may be required to assess materials or speak with staff are also appropriate at this stage, if applicable.
- **Data Analysis Activities** – The engagement team will capture claim extracts from the CMO and its subcontractors for a sample period in order to trace all claims from EDI, to adjudication, to payment, and finally to encounter submission for accuracy and completeness. The engagement team will also capture financial documentation from the CMO and its subcontractors for a sample period in order to assess the accuracy and completeness of CMO and subcontractor CDJs.
- **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 Amerigroup as DCH deems appropriate.
- **Amerigroup Review and Response to Draft Report** – Amerigroup may provide comments and clarifications to any part of the report. Responses from Amerigroup 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 Amerigroup. Findings from the agreed-upon procedures are only amended to correct errant findings or misstatements. The report will not be amended to reflect Amerigroup or its subcontractor comments. A final report will be submitted to the Department.

Agreed Upon Procedures

The agreed-upon procedures described below will be applied to Amerigroup and its subcontractors regarding Contract Compliance, Claims Management including Encounter Submissions, Program Integrity Oversight, and Subcontractor Oversight as it relates to the Georgia Families and Georgia Families 360° programs.

1. We will request that Amerigroup and its subcontractors identify and provide policies and procedures related to Contract Compliance in the following areas:
    - Behavioral Health;
    - Call Center Operations;
    - Internal Grievance/Appeal System;
    - Member Services;
    - Member Data Maintenance;
    - Pharmacy Services;
    - Provider Data Maintenance;
    - Provider Complaints;
    - Provider Network;
    - Provider Services;
    - Quality Management;
    - 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 Amerigroup.
        ii. Review the information provided during the Amerigroup staff interviews then determine if responses are in accordance with the contract between DCH and Amerigroup.

2. We will request that Amerigroup 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 Amerigroup.
        ii. Review the information provided during the Amerigroup staff interviews then determine if responses are in accordance with the contract between DCH and Amerigroup.
        iii. Analyze the claims workflows and processes within Amerigroup and between

Amerigroup and its subcontractors.

iv. Analyze the encounter workflows and processes within Amerigroup and between Amerigroup 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 Amerigroup'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 Amerigroup and its subcontractors identify and provide their policies and procedures related to Program Integrity 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 Amerigroup.
        ii. Review the information provided during the Amerigroup staff interviews then determine if responses are in accordance with the contract between DCH and Amerigroup.
        iii. Confirm that Amerigroup'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 Amerigroup has a monitoring system to address program integrity cases, along with methods and criteria for identifying, tracking, and resolving FWA cases.
        v. Ensure that Amerigroup have adopted and implemented training programs, which include FWA components.
        vi. Review reports to confirm evidence of the Amerigroup's oversight activities.
        vii. Review the Amerigroup'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 Amerigroup 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 Amerigroup and Amerigroup 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 Amerigroup and Amerigroup and its Subcontractors.
        iii. Review Amerigroup's approach to providing oversight of its Subcontractors.
        iv. Analyze the claims workflows and processes within the Subcontractors and

between the Subcontractors and Amerigroup.

v. Analyze the encounter workflows and processes within the Subcontractors and between the Subcontractors and Amerigroup.
vi. Analyze the member and provider enrollment workflows and processes within the Subcontractors and between the Subcontractors and Amerigroup.
vii. Analyze the member and provider data workflows and processes within the Subcontractors and between the Subcontractors and Amerigroup.
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 Amerigroup and Subcontractors outline program integrity responsibilities and include sanctions for non-performance.
xiv. Review corrective action procedures administered, if any, by Amerigroup as a result of Subcontractor contractual non-compliance.

5. We will request that Amerigroup and its subcontractors identify and provide Georgia Families 360° program policies and procedures related to the following areas:
    - Care Coordination;
    - Georgia Families 360° Member Enrollment and Disenrollment;
    - Internal Grievance/Appeals System;
    - Member Call Center;
    - Provider Network;
    - Quality Improvement;
    - Required Assessments and Screenings; 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 Amerigroup.
        ii. Review the information provided during the Amerigroup staff interviews then determine if responses are in accordance with the contract between DCH and Amerigroup.

Environment for Interview Procedures

Myers and Stauffer will meet both in person and virtually with key staff at Amerigroup and its subcontractors to establish the environment for the agreed-upon procedures. Myers and Stauffer and Amerigroup will discuss the timeframes for the staff interviews, procedures for conducting interviews, procedures for documentation requests, and other logistics. Below are general guidelines for the preferred conditions in which interview activities will be conducted. Please refer to Exhibit I for *Best Practices for Conducting Virtual Meetings*. We will communicate these requirements to Amerigroup during the engagement planning meeting.

- Generally, interviews with Amerigroup staff will be conducted in person. A virtual option, using a video conferencing tool, will be incorporated for Myers and Stauffer engagement staff performing off site activities such as identifying follow up items and note taking, etc. One to four Myers and Stauffer engagement team members will be speaking directly to a single representative. 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 Amerigroup staff interview procedures. Amerigroup should make every effort to provide those documents at their earliest convenience. This will help to minimize disruptions to normal business operations.

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

- An attestation form is required to certify that the data and documentation provided, and statements made to Myers and Stauffer, DCH, and/or other DCH designated representatives by the management or staff of Amerigroup 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 Amerigroup 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. Amerigroup staff interviews are projected to begin in September 2024. 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, Amerigroup, and other parties. Dates may require adjustment based on project events and other unforeseen situations.

Exhibit I: Best Practices for Conducting Virtual Meetings

- **General**
  - Virtual interviews will be conducted using a video conferencing tool with a title page or general topics showing on the screen. At times, the lead or moderator may need to assign privileges to other attendees so that they are able to share their screens for demonstration purposes.
  - Request that all attendees:
    - Join the video conferencing tool five minutes prior to the start time so that any technical issues can be quickly identified and resolved.
    - Mute device (phone, computer, etc.) unless they are speaking.
    - Speak clearly, but not too loudly.
  - For speakers and presenters:
    - Please turn webcams on so that the interviewers and interviewees can see each other. The additional attendees who are not speaking do not need to have their webcams on.
    - If you have a presentation to show, test it before the meeting to make sure it works properly.

- **Interviewee Best Practices**
  - Identify a lead speaker to answer questions for each session.
  - Allow time for the interviewer to ask questions and finish speaking.
  - Limit any side conversations.

Appendix C: GF Policy and Procedure Assessment Results

Myers and Stauffer completed a comparative analysis of AGP GF policies and procedures (P&Ps) against the DCH to CMO contract language to determine compliance with the contract. To begin, we identified relevant contract sections for the operational areas assessed in this engagement. We identified key words and concepts within the contract language and cross referenced against AGP policy and procedure documents to determine if they were captured in the AGP documentation. Instances where the key words and concepts from the contract are directly reflected in the P&Ps are deemed compliant. Policies and procedure documentation that either partially reflects, or does not directly reflect, the key words and concepts from the contract are deemed non-compliant. An indication of "Yes" reflects compliance with the contract, while a "No" is an indication of non-compliance as seen in the tables below.

GF - Behavioral Health

Behavioral Health	
Contract Language	**AGP Policy is Consistent with Contract Requirement(s)**
4.8.9.3 The Contractor shall maintain copies of all letters and other correspondence related to the inclusion of Community Behavioral Health Providers in its network. This documentation shall be provided to DCH upon request.	No

GF - Claims Management

Claims Management Inbound Claims Processing and Inbound Subcontractor	
Contract Language	**AGP Policy is Consistent with Contract Requirement(s)**
4.16.1.13 The Contractor shall perform and submit to DCH Quarterly scheduled Global Claims Analyses to ensure an effective, accurate, and efficient claims processing function that adjudicates and settles Provider Claims. In addition, the Contractor shall assume all costs associated with Claims processing, including the cost of reprocessing/resubmission, due to processing errors caused by the Contractor or to the design of systems within the Contractor's Span of Control. If, based on its review of such analysis, DCH finds the Contractor's claims management system and/or processes to be insufficient, DCH may require from the Contractor a Corrective Action Plan outlining how it will address the identified issues.	No
4.16.2.1 An adjustment to a paid Claim shall not be counted as a Claim for the purposes of reporting.	No

Claims Management Inbound Claims Processing and Inbound Subcontractor	
Contract Language	**AGP Policy is Consistent with Contract Requirement(s)**
4.16.2.2 Electronic Claims shall be treated as identical to paper-based Claims for the purposes of reporting.	No

GF - Member Data Maintenance

Member Data Maintenance	
Contract Language	**AGP Policy is Consistent with Contract Requirement(s)**
4.17.1.1.1 Contractor shall have information management processes and information Systems that enable it to retain and maintain access to Provider's historical information for the purpose of claims processing and Provider inquiries for a period of up to five (5) years.	No
4.17.2.3.4 Costs incurred by the Contractor to establish interoperability with the GaHIN shall be the sole responsibility of the Contractor.	No
4.17.2.4.1.1 Member-specific information including, but not limited to name, address of record, date of birth, race/ethnicity, gender and other demographic information, as appropriate:	No
4.17.2.4.1.2 Name and address of each Member's PCP;	No
4.17.2.4.1.3 Acquisition and retention of the Member's Medicaid ID;	No
4.17.2.4.1.4 Provider-specific information including, but not limited to, name of Provider, professional group, or facility, Provider's address and phone number, and Provider type including any specialist designations and/or credentials:	No
4.17.2.4.1.5 Record of each service event with a physician or other Provider, including routine checkups conducted in accordance with the Health Check program. Record should include the date of the service event, location, Provider name, the associated problem(s) or diagnoses, and treatment given, including drugs prescribed;	No
4.17.2.4.1.6 Record of future scheduled service appointments, if available, and referrals;	No
4.17.2.4.1.8 Listing of the Member's Durable Medical Equipment (DME), which shall be reflected in the claims or "visits" module of the VHR; and	No
4.17.2.4.1.9 Any utilization of an informational code set, such as ICD-9 or ICD-10, which should provide the used code value as well as an appropriate and understandable code description.	No
4.17.2.6 The Contractor shall provide DCH with a list of Authorized Users who may access patient health data from the Contractor's Systems. DCH shall review and approve the list, including revisions thereto, of the Contractor's Authorized Users who may access patient health data from the Contractor's systems. The Contractor shall be permitted to access the GaHIN for purposes associated with this Contract only.	No

GF - Provider Data Maintenance

Provider Data Maintenance	
Contract Language	**AGP Policy is Consistent with Contract Requirement(s)**
4.17.1.1.1 Contractor shall have information management processes and information Systems that enable it to retain and maintain access to Provider's historical information for the purpose of claims processing and Provider inquiries for a period of up to five (5) years.	No
4.17.1.2 The Contractor is responsible for maintaining Systems that shall possess capacity sufficient to handle the workload projected for the start of the program and will be scalable and flexible enough to adapt as needed, within negotiated timeframes, in response to program or Enrollment changes.	No
4.17.1.3 The Contractor shall provide a Web-accessible system hereafter referred to as the DCH Portal that designated DCH and other state agency resources can use to access Quality and performance management information as well as other system functions and information as described throughout this Contract. Access to the DCH Portal shall be managed as described in the System and Data Integration Requirements below.	No
4.17.2.1 The Contractor shall have in place or develop initiatives towards implementing electronic health information exchange and health care transparency to encourage the use of Qualified Electronic Health Records and make available to Providers and Members increased information on cost and Quality of care through health information technology.	No
4.17.2.3 The Contractor shall participate in the Georgia Health Information Network (GaHIN) as a Qualified Entity (QE).	No
4.17.2.3.1 If not already participating in the GaHIN, the Contractor shall sign and execute all required GaHIN participation documentation within ten (10) Calendar Days of the Contract Effective Date (or an alternative date approved in writing by DCH) and shall adhere to all related policy and process requirements as a QE in the GaHIN. Such application process shall include successful completion of the GaHIN accreditation process;	No
4.17.2.3.2 The Contractor shall make business and technology resources available to work with the GaHIN technology vendor to develop, implement and test technical interfaces and other interoperability services as deemed necessary by DCH;	No
4.17.2.3.4 Costs incurred by the Contractor to establish interoperability with the GaHIN shall be the sole responsibility of the Contractor.	No
4.17.2.4 The Contractor shall make Member health information accessible to the GaHIN.	No
4.17.2.4.1.1 Member-specific information including, but not limited to name, address of record, date of birth, race/ethnicity, gender and other demographic information, as appropriate;	No
4.17.2.4.1.2 Name and address of each Member's PCP;	No
4.17.2.4.1.3 Acquisition and retention of the Member's Medicaid ID;	No

Provider Data Maintenance	
Contract Language	**AGP Policy is Consistent with Contract Requirement(s)**
4.17.2.4.1.4 Provider-specific information including, but not limited to, name of Provider, professional group, or facility, Provider's address and phone number, and Provider type including any specialist designations and/or credentials;	No
4.17.2.4.1.5 Record of each service event with a physician or other Provider, including routine checkups conducted in accordance with the Health Check program. Record should include the date of the service event, location, Provider name, the associated problem(s) or diagnoses, and treatment given, including drugs prescribed;	No
4.17.2.4.1.6 Record of future scheduled service appointments, if available, and referrals;	No
4.17.2.4.1.7 Complete record of all immunizations;	No
4.17.2.4.1.8 Listing of the Member's Durable Medical Equipment (DME), which shall be reflected in the claims or "visits" module of the VHR; and	No
4.17.2.4.1.9 Any utilization of an informational code set, such as ICD-9 or ICD-10, which should provide the used code value as well as an appropriate and understandable code description.	No
4.17.2.5 The Contractor shall access the GaHIN to display Member health information within their system for the purpose of Care Coordination and management of the Members.	No
4.17.2.6 The Contractor shall provide DCH with a list of Authorized Users who may access patient health data from the Contractor's Systems. DCH shall review and approve the list, including revisions thereto, of the Contractor's Authorized Users who may access patient health data from the Contractor's systems. The Contractor shall be permitted to access the GaHIN for purposes associated with this Contract only.	No
4.17.2.8 The Contractor shall encourage contracted Providers' participation in the GAHIN as well.	No

Appendix D: GF 360 Policy and Procedure Assessment Results

Myers and Stauffer completed a comparative analysis of AGP GF 360 P&Ps against the DCH to CMO contract language to determine compliance with the contract. To begin, we identified relevant contract sections for the operational areas assessed in this engagement. We identified key words and concepts within the contract language and cross referenced against AGP policy and procedure documents to determine if they were captured in the AGP documentation. Instances where the key words and concepts from the contract are directly reflected in the P&Ps are deemed compliant. Policies and procedure documentation that either partially reflects, or does not directly reflect, the key words and concepts from the contract are deemed non-compliant. An indication of "Yes" reflects compliance with the contract, while a "No" is an indication of non-compliance as seen in the tables below.

GF 360 - Care Coordination

Care Coordination	
Contract Language	**AGP Policy is Consistent with Contract Requirement(s)**
4.11.8.17.7.1 Two (2) face-to-face visits;	No

GF 360 - Provider Network

Provider Network and Contracting	
Contract Language	**AGP Policy is Consistent with Contract Requirement(s)**
4.8.1.4.1 The Contractor is also expected to form productive relationships with provider associations with experience serving the population which comprises the Members.	No
4.8.1.4.2 The Contractor shall provide the option for Providers to enroll for the purposes of serving the GF 360º population only rather than the universe of all Medicaid Members associated with all Georgia Families enrollees in the Contractor's plan.	No
4.8.2.2.1 Require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Members;	No
4.8.3.2 The Contractor shall at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted Providers which shall include the use of access and availability audits described in Section 4.8.19.6. Failure to conduct quarterly validation and provide a clean file after determining errors through validation may result in liquidated damages up to $5,000 per day against the Contractor.	No
4.8.3.3 The Contractor shall ensure that all Provider network data files are tested and validated for accuracy prior to Contractor deliverable submissions,	No

Provider Network and Contracting	
Contract Language	**AGP Policy is Consistent with Contract Requirement(s)**
which shall include the use of access and availability audits described in Section 4.8.19.6. The Contractor shall scrub data to identify inconsistencies such as duplicate addresses; mismatched cities, counties, and regions; and incorrectly assigned specialties. The Contractor shall be responsible for submission of attestations for each network report. All reports are to be submitted in the established DCH format with all required data elements. Failure to submit all attestations and complete reports in the established DCH format with all required data elements may result in liquidated damages up to $5,000 per day against the Contractor.	