MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Contract Oversight for CareSource

Independent Accountant's Report on Applying Agreed-Upon Procedures

February 15, 2021

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

Independent Accountant's Report on Applying Agreed-Upon Procedures

State of Georgia
Department of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303

We have performed the procedures enumerated in Attachment A to evaluate CareSource's compliance with contract compliance, program integrity oversight, subcontractor oversight, and encounter submissions. We were asked to apply these procedures in connection with the preparation of the Appendix E, F, G, H, I, and J. CareSource's management is responsible for compliance with the Department's policies and procedures as well as the encounter submissions.

The Georgia Department of Community Health (DCH or Department) has agreed to and acknowledged that the procedures performed are appropriate to meet the intended purpose of evaluating contract compliance. This report may not be suitable for any other purpose. The procedures performed may not address all the items of interest to a user of this report and may not 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 Attachment A and our findings and recommendations are contained in Appendix J.

We were engaged by the Department to perform this agreed-upon procedures 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 the accompanying Appendix J. 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 CareSource and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements related to our agreed-upon procedures 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

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Atlanta, Georgia
February 15, 2021

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Appendix A – Glossary

The following listing of terms and references were used throughout our description of procedures and findings:

- ***837 Healthcare Claim Transaction*** – An electronic transaction designed to submit one or more encounters from the Care Management Organization to the fiscal agent contractor.

- ***Appeal*** – A request for review of an action, as "action" is defined in 42 C.F.R. §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).

- ***Care Management Organization (CMO)*** – An organization that has entered into a risk-based contractual arrangement with the Department to obtain and finance care for enrolled Medicaid and PeachCare for Kids® members. CMOs receive a per capita or capitation claim payment from the Department for each enrolled member.

- ***CareSource*** – CareSource is a Care Management Organization contracted by the Department of Community Health to deliver health care services to Georgia Families® enrollees.

- ***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.

- ***Children's Health Insurance Program (CHIP) –*** Provides health coverage to children in families with incomes too high to qualify for Medicaid but who cannot afford private coverage.

- ***Claim*** – An electronic or paper record submitted by a Medicaid provider to the MCO 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 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 that 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 and 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®.

- ***CVS/Caremark (CVS)*** – CVS is the CareSource subcontractor responsible for managing pharmacy 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.

- ***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 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.

- ***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 program and such application is approved by DCH or its Agent.

- ***Facets*** – Healthcare products and third-party applications used by CareSource to integrate consumer, care, claims and revenue management for their Medicaid product line.

- ***Fee for Service (FFS) Medicaid*** – For purposes of this engagement, fee-for-service 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.

- ***Fiscal Agent Contractor (FAC)*** – The entity contracted with the Department to process Medicaid and PeachCare for Kids® claims and other non-claim specific payments, as well as to 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 Care Management Organizations to manage and finance the care of eligible members.

- ***Grievance*** – An expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided or aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights.

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

- ***Health Insurance Portability and Accountability Act (HIPAA***) – The 1996 Act and its implementing regulations (45 C.F.R sections 142, 160, 162 and 164), all as may be amended.

- ***List of Excluded Individuals and Entities (LEIE)*** – A list maintained by the HHS-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.

- ***National Provider Identifier (NPI)*** – A unique 10-digit identification number required in administrative and financial transactions adopted under HIPAA for covered healthcare providers.

- ***Ombudsman*** – CareSource employees responsible for coordinating services with local community organizations and working with local advocacy organizations to assure that 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.

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

- ***Prescription Medication –*** Medications prescribed for mental and substance use. There are many different types of medication for mental health problems, including anti-depressants, medication for attention issues, anti-anxiety medications, mood stabilizers, and antipsychotic medications.

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

- ***Program Integrity*** – 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, program abuse, and ensuring that 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 time frames 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 Care Management Organization to provide health care services to Members.

- ***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 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.

- ***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.

- ***Scion Dental Inc. (Scion)*** – Scion also known as SKYGEN USA is the CareSource subcontractor responsible for managing dental services.

- ***Special Investigations Unit (SIU)*** – CareSource's department responsible for the detection, prevention, investigation, reporting, correction and deterrence of fraud, waste and abuse.

- ***State Fiscal Year (SFY)*** – 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.

- ***Third Party Liability (TPL)*** – Third party liability 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. Department of Health and Human Services – Office of Inspector General (HHS-OIG)*** – The office of the Federal government tasked with oversight of Medicare and Medicaid programs.

- ***Utilization Management –*** A service performed by the Contractor which seeks to assure that 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.

Appendix B – Project Background

Effective July 1, 2017, CareSource joined the three existing Care Management Organizations (CMOs) Amerigroup, WellCare of Georgia, and Peach State Health Benefit Plan as providers of care management services to Georgia Families®, Medicaid, PeachCare for Kids® Members 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, health care providers, and patients for the purpose of improving the health status of this population.

Myers and Stauffer has been engaged to assist the Department in its efforts in assessing the policies and procedures of the Georgia Families® program. Myers and Stauffer assessments include researching and reporting on specific issues presented to DCH by providers; certain claims paid or denied by the CMOs; and selected Georgia Families® policies and procedures. Previously issued reports are available online at https://dch.georgia.gov/. The Department has also engaged Myers and Stauffer to perform engagement procedures at each of the CMOs and the CMO's subcontractors in order to assess the effectiveness of contractually mandated monitoring and operational requirements.

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

Pre-On-site

We prepared and submitted a data and information request to CareSource prior to initiating field work. This request was sent to CareSource on August 27, 2018. The materials requested were designed to provide us with detailed background information specific to the objectives of this engagement for analysis.

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

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

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

- Identified the personnel responsible for the functional areas of: 1) Contract Compliance; 2) Program Integrity; 3) Subcontractor Oversight and 4) Encounter Submissions.
- Performed a risk assessment to identify the subcontractors for potential on-site visits. Myers and Stauffer determined the list of vendors for on-site visits by considering factors such as which vendors had specific complaints against them, whether Myers and Stauffer had previously visited the vendors, and which vendors were new to CareSource when it started in Georgia.
- Obtained DCH approval of the list of subcontractors identified, by the risk assessment, for which on-site procedures would be performed.
- Prepared and submitted a schedule of individuals to be interviewed at CareSource and/or the appropriate subcontractor(s).

On-site

On-site activities at the CareSource offices in Atlanta, GA and Dayton, OH, consisted of facility tours followed by Myers and Stauffer performing interviews of certain CareSource personnel. The interviews were conducted according to the schedules provided prior to arriving on-site. General and ad hoc questions were asked to ensure our thorough understanding of the item(s) being discussed. During certain interviews, Myers and Stauffer identified additional CareSource personnel to interview and met and interviewed those individuals while on-site.

Myers and Stauffer, with DCH approval, determined that visits and interviews would be conducted with subcontractors CVS and Scion Dental (SKYGEN USA). Visits and interviews at each subcontractor location were performed in the same manner as those performed at the CareSource corporate and local offices which included a facility tour.

Visits and interviews for the engagement began October 29, 2018 and ended January 30, 2019. Myers and Stauffer's engagement team interviewed the individuals identified in the table below on the dates and at the locations indicated. The preliminary findings from each location and discussion regarding certain interviews are included later in this report.

Organization	Date	Myers and Stauffer Engagement Team	Location
CareSource, Inc.	10/29/2018 - 10/31/2018	**Myers and Stauffer:** Savombi Fields Nickie Turner Stephanie Sawyer Joe Connell Mitchell Keister Phoebe Chiem **DCH:** Sandra Middlebrooks	Atlanta, GA
CareSource, Inc.	11/12/2018 - 11/13/2018	**Myers and Stauffer:** Savombi Fields Stephanie Sawyer Joe Connell Mitchell Keister	Dayton, OH
Scion/SKYGEN USA (Dental)	12/03/2018	**Myers and Stauffer:** Savombi Fields Stephanie Sawyer Joe Connell Mitchell Keister	Menomonee Falls, WI
CVS (Pharmacy)	01/30/2019	**Myers and Stauffer:** Nickie Turner Stephanie Sawyer	Atlanta, GA (Teleconference)

Organization	Date	Myers and Stauffer Engagement Team	Location
		Hailey Plemons Joe Connell Mitchell Keister Phoebe Chiem	

Myers and Stauffer concluded the on-site activities by compiling the interview notes; reviewing additional data and documentation received; and preparing any needed follow up questions for CareSource.

Post On-site

Myers and Stauffer transcribed the interviews with CareSource, CVS and Scion Dental (SKYGEN USA). We identified and documented key findings from facility tours and interview transcriptions. The contracts, policies and procedures, and other documents related to the engagement's objectives were assessed to validate CMO and subcontractor compliance.

Appendix D – 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 CareSource 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 conflicting 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 CareSource, CVS and Scion Dental.
6. We assumed data from CareSource's information systems operated as described in the documentation supplied by CareSource.
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.

Myers and Stauffer interviewed CareSource staff members and reviewed CareSource's existing policies and procedures related to Contract Compliance in the areas of call center operations (member and provider); claims management (including third party liability); compliance plan; grievances and appeals; member and provider data maintenance; member services; program integrity; provider complaints; provider network; quality improvement; subcontractor oversight and utilization management. We identified the key contract requirements and determined whether CareSource has policies and procedures consistent with the contract requirement(s) in the tables below.

Call Center Operations

We interviewed CareSource staff members and reviewed CareSource's existing policies and procedures in relation to call center operations for both members and providers. In the table below, we identified the key contract requirements and whether CareSource has policies and procedures consistent with the contract requirement(s) for member call center operations.

Contract Requirements and Consistency of CareSource Policies and Procedures for Call Center Operations – Member and Provider

Contract Language (Member)	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.3.7.1 The Contractor shall operate a toll-free telephone line to respond to Member questions and comments.	Yes
4.3.7.2 The Contractor shall develop call center policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.	Yes
4.3.7.3 The Contractor shall submit these call center policies and procedures, including performance standards, to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date, and as updated thereafter.	Yes
4.3.7.4 The call center must comply with Title IV of the Civil Rights Act. The call center shall be equipped to handle calls from non-English speaking callers, as well as calls from Members who are hearing impaired.	Yes
4.3.7.5 The Contractor shall fully staff the call center between the hours of 7:00 a.m. and 7:00 p.m. EST, Monday through Friday, excluding State holidays. The call center staff shall be trained to accurately respond to Member questions in all areas,	Yes

Contract Language (Member)	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
including, but not limited to, Covered Services, the Provider Network, and Non-Emergency Transportation (NET). Additionally, the Contractor shall have an automated system available between the hours of 7:00 a.m. and 7:00 p.m. EST Monday through Friday and at all hours on weekends and State holidays. This automated system must provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. A Contractor's Representative shall return messages on the next Business Day.	
4.3.7.6.1 Average Speed of Answer: Ninety percent (90%) of calls shall be answered by a person within thirty (30) seconds with the remaining ten percent (10%) answered within an additional thirty (30) seconds by a live operator measured weekly. "Answer" shall mean for each caller who elects to speak, is connected to a live representative. The caller shall not be placed on hold immediately by the live representative.	Yes
4.3.7.6.2 Abandoned Call Rate of five percent (5%) or less. DCH considers a call to be "abandoned" if the caller elects an option and is either (i) not permitted access to that option, or (ii) the system disconnects the call while the Member is on hold.	Yes
4.3.7.6.3 Blocked Call Rate, or a call that was not allowed into the system, does not exceed one percent (1%).	Yes
4.3.7.6.4 Average Hold Time of less than one (1) minute ninety-nine percent (99%) of the time. Hold time refers to the average length of time callers are placed on hold by a Call Center Representative.	Yes
4.3.7.6.5 Timely Response to Call Center Phone Inquiries: One hundred percent (100%) of call center open inquiries will be resolved and closed within seventy-two (72) clock hours. DCH will provide the definition of "closed" for this performance measure.	Yes
4.3.7.6.6 Accurate Response to Call Center Phone Inquiries: Call center representatives accuracy rate must be ninety percent (90%) or higher.	Yes
4.3.7.7 The Contractor shall establish remote phone monitoring capabilities for at least five (5) DCH staff. DCH or its Agent shall be able, using a personal computer and/or phone, to monitor call center and field office calls in progress and to identify the number of call center staff answering calls and the identity of the individual call center staff answering the calls.	Yes

Contract Language (Provider)	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.9.5.1 The Contractor shall operate a toll-free call center to respond to Provider questions, comments, and concerns.	Yes
4.9.5.2 The Contractor shall develop call center Policies and Procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.	Yes
4.9.5.3 The Contractor shall submit these call center Policies and Procedures, including performance standards, to DCH for initial review and approval as updated thereafter.	Yes
4.9.5.4 The Contractor's call center systems shall have the capability to track call management metrics identified in Attachment K.	Yes
4.9.5.5 Pursuant to O.C.G.A. 33-20A-7.1(c), the call center shall be staffed twenty-four (24) hours a day, seven (7) days a week to respond to Prior Authorization and Pre-Certification requests. This call center shall have staff to respond to Provider questions in all other areas, including the Provider complaint system, Provider responsibilities, etc. between the hours of 7:00am and 7:00pm EST Monday through Friday, excluding State holidays. The Contractor shall ensure that after regular business hours the non-Prior Authorization/ Pre-certification line is answered by an automated system with the capability to provide callers with operating hour information and instructions on how to verify enrollment for a Member with an Emergency or Urgent Medical Condition. The call center shall have the capability for callers to leave a message, which shall be returned within twenty-four (24) clock hours. The requirement that the Contractor shall provide information to Providers on how to verify enrollment for a Member with an Emergency or Urgent Medical Condition shall not be construed to mean that the Provider must obtain verification before providing Emergency Services.	Yes
4.9.5.6.1 Average Speed of Answer: Eighty percent (80%) of calls shall be answered by a person within thirty (30) seconds. "Answer" shall mean for each caller who elects to speak, is connected to a live representative. The caller shall not be placed on hold immediately by the live representative. The remaining twenty percent (20%) of calls shall be answered within one (1) minute of the call.	Yes
4.9.5.6.2 Abandoned Call Rate of five percent (5%) or less. DCH considers a call to be "abandoned" if the caller elects an option and is either (i) not permitted access to that option, or (ii) the system disconnects the call while the Provider is on hold.	Yes
4.9.5.6.3 Blocked Call Rate, or a call that was not allowed into the system, does not exceed one percent (1%).	Yes
4.9.5.6.4 Average Hold Time of less than one (1) minute ninety-nine percent (99%) of the time. Hold time refers to the average	Yes

Contract Language (Provider)	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
length of time callers are placed on hold by a live Call Center Representative.	
4.9.5.6.5 Timely Response to call center Phone Inquiries: One hundred percent (100%) of call center open inquiries will be resolved and closed within seventy-two (72) clock hours. DCH will provide the definition of “closed” for this performance measure.	Yes
4.9.5.6.6 Accurate Response to Call Center Phone Inquiries: Call Center representatives accuracy rate must be ninety percent (90%) or higher.	Yes
4.9.5.7 The Contractor shall set up remote phone monitoring capabilities for at least ten (10) DCH staff. DCH shall be able, using a personal computer or phone, to monitor call Center and field office calls in progress and to identify the number of call center staff answering calls and the call center staff identifying information. The Contractor will facilitate bi-annual calibration sessions with DCH. The purpose of the calibration sessions is to ensure call center monitoring findings conducted by DCH and the Contractor are consistent.	Yes

Overview of Call Center Operations and On-Site Observations for Members and Providers

CareSource members have access to customer advocates who have the ability to provide them with information about benefits and services provided by the CMO. The member call center is located in Atlanta, Georgia and is fully staffed Monday-Friday from 7:00 a.m. to 7:00 p.m. Eastern Standard Time (EST) excluding certain State of Georgia holidays. CareSource has a centralized toll-free call system that provides members with twenty-four (24) hours a day, seven (7) days a week access to medical advice and direction.

CareSource providers also have access to the customer advocates who have the ability to respond to their questions, comments and/or concerns. The provider call center is located in Atlanta, Georgia and is fully staffed Monday-Friday from 7:00 a.m. to 7:00 p.m. Eastern Standard Time (EST) excluding certain State of Georgia holidays. CareSource has a provider call center staff available twenty-four (24) hours a day, seven (7) days a week access to respond to prior authorization and pre-certification requests. Provider calls after regular business hours and not pertaining to prior authorizations or pre-certifications are answered by an automated system that reiterates regular operating hours and provides instruction for verifying member enrollment for members with emergent or urgent medical conditions. Providers may also leave a message which will be returned by customer advocates within twenty-four (24) hours.

CareSource's quarterly performance standards for both member and provider call center were met. Eighty percent (80%) of calls were being answered within thirty (30) seconds; abandoned calls did not surpass 5%; blocked calls did not exceed 1%, and the quality results were 90% or higher.

Additional Observations: Call Center Operations for Members and Providers

- The total number of member calls for Quarter 3, 2018 was 36,770.
- The total number of provider calls for Quarter 3, 2018 was 30,079.
- For Quarter 3, 2018, the average first contact resolution rate for member calls was 80%.
- For Quarter 3, 2018, the average first contact resolution rate for provider calls was 77%.
- Approximately 43% of current call center staff work from home and are given a laptop, docking station, two monitors, and an IP connection. The CareSource network is accessed remotely via VPN.
- The top reasons for member telephone inquiries for Quarter 3, 2018 were benefit inquiry, demographic inquiry, eligibility inquiry, PCP change, and provider inquiry.
- The top reasons for provider telephone inquiries for Quarter 3, 2018 were appeal request, claim inquiry, eligibility inquiry, claim status, UM history inquiry, and provider inquiry. While on-site at the CareSource Atlanta office, we listened to two live customer service calls. A CareSource Call Center Advocate (CCA) took a call from the parent of an adult member who was unable to speak due to an accident. The CCA did not provide the member's mother with the information; sounded irritated and seemed to have no knowledge of the Subrogation Unit. A second CCA took a call from a member who was being billed by the hospital. The CCA advised the member that it was her responsibility to give her Medicaid information to the hospital with a condescending tone of voice. As a result of these calls, additional coaching/training for the advocates who answered the calls, on empathy, listening skills, tone of voice, misuse of repetitive confirmation of the issue being expressed by the member, escalation procedures and subrogation case handling.

Myers and Stauffer determined CareSource's policies and procedures for member and provider call center operations were in accordance with the DCH contract. Areas/opportunities for improvement were identified during the demonstration of live calls and CareSource's business continuity plan.

Claims Management including Third Party Liability

We interviewed CareSource staff members and reviewed CareSource's existing policies and procedures in relation to claims management including third party liability. In the table below, we identified the key contract requirements and whether CareSource has policies and procedures consistent with the contract requirement(s).

Contract Requirements and Consistency of CareSource Policies and Procedures for Claims Management including Third Party Liability

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.16.1.1 The Contractor shall adhere to the time frames and deadlines for submission, processing, payment, denial, adjudication, and appeal of Medicaid Claims outlined in the DCH Policy Manuals. The Contractor shall administer an effective, accurate and efficient claims processing function that adjudicates and settles Provider Claims for Covered Services that are filed within the time frames specified by DCH (see Part I. Policy and Procedures for Medicaid/PeachCare for Kids® Manual) and in compliance with all applicable State and federal laws, rules and regulations. Any claims processing issues caused by the Contractor will be resolved within a forty-five (45) Calendar Day limit. The Contractor shall contact Providers within fifteen (15) Calendar Days to resolve claims processing issues. For all Claims that are initially denied or underpaid by the Contractor but eventually determined or agreed to have been owed by the Contractor to a provider of health care services, the Contractor shall pay, in addition to the amount determined to be owed, interest of twenty percent (20%) per annum, calculated from fifteen (15) Calendar Days after the date the Claim was submitted.	Yes
4.16.1.2 The Contractor shall maintain a Claims management system that can identify date of receipt (the date the Contractor receives the Claim as indicated by the date-stamp), realtime-accurate history of actions taken on each Provider Claim (i.e. paid, denied, suspended, Appealed, etc.), and date of payment (the date of the check or other form of payment).	Yes
4.16.1.3 At a minimum, the Contractor shall run one (1) Provider payment cycle per week, on the same day each week, as determined by DCH.	Yes
4.16.1.4 The Contractor shall support an Automated Clearinghouse (ACH) mechanism that allows Providers to request and receive electronic funds transfer (EFT) of Claims payments.	Yes
4.16.1.5 The Contractor shall encourage its Providers, as an alternative to the filing of paper-based Claims, to submit and receive Claims information through electronic data interchange (EDI), i.e. electronic Claims. Electronic Claims must be processed in adherence to information exchange and data management requirements specified in the Information Management and Systems section of this Contract, Section 4.17. As part of this Electronic Claims Management (ECM) function, the Contractor shall also provide on-line and phone-based capabilities to obtain Claims processing status information.	Yes

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.16.1.6 The Contractor shall generate explanation of Benefits and remittance advices in accordance with State standards for formatting, content and timeliness and will verify that Members have received the services indicated on the explanation of Benefits and the remittance advices.	Yes
4.16.1.7 The Contractor shall issue a formal tracking number for claims inquiries and shall tie any recoupment to the original payment on the remittance advice. The Contractor shall provide the ability to separate provider remittance advice by location identified through the location-specific provider number.	Yes
4.16.1.8 The Contractor shall not pay any Claim submitted by a Provider who is excluded or suspended from the Medicare, Medicaid or CHIP programs for Fraud, Waste or Abuse or otherwise included on the U.S. Department of Health and Human Services Office of Inspector General exclusions list, or who employs someone on this list. The Contractor shall not pay any Claim submitted by a Provider that is on payment hold under the authority of DCH or its Agent(s).	Yes
4.16.1.9 Not later than the fifteenth (15) Business Day after the receipt of a Provider Claim that does not meet Clean Claim requirements, the Contractor shall suspend the Claim and request in writing (notification via e-mail, the CMO web site/Provider Portal or an interim explanation of Benefits satisfies this requirement) all outstanding information such that the Claim can be deemed clean. Upon receipt of all the requested information from the Provider, the CMO shall complete processing of the Claim within fifteen (15) Business Days.	Yes
4.16.1.10 For services rendered within seventy-two (72) hours after the Provider verifies the eligibility of the patient with the Contractor, the Contractor shall reimburse the Provider in an amount equal to the amount to which the Provider would have been entitled if the patient had been enrolled as shown in the eligibility verification process. After resolving the Provider's claim, if the Contractor made payment for a patient for whom it was not responsible, then the Contractor may pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the Provider.	Yes
4.16.1.11 The Contractor shall not apply any penalty for failure to file Claims in a timely manner, for failure to obtain Prior Authorization, or for the Provider not being a participating Provider in the Contractor's network. The amount of reimbursement shall be that Provider's applicable rate for the service provided by an In Network or Out of Network Provider.	No. We did not identify a CareSource policy which included language stating CareSource shall not apply any penalty for failure to file claims in a timely manner or failure

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
	to obtain prior authorization for an in-network provider.
4.16.1.12 The Contractor shall inform all network Providers about the information required to submit a Clean Claim as a provision within the Contractor/Provider Contract. The Contractor shall make available to network Providers Claims coding and processing guidelines for the applicable Provider type. The Contractor shall notify Providers ninety (90) Calendar Days before implementing significant changes to Claims coding and processing guidelines. DCH's definition of 'significant' shall be binding.	No. We did not identify a CareSource policy which includes the 90 calendar day requirement for notification of providers prior to implementing significant changes to claims coding and processing guidelines. All other provisions of section 4.16.1.12 were addressed by CareSource policies and procedures.
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. We did not identify a CareSource policy containing the required submission timeframes for global claims analyses, however, CareSource does appear to adhere to the contract requirement based on the GA Families CMO Schedule of Reports which shows the Global Claims Analysis Report as being delivered quarterly.
4.16.1.14 The Contractor's web site shall be functionally equivalent to the web site maintained by the State's Medicaid Fiscal Agent Contractor.	Yes
8.4.1 Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the Health Care expenses of the Member.	Yes
8.4.1.1 Pursuant to Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D, DCH hereby authorizes the Contractor as its Agent to identify and cost avoid Claims for all CMO Members, including PeachCare for Kids® Members.	Yes

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
8.4.1.2 The Contractor shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to CMO Members. To the extent permitted by State and federal law, the Contractor shall use Cost Avoidance processes to ensure that primary payments from the liable third party are identified, as specified below in Section 8.4.2.	Yes
8.4.1.3 If the Contractor is unsuccessful in obtaining necessary cooperation from a Member to identify potential Third Party Resources after sixty (60) Calendar Days of such efforts, the Contractor may inform DCH, in a format to be determined by DCH, that efforts have been unsuccessful.	Yes
8.4.1.4 For situations other than Medicare payments where payment is already made to the Provider by the CMO, the CMO shall coordinate with the other responsible payer and shall not recoup funds directly from the Provider and cause the Provider to have to resubmit claims to the other responsible payer.	Yes
8.4.2.1 The Contractor shall cost avoid all Claims or services that are subject to payment from a third party health insurance carrier, and may deny a service to a Member if the Contractor is assured that the third party health insurance carrier will provide the service, with the exception of those situations described below in Section 8.4.2.2. However, if a third party health insurance carrier requires the Member to pay any cost-sharing amounts (e.g., co-payment, coinsurance, deductible), the Contractor shall pay the cost sharing amounts. The Contractor's liability for such cost sharing amounts shall not exceed the amount the Contractor would have paid under the Contractor's payment schedule for the service.	Yes
8.4.2.2 Further, the Contractor shall not withhold payment for services provided to a Member if third party liability, or the amount of third party liability, cannot be determined, or if payment will not be available within sixty (60) Calendar Days.	Yes
8.4.2.3 The requirement of Cost Avoidance applies to all Covered Services except Claims for labor and delivery, including inpatient hospital care and postpartum care, prenatal services, preventive pediatric services, and services provided to a dependent covered by health insurance pursuant to a court order. For these services, the Contractor shall ensure that services are provided without regard to insurance payment issues and must provide the service first. The Contractor shall then coordinate with DCH or its Agent to enable DCH to recover payment from the potentially liable third party.	Yes
8.4.2.4.1 Pursue a cause of action against any person who was responsible for payment of the services at the time they were	Yes

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
provided but may not recover any payment made to the Provider; and	
8.4.2.4.2 Pay the Provider only the amount, if any, by which the Provider's allowable Claim exceeds the amount of third party liability.	Yes
8.4.2.5 If the provider determines that a person other than the Contractor to which it has submitted a Claim is responsible for coverage of the Member at the time the service was rendered, the provider may submit the claim to the person that is responsible and that person shall reimburse all Medically Necessary Services without application of any penalty for failure to file claims in a time manner, for failure to obtain Prior Authorization, or for the provider not being a participating provider in the person's network, and the amount of reimbursement shall be that person's applicable rate for the service if the provider is under contract with that person or the rate paid by the DCH for the same type of claim that it pays directly if the provider is not under contract with that person.	Yes

Overview of Claims Management including Third Party Liability and On-Site Observations

Claims Management

According to CareSource's claims operations policy and procedures, the CMO will pay providers for covered medically necessary services that are rendered to its members in accordance with DCH's claim management requirements. CareSource's provider manual states that initial claims must be received within 180 days from the date of service or date of discharge to be considered for payment. CareSource accepts both paper and electronic claims; however, electronic submission is the preferred format. To promote electronic claims submission, providers are advised of some of the advantages of electronic claim submission which include faster processing, reduced potential errors, reduced likelihood of missing information, and faster feedback on claim status.

Claims filed that meet the definition of a "clean" claim will pay or deny within fifteen (15) business days of receipt. CareSource monitors claims daily as they mature to ensure the prompt pay deadline is not exceeded. The claims are grouped in "buckets" by the number of days, for example 1-10; 11-20, etc. These buckets are processed and monitored to make sure claims do not exceed the fifteen (15) business day rule. Claims aging at eleven (11) days and above are escalated to a team dedicated to their resolution within the prompt pay guidelines.

Unpaid or incorrectly paid "clean" claims and claims that exceed the fifteen (15) business day prompt pay rule are entitled to interest in the amount of 12% annual calculated daily for every

day past the 15th day. Claims that are initially denied or underpaid by CareSource, but later processed and paid will reimburse the provider the amount determined to be owed in addition to interest at an annual rate of 20% calculated from fifteen (15) calendar days after the submission date of the claim. Interest is paid to both in-network and out-of-network providers for both paper and electronic claims. Claims received that do not meet the requirements of a clean claim will suspend within fifteen (15) business days of receipt. CareSource will submit a written request to the provider asking for the information deemed necessary to make the claim "clean" for processing. This process takes place within the initial 15 business days. Upon receipt of all requested information, the claim will be processed within fifteen (15) business days.

Third Party Liability/Coordination of Benefits

Third party liability (TPL) and coordination of benefits (COB) claims are responsible for the highest number of pended claims. Third party liability refers to the legal responsibility of insurers to pay all or part of medical claims, while coordination of benefits establishes the order in which insurance plans pay claims when a member is covered by more than one plan.

The TPL/COB claim process begins with the provider submitting a claim containing COB information. A claims analyst reviews the claim in *Facets* and enters "new" on the line with the claim identification number. This action indicates the claim needs to be processed by the analysts who handle TPL/COB claims. The TPL/COB claims analyst reviews the COB information to determine whether or not it is accurate and meets claims processing requirements. They determine accuracy by calling the other insurance company to verify the coverage. They may also utilize a web portal supplied by *Emdeon* (also known as Change Health Care) to validate the members other insurance coverage. Once validation is complete, the member information and claim information are updated in *Facets* for claim processing. The TPL/COB claims are manually priced. In the event a recovery of funds is due from the other insurance company or a claims should not have been paid, the TPL/COB analysts perform post payment adjustments and utilize HMS (Health Management Systems) to recover funds due to CareSource.

Additional Observations: Claims Management including Third Party Liability

- According to Denise Craven, Manager of Claims Operational Integrity, CareSource's "clean" claim percentage for 3rd Quarter of 2018 was 92%.
- Per Denise Craven, Manager of Claims Operational Integrity, 12-15 inpatient transfer claims (per day) require manual pricing due to the need to verify the qualification for non-transfer DRG rate and 48-75 claims (per day) pend, erroneously for manual price review due to fee schedule load.
- Approximately 15% of Georgia claims pend for manual review.
- At the corporate level, Emdeon (Change Health Care) is the COB vendor for CareSource.
- High dollar thresholds are factored based on the claim's paid amount. Approval tiers for analysts begin at $40,000 and team leads may approve up to $100,000.
- As of November 11, 2018, CareSource received 95% electronic claims, 4.3% paper claims and 0.7% provider web portal claims.

After review of CareSource's policies and procedures for claims management including third party liability, we did not identify policies or standard operating procedures for contract sections 4.16.1.11, 4.16.1.12 and 4.16.1.13. We recommend that CareSource, in accordance with their contract with DCH, create policies to address the contract requirements outlined in these areas.

Compliance Plan

We interviewed CareSource staff members and reviewed CareSource's existing policies and procedures in relation to the compliance plan. In the table below, we identified the key contract requirements and whether CareSource has policies and procedures consistent with the contract requirement(s).

Contract Requirements and Consistency of CareSource Policies and Procedures for the Compliance Plan

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.13.2.1.1 The designation of a Compliance Officer who is accountable to the Contractor's senior management and is responsible for ensuring that policies to establish effective lines of communication between the Compliance Officer and the Contractor's staff, and between the Compliance Officer and DCH staff, are followed.	Yes
4.13.2.1.2 Provision for internal monitoring and auditing of reported Fraud, Waste and Abuse violations, including specific methodologies for such monitoring and auditing;	Yes
4.13.2.1.3 Policies to ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's Fraud, Waste and Abuse compliance plan;	Yes
4.13.2.1.4 Policies to establish a compliance committee that meets quarterly and reviews Fraud, Waste and Abuse compliance issues;	Yes
4.13.2.1.5 Policies to ensure that any individual who reports CMO violations or suspected Fraud, Waste and Abuse will not be retaliated against;	Yes
4.13.2.1.6 Policies of enforcement of standards through well-publicized disciplinary standards;	Yes
4.13.2.1.7 Provision of a data system, resources and staff to perform the Fraud, Waste and Abuse and other compliance responsibilities;	Yes
4.13.2.1.8 Procedures for the detection of Fraud, Waste and Abuse that includes, at a minimum, the following: 4.13.2.1.8.1 Prepayment review of claims; 4.13.2.1.8.2 Claims edits;	Yes

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.13.2.1.8.3 Post-processing review of Claims; 4.13.2.1.8.4 Provider profiling; 4.13.2.1.8.5 Quality Control; and 4.13.2.1.8.6 Utilization Management.	
4.13.2.1.9 Written standards for organizational conduct;	Yes
4.13.2.1.10 Effective training and education for the Compliance Officer and the organization's employees, management, board Members, and Subcontractors;	Yes
4.13.2.1.11 Inclusion of information about Fraud, Waste and Abuse identification and reporting in Provider and Member materials;	Yes
4.13.2.1.12 Provisions for the investigation, corrective action and follow-up of any suspected Fraud, Waste and Abuse reports;	Yes
4.13.2.1.13 Procedures for notification to DCH Office of the Inspector General requesting permission before initiating an investigation, notifying a provider of the outcome of an investigation, and/or recovery of any overpayments identified;	Yes
4.13.2.1.14 Procedures for reporting suspected Fraud, Waste and Abuse cases to the Georgia Medicaid Fraud Control Unit, through the State Program Integrity Unit, including timelines and use of State approved forms.	Yes

Overview of Compliance Plan

CareSource's compliance plan and standards of conduct apply to all lines of business, legal entities, and markets. The compliance plan is a tool utilized to describe the expectations of employees, vendors and providers as it relates to the program functional areas such as code of conduct, hotline reporting, monitoring, oversight, corrective action plans (CAPs), etc. CareSource employs a corporate compliance officer whose responsibility is to ensure an effective compliance plan, oversee its daily operations, and ensure compliance of the workforce.

The corporate compliance committee is a group of senior executives representing different areas of the corporation such as legal, information technology (IT), privacy, finance, operations, internal audit, special investigations unit (SIU), enterprise risk leaders, non-voting members and the markets. Individuals from quality and clinical are also included to address case management and disease management activities. The committee meets bi-monthly to review high risk compliance items such as audit results (internal and external), CAPs, and material regulatory sanctions. From a market perspective, the compliance committee identifies trends, patterns, or areas of risk, and escalates them up to corporate where both levels monitor them through resolution. The functional areas represented in the market compliance

committee meetings vary depending on the activities within the market. These quarterly meetings may include representatives from quality, program integrity, UM, Care4U call center, pharmacy, behavioral health, encounters, delegated oversight, contracting, IT, grievances, appeals and fraud, waste and abuse (FWA). Both the corporate and market compliance committees share the responsibility of monitoring the activities of committees such as the Delegation Oversight Committee, Ethics Committee, Investigative Committee, Policy and Procedure Committee and other product specific compliance sub-committees.

CareSource requires certain compliance trainings for their entire workforce which consists of all employees, including senior and executive management, consultants, temporaries, contractors, interns, volunteers, committee and board members and any other person or entity providing services for the CareSource Family of Companies. The trainings for the workforce are administered ninety (90) days from the date of hire and annually thereafter. The subject areas include Compliance, Code of Conduct, Health Insurance Portability and Accountability Act (HIPAA) Privacy, Fraud, Waste and Abuse (FWA) and Security. A quiz is taken upon completion of the training where an 80% pass rate is required for most subject areas.

Employee trainings are tracked in *Cornerstone*. *Cornerstone* is reviewed periodically to ensure compliance with the required courses. Employees who fail to complete the yearly compliance trainings before the deadlines will be reported to management. In addition, the failure to complete the required trainings will be documented in the employees performance evaluation and the employee will be denied access (i.e. cannot log in) to CareSource systems until the required trainings are completed.

Delegated subcontractors and vendors are required to complete the yearly compliance training. The subcontractors have the option of using CareSource's training material or they can create and use their own with CareSource approval. The completion of compliance training by delegated subcontractors is validated as part of CareSource's annual oversight.

Myers and Stauffer determined CareSource's policies and procedures are consistent with the DCH contract for corporate compliance.

Grievances and Appeals

We interviewed CareSource staff members and reviewed CareSource's existing policies and procedures in relation to grievances and appeals. In the table below, we identified the key contract requirements and whether CareSource has policies and procedures consistent with the contract requirement(s).

Contract Requirements and Consistency of CareSource Policies and Procedures for Grievances and Appeals

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.14.1.1 The Contractor's Grievance System shall include a process to receive, track, resolve and report on Grievances from its Members. The Contractor's Appeals Process shall include an Administrative Review process and access to the State's Administrative Law Hearing (State Fair Hearing) system. The Contractor's Appeals Process shall include an internal process that must be exhausted by the Member prior to accessing an Administrative Law Hearing. See O.C.G.A. §49-4-153.	Yes
4.14.1.2 The Contractor shall develop written Grievance System and Appeals Process Policies and Procedures that detail the operation of the Grievance System and the Appeals Process. The Contractor's policies and procedures shall be available in the Member's primary language. The Grievance System and Appeals Process Policies and Procedures shall be submitted to DCH for initial review and approval, and as updated thereafter.	Yes
4.14.1.3 The Contractor shall process each Grievance and Administrative Review using applicable State and federal laws and regulations, the provisions of this Contract, and the Contractor's written policies and procedures. Pertinent facts from all parties must be collected during the investigation.	Yes
4.14.1.4 The Contractor shall give Members any reasonable assistance in completing forms and taking other procedural steps for both Grievances and Administrative Reviews. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTD and interpreter capability.	Yes
4.14.1.5 The Contractor shall acknowledge receipt of each filed Grievance and Administrative Review in writing within ten (10) Business Days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Grievance and Appeal resolutions.	Yes
4.14.1.6 The Contractor shall ensure that the individuals who make decisions on Grievances and Administrative Reviews were not involved in any previous level of review or decision making; and are Health Care Professionals who have the appropriate clinical expertise, as determined by DCH, in treating the Member's Condition or disease if deciding any of the following:	Yes
4.14.1.6.1 An Appeal of a denial that is based on lack of Medical Necessity;	Yes
4.14.1.6.2 A Grievance regarding denial of expedited resolutions of an Administrative Review; and	Yes
4.14.1.6.3 Any Grievance or Administrative Review that involves clinical issues.	Yes

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.14.3.1 A Member or Member's Authorized Representative may file a Grievance to the Contractor either orally or in writing. A Grievance may be filed about any matter other than a Proposed Action. A Provider cannot file a Grievance on behalf of a Member.	Yes
4.14.3.2 The Contractor shall ensure that the individuals who make decisions on Grievances that involve clinical issues are Health Care Professionals, under the supervision of the Contractor's Medical Director, who have the appropriate clinical expertise, as determined by DCH, in treating the Member's Condition or disease and who were not involved in any previous level of review or decision-making.	Yes
4.14.3.3 The Contractor shall acknowledge receipt of each filed Grievance in writing within ten (10) Calendar days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Grievance resolutions.	Yes
4.14.3.4 The Contractor shall issue disposition of the Grievance as expeditiously as the Member's health condition requires but such disposition must be completed within ninety (90) Calendar Days of the filing date.	Yes

Overview of Grievances and Appeals and On-Site Observations

Grievances

CareSource members are entitled to submit a grievance for matters such as dissatisfaction with the quality of care provided, rude providers or office staff, dissatisfaction with access to providers or failure to respect the member's rights as a Medicaid participant. A grievance cannot be used to express dissatisfaction with an action or proposed action such as denying or limiting authorization of a requested service, reducing, suspending, or terminating a previously authorized service, or denying payment for a service.

The member, the legal guardian of the member (for a minor or incapacitated adult), or a representative of the member as designated in writing (to CareSource) may file a grievance on the member's behalf. CareSource does not allow a provider to file a grievance on behalf of a member unless he/she is acting as the member's authorized representative and/or has the member's written permission. CareSource will provide a reasonable amount of assistance, such as guidance with the completion of forms, to members seeking to submit a grievance.

Grievances may be filed orally or in writing. CareSource acknowledges the receipt of the grievance by sending a letter to the individual who filed it within ten (10) business days. The acknowledgement letter includes the expected date of resolution. CareSource will investigate the grievance and respond in writing to the requestor no later than ninety (90) days of receipt.

Appeals

CareSource members are entitled to submit an appeal for an action or proposed action. The member, the member's authorized representative, or a provider who has been given written consent to act on the member's behalf may file an appeal. CareSource will provide a reasonable amount of assistance, such as guidance with the completion of forms, to members seeking to submit an appeal.

Appeals may be filed orally or in writing. Members have up to thirty (30) calendar days after receiving notice of an action or proposed action to file an appeal. CareSource acknowledges the receipt of the appeal by sending a letter to the individual who filed it within ten (10) business days of receipt. The acknowledgement includes the expected date of resolution. The appeals department will initiate the investigation and resolution process. Appeal staff will contact the provider to allow them to submit additional information relating to the appeal which has to be submitted within two (2) business days. Clinical information submitted will be reviewed by an appeal nurse who will perform the initial review. The nurse reviewer may uphold the initial decision or overturn the initial decision based on the review of new and/or previously un-submitted clinical information that supports medical necessity. In the event the appeal nurse is unable to confirm medical necessity with the clinical information submitted in support of the appeal, the information will be forwarded to a medical director for review and decision.

The appeal decision will be communicated to the individual who initiated the appeal no later than ninety (90) days of receipt. The next level of appeal is described in the decision letter if the appeal results in the initial decision are being upheld.

Additional Observations: Grievances and Appeals

- At the time of the review, the percentage of pharmacy appeals was 11.3%.
- When asked to provide the percentage of overturned appeals from 7/2017 – present, we were advised that the percentage was 26.6%.
- At the time of the review, there were 471 grievances from July 2017 to November 2018.

Myers and Stauffer determined CareSource's policies and procedures are consistent with DCH contract for grievances and appeals.

Member and Provider Data Maintenance

We interviewed CareSource staff members and reviewed CareSource's existing policies and procedures in relation to member and provider data maintenance. In the table below, we identified the key contract requirements and whether CareSource has policies and procedures consistent with the contract requirement(s).

Contract Requirements and Consistency of CareSource Policies and Procedures for Member and Provider Data Maintenance

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.17.1.1 The Contractor shall have Information management processes and Information Systems (hereafter referred to as Systems) that enable it to meet GF requirements, State and federal reporting requirements, all other Contract requirements and any other applicable State and federal laws, rules and regulations, as amended, including HIPAA.	No. We did not identify a CareSource policy which addresses the requirement to have information management processes and information systems that meet requirements for GF, state and federal reporting among others.
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.	Yes
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. We did not identify a CareSource policy addressing the requirement of maintaining scalable systems with the capacity to handle the workload projected for the start of the program.
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.	Yes
4.17.1.4 The Contractor shall attend DCH's Systems Work Group meetings as scheduled by DCH. The Systems Work Group will meet on a designated schedule as agreed to by DCH, its Agents and every Contractor.	Yes
4.17.1.5.1 Available from the workstations of the designated Contractor contacts; and	Yes
4.17.1.5.2 Capable of attaching and sending documents created using software products other than Contractor systems, including the State's currently installed version of Microsoft Office and any subsequent upgrades as adopted.	Yes
4.17.1.6 By no later than the 30th of April of each year, the Contractor will provide DCH with an annual	Yes

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
progress/status report of the Contractor's Systems refresh plan for the upcoming State fiscal year. The plan will outline how Systems within the Contractor's Span of Control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or Systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. The Systems refresh plan will also indicate how the Contractor will ensure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF) or a third party authorized by the OEM and/or SDF to support the Systems' components.	
4.17.1.7 The Contractor is responsible for all costs associated with the Contractor's Systems refresh plan.	Yes
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.	Yes
4.17.2.2 The Contractor shall develop an incentive program for the adoption and utilization of electronic health records that result in improvements in the Quality and cost of health care services. This incentive program shall be submitted to DCH initially and as revised thereafter. The Contractor shall provide to DCH quarterly reports illustrating adoption of electronic health records by Providers.	No. We did not identify a CareSource policy defining an incentive program for the adoption and utilization of electronic health records.
4.17.2.3 The Contractor shall participate in the Georgia Health Information Network (GaHIN) as a Qualified Entity (QE).	Yes
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	Yes

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
successful completion of the GaHIN accreditation process;	
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;	Yes
4.17.2.3.3 DCH and/or its designee shall provide detailed on-boarding information for use by the Contractor to establish interoperability with the GaHIN; and	Yes
4.17.2.3.4 Costs incurred by the Contractor to establish interoperability with the GaHIN shall be the sole responsibility of the Contractor.	Yes
4.17.2.4 The Contractor shall make Member health information accessible to the GaHIN.	Yes
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. We did not identify a CareSource policy requiring member specific patient health information.
4.17.2.4.1.2 Name and address of each Member's PCP;	No. We did not identify a CareSource policy requiring the name and address of each member's PCP.
4.17.2.4.1.3 Acquisition and retention of the Member's Medicaid ID;	No. We did not identify a CareSource policy requiring the acquisition and retention of the member's Medicaid ID.
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. We did not identify a CareSource policy requiring the acquisition and retention of provider specific information.
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. We did not identify a CareSource policy which requires a record be kept of each member service event with a physician or other provider.
4.17.2.4.1.6 Record of future scheduled service appointments, if available, and referrals;	No. We did not identify a CareSource policy requiring a record be kept of future scheduled appointments and/or referrals.
4.17.2.4.1.7 Complete record of all immunizations;	No. We did not identify a CareSource policy which requires

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
	maintaining a complete record of all member's immunizations.
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. We did not identify a CareSource policy which requires a listing of the member's durable medical equipment.
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. We did not identify a CareSource policy acknowledging the code sets used along with a description.
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. We did not identify a CareSource policy which states the purpose for accessing the GaHIN is to display member information for use in care coordination and member management.
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. We did not identify a CareSource policy requiring a detailed list of authorized users be provided to DCH for approval and restricting access to the GA contract only.
4.17.2.8 The Contractor shall encourage contracted Providers' participation in the GAHIN as well.	Yes

Overview of Member and Provider Data Maintenance and On-Site Observations

According to CareSource personnel, the CMO has a fully automated 834 member data file process for member data maintenance. CareSource receives and processes 834 files from DCH daily. The *Facets* system imports the EDI transactions and places them into staging databases. The system performs a comparison of the member data and validates member points such as social security numbers or Medicaid IDs, in addition to, key values such as eligibility dates and timelines. In the event that comparison identifies invalid data, the member cases would go into a queue to be worked by the business owners. The system performs updates of valid data to existing member files and new member updates. During the update process, the data from DCH is not over-written.

CareSource has an enrollment team that is totally dedicated to performing member enrollment and maintenance processes for the state of Georgia. They confirm that all files have been received and ensure that the delegated vendors receive updated member information.

Delegated vendors are required to reconcile with the CareSource data. As an audit path, the IT department takes a flat file from the vendor and reconciles/compares to information contained in *Facets*. The data comparison process is automated. Any "fall out" issues or vendor and *Facets* member data mismatches are captured in a daily "fall out" report that is worked by the business owners. CVS reconciliation of issues on the "fall out" report is performed weekly.

CareSource utilizes HMS as their vendor to validate member coordination of benefit (COB) information. The process for validating the COB information from HMS is automated. Member data is submitted to HMS on a weekly basis. HMS compares CareSource member data against their information that comes from national data bases. Upon completion of their processes, HMS submits a response file to CareSource. If the response file indicates that the information is accurate, CareSource uploads the COB information into *Facets*. In the event there is inaccurate information or new or different information is provided by HMS, the TPL/COB team will apply certain criteria to determine which COB information should be included in *Facets*. The TPL/COB team will look at claims information, HMS data, and information regarding when was the last time the COB information was verified. CareSource will use the most recent information that includes all segments needed to load information into *Facets*. In addition to housing the member data, the system also contains the provider information for Georgia.

CareSource receives a 7400 provider data file from the State on a daily basis. The 7400 file is loaded in a staging area and the provider data is compared against the provider data in *Facets*. The provider focus group team performs demographic updates in *Facets*. According to CareSource personnel, the updates are a manual process. Reports are then generated including the outbound 7430 file which goes to DCH. The aforementioned is the process for providers that are under contract. Newly contracted providers are loaded into *Facets* by the Provider Information Management group.

After review of CareSource's policies and procedures for member and provider data maintenance, we did not identify policies or standard operating procedures for contract sections 4.17.1.1, 4.17.1.2, 4.17.2.2, 4.17.2.4, 4.17.2.4.1, 4.17.2.4.11, 4.17.2.4.2, 4.17.2.4.3, 4.14.17.2.4.4, 14.17.2.4.5, 14.17.2.4.6, 14.17.2.4.7, 14.17.2.8, 4.17.2.9, 4.17.2.5, 4.17.2.6 and 4.17.2.8. We recommend that CareSource, in accordance with their contract with DCH, create policies to address the contract requirements outlined in these areas.

Member Services

We interviewed CareSource staff members and reviewed CareSource's existing policies and procedures in relation to member services. In the table below, we identified the key contract requirements and whether CareSource has policies and procedures consistent with the contract requirement(s).

Contract Requirements and Consistency of CareSource Policies and Procedures for Member Services

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.3.1.1.1 Member rights and responsibilities;	Yes
4.3.1.1.2 The role of PCPs and Dental Home;	Yes
4.3.1.1.3 The role of the Family Planning Provider and PCP (for IPC P4HB Participants only);	Yes
4.3.1.1.4 How to obtain care;	Yes
4.3.1.1.5 What to do in an emergency or urgent medical situation (for P4HB participants information must address what to do in an emergency or urgent medical situation arising from the receipt of Demonstration related Services);	Yes
4.3.1.1.6 How to request a Grievance, Appeal, or Administrative Law Hearings;	Yes
4.3.1.1.7 How to report suspected Fraud and Abuse;	Yes
4.3.1.1.8 Providers who have been terminated from the Contractor's network;	Yes
4.3.1.2 The Contractor must be prepared to utilize all forms of population-appropriate communication to reach the most Members and engender the most responses. Examples of communications include but are not limited to telephonic; hard copy via mail; social media; texting; and email that allow Members to submit questions and receive responses from the Contractor while protecting the confidentiality and PHI of the Members in all instances. The Contractor shall attempt to collect/obtain Member email addresses from Members. Upon request, the Contractor must provide materials in the format preferred by the Member.	Yes

Overview of Member Services and On-Site Observations

CareSource member advocates are the first point of contact for members. Member advocates are responsible for educating members about their rights and responsibilities. They respond to questions regarding benefit coverage, finding a doctor, obtaining a new identification card (ID), requesting transportation, and any member related questions. CareSource utilizes a system called *Streamline* to verify member information and record notes from all member contacts. The notes entered by the member advocates typically include subject, category, and their responses to member questions. *Streamline* is also used to assign members to a PCP and contains a benefit grid to be used by the member advocates to educate members on covered and non-covered services.

CareSource members can also contact their Ombudsman liaison for assistance. The Ombudsman liaison's role is to provide assistance to members with issues that member advocates are unable to resolve. They assist members and providers with coordinating

services including services provided by local community organizations. The Ombudsman liaison works with DCH on issues such as member access to health care and identifying communication and educational needs of members, caregivers, and providers.

Additional Observations: Member Services

- The ombudsman sends information on members who require additional assistance to the call center operations manager for research and resolution.
- Per Steve Beauford, Operations Manager of the Call Center, there are three (3) designated representatives to handle cases sent by the ombudsman. The resolution target time is seventy-two (72) hours.
- Member services representatives may be contacted via telephone and chat. There are two (2) designated staff who respond to member chat requests from 7 am until 7 pm.
- It generally takes seven (7) days for a member to receive a new or replacement identification card.
- Member services representatives assist members with transportation requests by utilizing member location and/or demographic information to assign a vendor.

Myers and Stauffer determined CareSource's policies and procedures for member services were in accordance with the DCH contract.

Provider Complaints

We interviewed CareSource staff members and reviewed CareSource's existing policies and procedures in relation to provider complaints. In the table below, we identified the key contract requirements and whether CareSource has policies and procedures consistent with the contract requirement(s).

Contract Requirements and Consistency of CareSource Policies and Procedures for Provider Complaints

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.9.7.1 The Contractor shall establish a Provider Complaint system that permits a Provider to dispute the Contractor's policies, procedures, or any aspect of a Contractor's administrative functions.	Yes
4.9.7.2 The Contractor shall submit its Provider Complaint System Policies and Procedures to DCH for review and approval quarterly and annually and as updated thereafter. The Contractor shall include its Provider Complaint System Policies and Procedures in its Provider Handbook that is distributed to all network Providers. This information shall include, but not be limited to, specific instructions regarding how to contact the Contractor's Provider services to file a Provider complaint and	Yes

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
which individual(s) have the authority to review a Provider complaint.	
4.9.7.3 The Contractor shall distribute the Provider Complaint System Policies and Procedures to Out-of-Network Providers with the remittance advice of the processed Claim. The Contractor may distribute a summary of these Policies and Procedures if the summary includes information on how the Provider may access the full Policies and Procedures on the Web site. This summary shall also detail how the Provider can request a hard copy from the Contractor at no charge to the Provider.	Yes
4.9.7.4.1 Allow Providers thirty (30) Calendar Days from the date of issue or incident to file a written complaint;	Yes
4.9.7.4.2 Allow Providers to consolidate complaints or appeals of multiple Claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment Claims included in the bundled complaint or appeal;	Yes
4.9.7.4.3 Require that Providers' complaints are clearly documented;	Yes
4.9.7.4.4 Allow a Provider that has exhausted the Contractor's internal appeals process related to a denied or underpaid Claim or group of Claims bundled for appeal the option either to pursue the administrative appeals process described in O.C.G.A. § 49-4-153(e) or to select binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution as described in O.C.G.A. § 33-21A-7. If the Contractor and the Provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Code section shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) Calendar Days of being selected, unless the Contractor and the Provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties;	Yes
4.9.7.4.5 For all Claims that are initially denied or underpaid by the Contractor but eventually determined or agreed to have been owed by the Contractor to a provider of health care services, the Contractor shall pay, in addition to the amount determined to be owed, interest of twenty percent (20%) per annum (based on simple interest calculations), calculated from fifteen (15) Calendar Days after the date the Claim was submitted. The Contractor shall pay all interest required to be paid under this provision or Code Section O.C.G.A. 33-21A-7 automatically and	Yes

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
simultaneously whenever payment is made for the Claim giving rise to the interest payment;	
4.9.7.4.6 Accurately identify all interest payments on the associated remittance advice submitted by the Contractor to the Provider;	Yes
4.9.7.4.7 Require that Providers exhaust the Contractor's internal Provider Complaint process prior to requesting an Administrative Law Hearing (State Fair Hearing);	Yes
4.9.7.4.8 Have dedicated staff for Providers to contact via telephone, electronic mail, or in person, to ask questions, file a Provider Complaint and resolve problems;	Yes
4.9.7.4.9 Identify a staff person specifically designated to receive and process Provider Complaints;	Yes
4.9.7.4.10 Thoroughly investigate each GF Provider Complaint using applicable statutory, regulatory, and Contractual provisions, collecting all pertinent facts from all parties and applying the Contractor's written policies and procedures; and	Yes
4.9.7.4.11 Ensure that Contractor executives with the authority to require corrective action are involved in the Provider Complaint process.	Yes

Overview of Provider Complaints and On-Site Observations

CareSource allows providers to file complaints regarding the CMO's policies, procedures, or other administrative functions. Provider complaints must be submitted within thirty (30) calendar days of the incident. Complaints must be submitted in writing via the mail or through the provider web portal. Complaints received via the web portal are automatically loaded into a system called *OnBase*. Providers are permitted to consolidate multiple claims into a single complaint if they all have similar issues.

Complaints received in any other written format are loaded into *OnBase* manually by the grievance and appeals specialists. Grievance and appeals specialists receive their work via a queue in *OnBase*. Complaints are reviewed to determine the nature of the complaint which may involve contacting the provider for clarity. If the grievance and appeals specialist is unable to contact the provider or obtain necessary information via the telephone, they will send a letter to the provider requesting that the complaint be resubmitted with more information and/or supporting documentation. The specialist, upon receipt of the information necessary to resolve the complaint, will conduct research, determine action steps, develop an understanding of issue, coordinate with other departments to resolve the matter as appropriate, and issue a written resolution to the provider within thirty (30) days.

OnBase is used to monitor and track provider complaints. The *OnBase* system captures the date the complaint was received; the category/type of complaint based on DCH's criteria; an explanation of the nature of the complaint; the action steps taken; and the resolution letter sent to the provider.

Additional Observations: Provider Complaints

- The same staff work member grievances and provider complaints.
- On average, CareSource receives one provider complaint each week.
- Providers may request an Administrative Law Hearing or request binding arbitration. These are not options for members.
- Provider complaints and grievances including those pertaining to the delegated vendors go through CareSource.

Myers and Stauffer determined CareSource's policies and procedures for provider complaints were in accordance with the DCH contract.

Provider Network Management

We interviewed CareSource staff members and reviewed CareSource's existing policies and procedures in relation to provider network management. In the table below, we identified the key contract requirements and whether CareSource has policies and procedures consistent with the contract requirement(s).

Contract Requirements and Consistency of CareSource Policies and Procedures for Network Management

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.8.1.1 The Contractor shall develop and maintain a network of Providers and facilities adequate to deliver Covered Services as described in the RFP and this Contract while ensuring adequate and appropriate provision of services to Members in rural areas, and which may include the use of telemedicine when appropriate to the condition and needs of the Member. The Contractor is solely responsible for providing a network of physicians, pharmacies, hospitals, physical therapists, occupational therapists, speech therapists, Border Providers and other health care Providers through whom it provides the items and services included in Covered Services.	Yes
4.8.1.2 The Contractor shall include in its network only those Providers that have been appropriately credentialed by DCH or its Agent, that maintain current license(s), and that have appropriate locations to provide the Covered Services.	Yes
4.8.1.3 The Contractor's Provider Network shall reflect, to the extent possible, the diversity of cultural and ethnic backgrounds	Yes

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
of the population served, including those with limited English proficiency.	
4.8.1.4 The Contractor shall notify DCH sixty (60) Calendar Days in advance when a decision is made to close network enrollment for new Provider contracts and also notify DCH when network enrollment is reopened. The Contractor must notify DCH sixty (60) Calendar Days prior to closing a Provider panel.	Yes
4.8.1.5 The Contractor shall not include any Providers who have been excluded from participation by the United States Department of Health and Human Services, Office of Inspector General, or who are on the State's list of excluded Providers. The Contractor shall check the exclusions list on a monthly basis and shall immediately terminate any Provider found to be excluded and notify the Member per the requirements outlined in this Contract.	Yes

Overview of Provider Network Management and On-Site Observations

CareSource is required by contract to develop and maintain an adequate network of providers and facilities to deliver services to their members. The network should contain hospitals, physicians, pharmacies, physical therapists, occupational therapists, speech therapists, border providers, and other health care providers. The network must also ensure adequate services to CareSource's members residing in rural areas.

According to Tonya Davis, Director of Network Development, the primary way CareSource ensures an adequate provider network is by recruiting. The health partners, also identified as provider field representatives, play an essential role in ensuring the adequacy of the network. They assess the needs of the network by reviewing monthly adequacy reports from the enterprise team. The adequacy reports are reviewed to ensure that each member has at least 90% access to providers in their county. If they identify an area(s) of deficiency, they initiate recruiting efforts for the deficient specialty within in specified regions and/or counties.

CareSource uses the 7400 file to identify providers who are enrolled as Medicaid providers with DCH and it is used in conjunction with the adequacy report to identify providers to recruit. Their recruiting engagement consists of contacting the providers in the deficient area with the desired specialty who are credentialed and have a Medicaid provider number. They attempt to negotiate contracts with the providers. New providers who choose to participate must complete the electronic health partner contracting form found on the CareSource website. The contract administration department processes the health partner contracting form which includes confirming the provider's status with DCH via the Credentialing Verification Organization (CVO). The entire contracting process takes approximately forty-five (45) days.

CareSource attempts to negotiate single case agreements with providers that choose to not sign a contract for network participation in order to address network gaps. Bi-weekly meetings are held to discuss the progress of recruiting efforts.

Additional Observations: Provider Network Management

- There are fifteen (15) health partner representatives throughout the state of Georgia working to recruit and retain network providers.
- CareSource representatives indicated a provider with a Georgia Medicaid number, who is able to be credentialed by the CVO, would be accepted into the network regardless of whether or not geographic or specialty deficiencies exist in the provider's area.
- CareSource does not include any providers in its network who are on the Georgia's list of excluded providers or who have been excluded from participation by U.S. HHS, and/or OIG.

Myers and Stauffer determined CareSource's policies and procedures for provider network management were in accordance with the DCH contract.

Quality Improvement

We interviewed CareSource staff members and reviewed CareSource's existing policies and procedures in relation to quality improvement. In the table below, we identified the key contract requirements and whether CareSource has policies and procedures consistent with the contract requirement(s).

Contract Requirements and Consistency of CareSource Policies and Procedures for Quality Improvement

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.12.6.1.1 A method of monitoring, analysis, evaluation and improvement of the delivery, Quality and appropriateness of Health Care furnished to all Members (including under and over Utilization of services), including those with special Health Care needs;	Yes
4.12.6.1.2 Written policies and procedures for Quality assessment, Utilization Management and continuous Quality improvement that are periodically assessed for efficacy;	Yes
4.12.6.1.3 A health information system sufficient to support the collection, integration, tracking, analysis and reporting of data;	Yes
4.12.6.1.4 Designated staff with expertise in Quality assessment, Utilization Management and Care Coordination;	Yes

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.12.6.1.5 Reports that are evaluated, indicated recommendations that are implemented, and feedback provided to Providers and Members;	Yes
4.12.6.1.6 A methodology and process for conducting and maintaining Provider profiling;	Yes
4.12.6.1.7 Ad-Hoc Reports to the Contractor's multi-disciplinary Quality Oversight Committee and DCH on results, conclusions, recommendations and implemented system changes; and annual Performance Improvement Projects (PIPs) that focus on clinical and non-clinical areas;	Yes
4.12.6.1.8 Integration of the results from annual Performance Improvement Projects (PIPs), performance measure rate monitoring, and compliance with federal and state standards;	Yes
4.12.6.1.9 The impact of the Contractor's Member demographics on their ability to improve health outcomes; and	Yes
4.12.6.1.10 A process for evaluation of the impact and assessment of the Contractor's QAPI program.	Yes
4.12.6.2 The Contractor shall conduct PCP and other Provider profiling activities as part of its QAPI Program. Provider profiling must include multi-dimensional assessments of PCPs or Provider's performance using clinical, administrative and Member satisfaction indicators of care that are accurate, measurable and relevant to Members.	Yes
4.12.6.3 The Contractor's QAPI Program Plan must be submitted to DCH for initial review and approval and as updated thereafter.	Yes
4.12.6.4 The Contractor shall submit any changes to its QAPI Program Plan to DCH for review and prior approval sixty (60) Calendar Days prior to implementation of the change.	Yes
4.12.6.5 Upon the request of DCH, the Contractor shall provide any information and documents related to the implementation of the QAPI program.	Yes
4.12.6.6 Annually, the Contractor shall submit to DCH a comprehensive QAPI Report, utilizing the report template that integrates all aspects of the QAPI Plan and tells the story of the effectiveness of the Contractor's QAPI Plan in meeting defined goals and objectives and achieving improved health outcomes for the Contractor's Members. DCH may require interim reports more frequently than annually to demonstrate progress.	Yes
4.12.8.1.1 Be based on the health needs and opportunities for improvement identified as part of the QAPI program;	Yes
4.12.8.1.2 Be based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field;	Yes
4.12.8.1.3 Consider the needs of the Members;	Yes
4.12.8.1.4 Be adopted in consultation with network Providers; and	Yes

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.12.8.1.5 Be reviewed and updated periodically as appropriate.	Yes
4.12.8.2 The Contractor shall submit to DCH for review and prior approval and as updated thereafter all Clinical Practice Guidelines in use, which shall include a methodology for measuring and assessing compliance as part of the QAPI program plan.	Yes
4.12.8.3 The Contractor shall disseminate the guidelines to all affected Providers and, upon request, to Members.	Yes
4.12.8.4 The Contractor shall ensure that decisions for Utilization Management, Member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	Yes
4.12.9.5 To ensure consistent application of the guidelines, the Contractor shall require Providers to utilize the guidelines, and shall measure compliance with the guidelines, until ninety percent (90%) or more of the Providers are consistently in compliance. The Contractor will conduct this review on a quarterly basis. The Contractor may use Provider incentive strategies to improve Provider compliance with guidelines.	Yes
4.12.9.6 To further ensure consistent application of the Clinical Practice Guidelines, the Contractor shall perform a review of a minimum random sample of fifty (50) Members' medical records per evidence-based CPG, each quarter.	Yes

Overview of Quality Improvement and On-Site Observations

CareSource is required to provide for the delivery of quality care with the goal of improving the health of its members. In situations where the member's health status cannot be improved, they must implement measures to prevent further decline of the member's condition and/or deterioration of the member's health. CareSource must create strategies for identifying members at risk of developing health conditions and intervening on their behalf to prevent decline or deterioration of those health conditions. Improving, and in some instances maintaining, the member's health condition will involve the member, providers, community resources and other health agencies. The goal is to improve the member's overall quality of care.

CareSource employs a director of quality improvement to oversee quality improvement (QI). The director and QI team have duties and responsibilities that include overseeing quality assurance, monitoring NCQA standards, ensuring DCH requirements are met, providing evidence based strategies, implementing evidence based interventions and monitoring and evaluating trends along with the utilization management (UM) group. Additional responsibilities include monitoring and evaluating the Care Coordination program and the

Behavioral Health program, overseeing clinical and nonclinical performance improvement projects and assisting the QI committees.

The QI department along with the chief medical officer and the Clinical Advisory Committee, develop, approve and distribute the clinical practice guidelines and preventative health guidelines. CareSource must receive DCH approval of any clinical practice guidelines and methodologies to be used in measuring and assessing compliance.

Myers and Stauffer determined CareSource's policies and procedures for quality improvement were in accordance with the DCH contract.

Utilization Management

We interviewed CareSource staff members and reviewed CareSource's existing policies and procedures in relation to utilization management. In the table below, we identified the key contract requirements and whether CareSource has policies and procedures consistent with the contract requirement(s).

Contract Requirements and Consistency of CareSource Policies and Procedures for Utilization Management

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.11.1.1 The Contractor shall implement innovative and effective Utilization Management processes to ensure a high quality, clinically appropriate yet highly efficient and cost effective delivery system. The Contractor shall continually evaluate the cost and Quality of medical services provided by Providers and identify the potential under and over-utilization of clinical services. The Contractor must apply objective and evidence-based criteria that take the individual Member's circumstances and the local delivery system into account when determining the medical appropriateness of Health Care services.	Yes
4.11.1.2 The Contractor shall enable Pre-Certification of service requests when required and direct providers in making appropriate clinical decisions for the Member in the right setting and at the right time. As part of its regular processes for conducting Utilization Review, the Contractor must evaluate all review requests for Medical Necessity and make recommendations that are more appropriate and more cost-effective. The Contractor should leverage findings from current federal efforts around comparative effectiveness research to support its evaluation of requests.	Yes
4.11.1.3.1 Include protocols and criteria for evaluating Medical Necessity, authorizing services, and detecting and addressing	Yes

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
over-Utilization and under-Utilization. Such protocols and criteria shall comply with federal and State laws and regulations.	
4.11.1.3.2 Address which services require PCP Referral; which services require Prior-Authorization and how requests for initial and continuing services are processed, and which services will be subject to concurrent, retrospective or prospective review.	Yes
4.11.1.3.3 Describe mechanisms in place that ensure consistent application of review criteria for authorization decisions.	Yes
4.11.1.3.4 Require that all Medical Necessity determinations be made in accordance with DCH's Medical Necessity definition as stated in Sections 1.4 and 4.5.4.	Yes
4.11.1.3.5 Provide for the appeal by Members, or their representative, of authorization decisions, and guarantee no retaliation will be taken by the Contractor against the Member for exercising that right.	Yes
4.11.1.4 The Contractor shall submit the Utilization Management Policies and Procedures to DCH for review and prior approval annually and as changed. Nothing in this Section shall prohibit or impede the Contractor from applying a person-centric clinical decision that may vary from the written Utilization Management Policies and Procedures insofar as that decision is accompanied by the clinical rationale for such a decision.	Yes
4.11.1.5 Network Providers may participate in Utilization Review activities to the extent that there is not a conflict of interest. The Utilization Management Policies and Procedures shall define when such a conflict may exist and shall describe the remedy.	No. We did not identify a CareSource policy that defined a conflict of interest where UM was concerned.

Overview of Utilization Management and On-Site Observations

Utilization management (UM) is the means by which CareSource maintains quality and the appropriate use of health care related services to their members. All medical, dental, and behavioral health services that require authorization for payment are evaluated for medical necessity, level of care, clinical appropriateness, and site appropriateness of healthcare services.

Tracy Leslie, the Manager of Utilization Management, oversees the day to day UM processes and monitors the cases that are received. Utilization management requests are received via fax or the provider web portal. Non-clinical prior authorization support staff prepare the requests for clinical review. The cases are distributed to the nurses and clinical staff who review the cases for medical necessity and monitor their turnaround times. The nurses and clinical staff approve the cases within their jurisdiction. Cases that cannot be reviewed by the nurses and clinical staff are sent to the medical director for review. Dr. Mary Gregg is the Medical Director for GA and her primary role is to review cases for medical necessity.

A letter is generated to both the member and provider upon completion of the review. Approvals and denials are accompanied by a letter. In the event of a denial, the letter advises of the right to appeal.

Additional Observations: Utilization Management

- Providers within the Georgia market submit the most authorization requests for therapy cases.
- Genetic testing represents the procedure with the highest number of denied authorizations due to the provider not performing the genetic counseling first.

After review of CareSource's policies and procedures for utilization management, we did not identify policies or standard operating procedures for contract section 4.11.1. We recommend that CareSource, in accordance with their contract with DCH, create a policy to address the contract requirement outlined in this area.

Appendix F – Program Integrity

Myers and Stauffer reviewed the DCH's and CareSource's policies and procedures in relation to program integrity (PI). In the table below, we identified the key contract requirements and whether CareSource has policies and procedures consistent with the contract requirement(s).

Contract Requirements and Consistency of CareSource Policies and Procedures for Program Integrity

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.13.1.1 The Contractor shall have a Program Integrity Program, including a mandatory compliance plan, designed to guard against Fraud and Abuse. This Program Integrity Program shall include policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for suspected cases of Fraud, Waste and Abuse in the administration and delivery of services under this Contract.	Yes
4.13.1.2 The Contractor shall submit its Program Integrity Policies and Procedures, which include the compliance plan and pharmacy lock-in program described below.	Yes
4.13.1.3 The Contractor shall provide DCH with a copy of any Program Integrity settlement agreement entered into with a Provider including the settlement amount and Provider type within seven (7) Business Days of the settlement.	Yes
4.13.2.2 As part of the Program Integrity Program, the Contractor may implement a pharmacy lock-in program. The policies, procedures and criteria for establishing a lock-in program shall be submitted to DCH for review and approval as part of the Program Integrity Policies and Procedures described in Section 4.13.1.	Yes
4.13.2.2.1 Allow Members to change pharmacies for good cause, as determined by the Contractor after discussion with the Provider(s) and the pharmacist. Valid reasons for change should include recipient relocation or the pharmacy does not provide the prescribed drug;	Yes
4.13.2.2.2 Provide Case Management and education reinforcement of appropriate medication use;	Yes
4.13.2.2.3 Annually assess the need for lock in for each Member;	No. We did not identify a CareSource policy addressing the annual requirement of conducting lock in reviews for each CareSource member.

Contract Language	CareSource Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.13.2.2.4 Require that the Contractor's Compliance Officer report on the program on a monthly basis to DCH; and	Yes
4.13.2.2.5 Not allow a Member to transfer to another pharmacy, PCP, or CMO while enrolled in their existing CMO's pharmacy lock-in program.	Yes
4.13.3.1 The Contractor shall cooperate and assist any State or federal agency charged with the duty of identifying, investigating, or prosecuting suspected Fraud, Waste and Abuse cases, including permitting access to the Contractor's place of business during normal business hours, providing requested information, permitting access to personnel, financial and Medical Records, and providing internal reports of investigative, corrective and legal actions taken relative to the suspected case of Fraud and Abuse.	Yes
4.13.3.2 The Contractor's Compliance Officer shall work closely, including attending quarterly meetings, with DCH's program integrity staff to ensure that the activities of one entity do not interfere with an ongoing investigation being conducted by the other entity.	Yes
4.13.3.3 The Contractor shall inform DCH immediately about known or suspected fraud cases and it shall not investigate or resolve the suspicion without making DCH aware of, and if appropriate involved in, the investigation, as determined by DCH.	Yes
4.13.4.1 The Contractor shall submit to DCH a quarterly Fraud and Abuse Report, as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein. This Report shall include information on the pharmacy lock-in program described in Section 4.13.2.2. This report shall also include information on the prohibition of affiliations with individuals debarred and suspended described in Section 33.20.	Yes
4.13.1.1 Contractor shall have a Program Integrity Program, including a mandatory compliance plan designed to guard against Fraud and Abuse. This Program Integrity Program shall include policies, procedures, and standards of conduct for prevention, detection, reporting, and corrective action for suspected cases of Fraud, Waste and Abuse in the administration and delivery of services.	Yes
4.13.1.3 Contractor shall submit its Program Integrity Policies and Procedures, which include the compliance plan and pharmacy lock-in program, to DCH for approval as updated.	Yes

Overview of Program Integrity and On-Site Observations

Myers and Stauffer reviewed CareSource's policies, procedures and programs relating to program integrity (PI) and fraud, waste**,** and abuse (FWA) and interviewed CareSource's program integrity staff members. By contract, CareSource is required to have a PI program. The program must encompass the prevention, detection, reporting, and corrective action for suspected cases of fraud, waste, and abuse in the administration and delivery of Medicaid services. Program integrity policies, procedures, and standards of conduct must be documented. As we reviewed CareSource's program integrity program, we organized our observations under the following topics:

- Program Integrity Organizational Structure
- FWA Prevention
- FWA Detection
- Corrective Action
- Internal Audit

Program Integrity Organizational Structure

Based on interviews with CareSource staff members, there are two main CareSource units that address CareSource's Georgia Families PI and FWA initiatives: the Georgia Special Investigations Unit (SIU) and the corporate SIU, located in the Dayton corporate office. The corporate SIU oversees all CareSource healthcare plans and markets, including Medicaid managed care plans for other states. More specifically, they serve multiple functions, including, but not limited to:

- Developing FWA policies and procedures;
- Supporting FWA investigative functions;
- Providing FWA training and resources internally and externally;
- Updating provider manuals and provider/member newsletters;
- Supporting oversight functions of FWA with CareSource's subcontractors; and
- Managing monthly meetings with all markets' SIU and fraud examiners.

The Georgia SIU receives FWA allegations specific to the Georgia market from the corporate SIU. The Georgia SIU will conduct further review to determine if an investigation should be opened and facilitate communications with DCH and the corporate SIU about the investigations they pursue.

FWA Prevention

CareSource's FWA policy outlines their FWA prevention mechanisms, including how CareSource intends to abide by its legal requirements. On a monthly basis or as needed, CareSource verifies that they do not have any relationships with prohibited affiliations. Verification is completed using the Excluded Parties List System (EPLS) and the Department of Health and Human Services – Office of Inspector General (HHS-OIG) websites for all incoming and existing workforce members, providers, and delegated vendors.

CareSource uses education and training as a primary means to prevent FWA, therefore CareSource employees are required to take FWA training within 90 days of hire. All existing staff members are required to take FWA training annually. The employee FWA training

completion status is monitored by the Compliance department, and in an effort to ensure compliance, CareSource employees who fail to complete the training may lose system access until the training is complete. In addition to the required training, each SIU staff member attends a minimum of 10 hours of training in FWA trends and CMS initiatives annually.

CareSource's delegated vendors are required to complete FWA training annually. Delegated vendors may choose to use CareSource's training or their own with CareSource approval. The delegated vendors are required to attest to completing the FWA training and are not required to conduct testing to verify competency. The completion of the FWA education requirement is verified during the annual delegated entity audit.

In addition to the FWA training, CareSource corporate compliance also requires all CareSource employees complete annual trainings in topics such as policy compliance, code of conduct, IT security, HIPAA and cultural competency. Training sessions are followed by testing and all employees must receive a passing score to satisfy corporate training requirements.

According to CareSource's FWA policies, CareSource's corporate SIU provides various annual communication methods to inform providers, members, and subcontractors about identifying and reporting FWA. Providers and members receive their respective annual newsletters and provider manual/member handbook with instructions on how to identify FWA and how to report FWA to CareSource. Information can also be found on the CareSource's Georgia Medicaid web page, where there is a specific link for reporting FWA. Subcontractors also receive an annual letter with FWA information. It appears that any entity can report FWA via a FWA reporting form, handwritten letter, hotline phone number, or via an e-mail address, with the option to remain anonymous. CareSource makes information on identifying FWA and contact information regarding FWA readily available on their website and in the provider/member newsletters.

FWA Detection

For all CareSource markets, the corporate SIU appears to be the primary entity when identifying potential FWA activity. CareSource's corporate office also processes FWA allegations sourced from the hotline, fax, email, CareSource website, internal referrals, and internal data analysis for all CareSource markets.

FWA allegations received by the corporate SIU are handled by the corporate intake and triage team, where the allegation is reviewed for credibility. If the corporate SIU decides to continue researching the FWA allegation, it will be further delegated to the specific market for review, such as the Georgia SIU for Georgia-specific FWA allegations.

One (1) of the two (2) managers of the Georgia Special Investigations Unit (SIU) will review all available information surrounding the allegation and make a final determination as to whether an investigation seems warranted. If the information does not substantiate the need for an investigation, yet requires attention, tools such as provider education, pre-payment reviews, post-payment reviews and on-site reviews can be used to change provider billing behaviors. If

the information supports an investigation, Lora Jones, Manager, Special Investigations Unit, will submit a request to DCH for approval to open a case. Open cases are assigned to one (1) of the two (2) fraud examiners assigned to Georgia who investigate member and provider allegations of fraud. They use claim and encounter data, provider billing and medical records, in addition to certain internal reports and databases to complete their investigations. The investigators findings can lead to claim payment recovery; formal provider CAPs; internal education and training; member disenrollment; legal actions; member termination, suspension, or reduction of previously authorized covered services; pharmacy lock-in program; provider training, termination or suspension; repayment of embezzled or stolen funds; submission to and cooperation with law enforcement agencies; workforce member disciplinary actions and written provider warnings and/or education. The SIU reaches out to state and federal law enforcement agencies during investigations to alert them to findings and to cooperate by providing case information and claims data upon request.

The pre-pay software reviews all institutional and professional claim lines daily and assigns the un-adjudicated claim lines a predictive score for the likelihood of fraudulent activity. Claim lines with high scores are flagged for manual review by the clinical team. The clinical team will review as many claim lines as possible within a day and deny claim lines suspected of inappropriate billing. Flagged claims that are not reviewed by the end of the day proceed through the normal adjudication process. Per a Myers and Stauffer request, CareSource provided the quarter three 2018 (i.e., July 2018 through September 2018) metrics for pre-pay review, and approximately 670 claim lines were reviewed out of approximately 38,300 claim lines, with 30 claim lines denied in total as a result of pre-pay review. This led to approximately $16,400 in savings for quarter three in 2018.

The corporate SIU generates reports using post-pay software, both monthly and as needed, to identify claim payment outliers and/or trends. One analyst in the corporate SIU solely focuses on FWA identification by reviewing industry reports, conferences, studies, and other data sources, while also maintaining a dashboard of all potential allegations noted for CareSource's markets. The CareSource FWA procedure policy outlines the various types of FWA that their corporate SIU looks for in the FWA review, such as provider kickbacks, provider upcoding, member eligibility fraud, etc.

The CareSource SIU also performs reviews of internal data and data mining activities in order to proactively identify potential FWA. The types of data include claims, grievances and appeals, prior authorizations and controlled substance utilization reports. CareSource also uses provider profiling, where *Lexis Intelligent Investigator* software makes peer to peer comparisons on all providers based on known fraud scenarios to proactively identify potentially fraudulent activity. The software considers the providers billing and other activity as compared to their peers. Providers identified as high risk of fraud are reviewed to determine if their activities warrant further investigation. In addition, CareSource performs prior authorization review as another means to detect current and proactively identify fraudulent activity. The prior authorization review looks at PA data for over and underutilization trends that can indicate potentially fraudulent activity. Other activities include: prepayment review of claims, claims edits, and post-payment review of claims.

CareSource performs provider checks when uploading a provider into their claims system and monthly thereafter against the System for Award Management (SAM), Death Master File, the List of Excluded Individuals/Entities (LEIE), and state-initiated exclusions from Medicaid lists. In addition, providers are screened against provider license boards and the Specially Designated Nationals list. CareSource's Pharmacy Benefit Manager (PBM) screens all pharmacies and providers at the point of sale. A pharmacy claim will not pay if written by a prohibited prescriber or if filled at a prohibited pharmacy. CareSource utilizes *Zebu*, a database application tool, to review providers, vendors, and employees for prohibited affiliations, state sanctions, and license status. *Zebu* also allows for review and verification of the national terrorist list. If CareSource discovers a payment was made to an excluded individual or entity, CareSource will attempt to recover these funds. Any amounts paid that cannot be recovered are allocated to non-Medicaid/Medicare funds.

Corrective Action

When investigative findings call for corrective actions, CareSource's FWA procedure outlines a list of potential corrective actions including, but not limited to:

- Provider written warnings and/or education;
- Formal provider corrective action plans;
- Provider termination or summary suspension;
- Repayment of embezzled or stolen funds;
- Pharmacy lock-in program;
- Internal education and training; and
- Legal actions.

As of November 2018, the Georgia SIU manager reported, in the on-site interviews, that they were working to obtain recoupment on a few cases. Their corrective action plan for these instances was to send a letter to the provider and allow a response within thirty (30) days. If CareSource received a settlement from the provider, CareSource would report the settlement amount to DCH within seven days.

Myers and Stauffer also reviewed the CareSource Pharmacy Lock-In policies and monthly Pharmacy Lock-in report to DCH, and interviewed CareSource's Georgia pharmacy lock-in staff members. The CareSource Georgia market pharmacy lock-in team decides which members should be enrolled in pharmacy lock-in, supports any adjustments needed throughout the member's enrollment, and ensures members are discharged appropriately. The Georgia pharmacy lock-in team receives a monthly analysis report from the analytics team and reviews approximately 400 Georgia Families members on average to observe trends in the utilization of services and overall patterns. Once specific members have been identified, the Georgia pharmacy lock-in team recommends these members to the case management team, who will further contact the member to inform their enrollment into the program. The manager of the Georgia pharmacy lock-in team sends monthly reports to DCH with metrics for how many members are enrolled in the program and how many members are released. CareSource's Pharmacy Lock-In policies did not appear to document guidelines regarding what CareSource's requirements are in its annual assessment of members enrolled in the lock-in program.

Internal Audit

The CareSource oversight team typically performs an internal audit annually; however, according to the corporate compliance director, “CareSource does not have a specific cadence for evaluating the Program Integrity Department.” Each CareSource department is subject to a risk assessment and given a risk rating, which therefore, determines if a department is selected for internal audit. The CareSource oversight team conducted a limited-scope audit of its FWA program, which is included in the 2018 Internal Audit plan. The scope of the 2018 engagement of the program integrity unit was to review all the FWA processes that the SIU and the Ethics and Compliance business areas conduct. The closing memo of the 2018 engagement appeared to describe the general methodology of the program integrity processes and the result was that these processes were determined to be “well-documented and receive appropriate governance attention”.

Additional Observations: Program Integrity

- The SIU is comprised of a Director, four (4) managers, an intake team, a triage team, fraud examiners, a clinical team (for pre-payment activities), the GA team managers (for post-payment activities) and the data analytics team.
- SIU staff dedicated one hundred percent (100%) to Georgia include two (2) managers and two (2) fraud examiners.
- In 2018, Program Integrity received a risk assessment rating of “high” and an oversight review was performed.
- The scope of the August 7, 2018 audit conducted by the Internal Audit department included a review of processes to receive, investigate, track resolve and report allegations of FWA received through various reporting venues. The evaluation of the results of these activities was not included as a part of the scope for this audit.
- The results of the Program Integrity audit conducted in 2018 state that “no observations requiring management response were issued and it is Internal Audit’s overall opinion that the areas reviewed as part of this audit are Satisfactory.”

After review of CareSource’s policies and procedures for program integrity, we did not identify policies or standard operating procedures for contract section 4.13.2.2.3. We recommend that CareSource, in accordance with their contract with DCH, create a policy to address the contract requirement outlined in this area.

Overview of Subcontractor Program Integrity and On-Site Observations

CareSource’s corporate SIU regularly communicates with its subcontractors’ program integrity staff members, in addition to having limited access to its subcontractors’ data. For both Scion Dental and CVS Caremark, CareSource’s corporate SIU conducts a monthly meeting with each respective subcontractor, provides FWA training documentation, and requires an authorized subcontractor representative to sign an attestation that the subcontractor is in compliance with all CareSource FWA requirements. The corporate SIU will also work with CareSource’s internal delegated vendor oversight team to ensure that the annual audit tool for subcontractors contains the applicable FWA requirements.

Scion Dental

Due to limited access to the Scion dental data, it appears that CareSource's corporate SIU conducts most of the FWA detection analysis for Scion Dental. In order to address potential FWA concerns if either Scion Dental or CareSource has a potential FWA concern, both parties meet monthly to review the data analytics and discuss whether to open an investigation.

CVS Caremark

In contrast to Scion dental, CVS Caremark does have its own FWA investigations and reporting; however, CareSource's corporate SIU also analyzes the CVS Caremark data internally. Myers and Stauffer interviewed CVS Caremark's program integrity staff members and reviewed their quarterly CareSource Medicaid investigative audit logs and field audit/daily review logs.

CareSource receives quarterly reporting from CVS Caremark, which appears to include the investigations that CVS Caremark initiates. We received the quarter three 2018 (i.e., audits conducted between July 2018 and September 2018) and quarter four 2018 (i.e., audits conducted between October 2018 and December 2018) investigative audit logs from CVS Caremark. There appeared to be two cases on each respective log, with a potential exposure of approximately $10,000 total for both cases per log. CareSource's corporate SIU also conducts monthly internal analysis with CVS Caremark data to identify FWA. The Georgia SIU will ultimately determine if a potential CVS Caremark FWA allegation, whether identified by CVS Caremark or by CareSource internally, should be reported to DCH.

Additionally, CVS Caremark regularly performs two types of audits: Daily claims review and quarterly field audits. CVS Caremark conducts a daily review of claims across all markets, including the Georgia market. The daily claims review staff members make concurrent outreach calls for any claims adjudicated the previous day and will run a CVS Caremark proprietary algorithm to identify outliers in the data. In the CVS Caremark audit review log for quarter three 2018 (i.e., July 2018 through September 2018), there was a reported audit recovery amount of approximately $10,300.

The second type of audit performed by CVS Caremark is the quarterly field audit. According to the CVS Caremark program integrity manager, there are 12 on-site auditors across the country that conduct in-person audits at pharmacies, with one auditor located in the state of Georgia. The quarterly field audit can cover 12 to 18 months in some instances, and is a company-wide audit that includes the Georgia market. Specific pharmacy providers are selected for the field audit based on any indication (i.e., a member tip) that a specific pharmacy provider may need to be audited or based on claims data outlier reports. Since the daily claims review and the quarterly field audit are completed at the national level, certain pharmacy providers may be overlooked if the benchmark to determine an outlier could be potentially based on the national benchmark, rather than a Georgia-specific benchmark.

Fraud, Waste, and Abuse Reporting

By contract, CareSource is required to submit quarterly Fraud and Abuse Reports to DCH.[1] The contract specified that the reports must contain suspected cases of fraud and abuse in the administration and delivery of Medicaid services. FWA case reporting was required to include at minimum:

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

Myers and Stauffer reviewed the four quarterly Fraud and Abuse Reports submitted for CareSource and CareSource's subcontractors since CareSource's inception into the Georgia Families program. The four reports consisted of investigative cases for the period of July 2017 through June 2018. The layout of the reports submitted by CareSource appeared to be inconsistent. For some instances, the "Administrative disposition of the case" field typically contain values describing the status of the case; however, there appear to be additional description in the "investigative activities, corrective actions, and prevention efforts" field that could perhaps be applicable to disposition. All other data fields appear to satisfy the contractual requirements for case information stated above.

Myers and Stauffer also reviewed the Medicaid Fraud Control Unit (MFCU) Joint Quarterly Meeting reports published for the same period as CareSource's Fraud and Abuse Reports that we received to evaluate the consistency of CareSource's FWA investigations. We noted that there is an investigation mentioned on the July 16, 2018 MFCU meeting report that does not appear to be included in the CareSource Fraud and Abuse reports. This case appeared to be open and active for the period reviewed. CareSource should ensure quarterly Fraud and Abuse reports are complete and include all open cases during the reporting period.

CareSource's Fraud and Abuse reporting for the period of July 2017 through June 2018 comprised 19 cases, with one closed case. These cases covered 19 providers, including eight laboratory providers, two dental providers, and one pharmacy provider. The remaining eight cases included various professional or institutional providers such as allergy, behavioral health, etc. Of the 19 cases, 15 (approximately 79%) reported an estimate of the potential dollar amount involved, totaling approximately $1,340,000. The actual amount recovered is

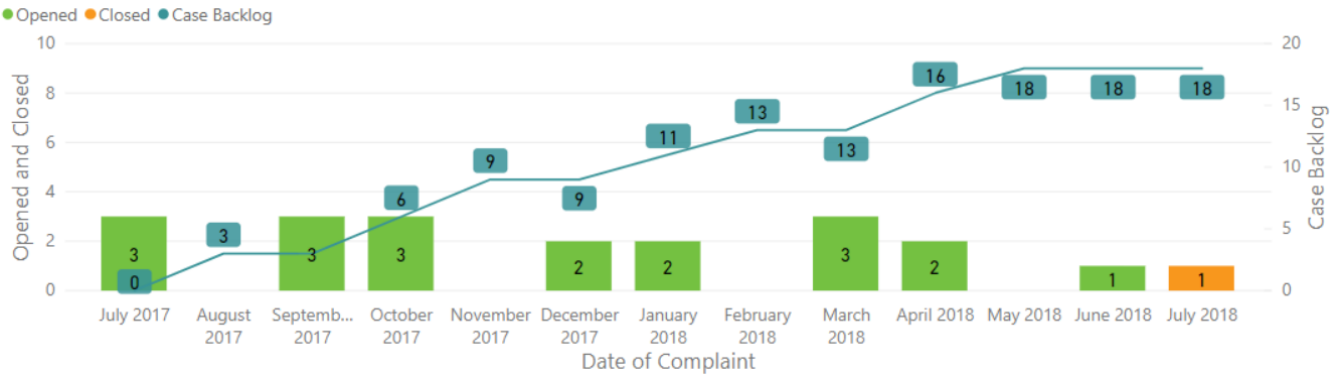
[1] Section 4.18.3.5 of *Amended and Restated Contract between the Georgia Department of Community Health and Care Management Organization for Provision of Services to Georgia Families Contract No. Amendment # 12* http://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/site_page/CMO_DCH%20Contract.pdf

not logged on the Fraud and Abuse reports; however, upon request, CareSource submitted a separate overpayment report to Myers and Stauffer that included three cases, which logged approximately $166,000 that were in the process of pursuing recovery as of November 2018.

Additionally, there appeared to be nine cases with allegations sourced within CareSource internally, while there were five cases sourced from state Medicaid departments. The investigations sourced from CareSource internally appear to have been opened due to observations of a high utilization of procedure code or payment spikes, while the investigations sourced from the state Medicaid departments were opened due to observations of various potential fraudulent activity, such as performing unnecessary services, a phantom provider, prescribing practices, and use of services. The remaining five cases appeared to be sourced from members (i.e., two cases), industry reports, and other public sources such as the media/internet.

Myers and Stauffer reviewed changes in CareSource's FWA caseload as reported during the period of July 2017 through June 2018. Myers and Stauffer counted the number of new cases opened each month, the number of existing cases closed each month, and the number of active cases at the end of each month (the "backlog"). It appeared the backlog of cases grew somewhat steadily throughout the year; however, there was a steady number of cases from May 2018 through July 2018. This may be due to the addition of another fraud examiner in the Georgia SIU that potentially contributed to this trend. Figure 1, *FWA Case Load Trends*, illustrates the trends.

Figure 1: FWA Case Load Trends



Myers and Stauffer identified the entity associated with each FWA case reported during the period of July 2017 through June 2018 in order to gauge their contribution to CareSource's program integrity efforts. The following table shows a summary by entity of the FWA cases reported by CareSource to the DCH during this period.

Entity	FWA Case Count	Approximate Dollars Involved	Outcome (as of July 2018)
CareSource *Medical, Behavioral Health, and Laboratory*	16	$ 1,320,000	All cases still under review.
Scion *Dental*	2	$ 18,000	All cases still under review.
CVS Caremark *Pharmacy*	1	$ 650	This case was closed as of July 9, 2018 since the original allegation was resolved and Georgia claims were reported to not have been included in the audit.

Appendix G – Subcontractor Oversight

Myers and Stauffer reviewed the policies and procedures for subcontractor oversight provided by DCH, CareSource and any related subcontractors. In the table below, we identified the key contract requirements and whether CareSource has policies and procedures consistent with the contract requirement(s).

Contract Requirements and Consistency of CareSource Policies and Procedures for Subcontractor Oversight

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

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

Overview of Subcontractor Oversight and On-Site Observations

Myers and Stauffer reviewed policies and procedures provided by CareSource in relation to subcontractor oversight and monitoring delegated services. We also interviewed key CareSource staff during on-site visits and obtained explanations of the monitoring and oversight activities performed by CareSource to ensure subcontractor compliance. Myers and Stauffer requested contracts between CareSource and its subcontractors to determine if requirements established within those contracts were in accordance with the contract between DCH and CareSource.

The use of subcontractors in the Georgia Families® program, is outlined in sections 18.1.1 through 18.1.10 of the contract between DCH and the CMO. The contract requires the CMO to conduct ongoing monitoring of each subcontractor's performance and perform scheduled periodic reviews. The table below represents CareSource's reported delegated functions and their corresponding subcontractors.

Functions Delegated to Subcontractors	CVS Caremark	Scion Dental (SKYGEN USA)
Claims Processing	X	X
Dispensing of Drugs	X	
Drug Recalls	X	
Credentialing	X	
Call Center Operations	X	
OIG/GSA Excluded Provider Management	X	
Pharmacy Network Management	X	
Rebate Management	X	

The Myers and Stauffer engagement team reviewed CareSource's standard operating procedure (SOP) entitled Submission of Delegated Agreements to the Department of Community Health. It states that the CareSource regulatory department is required to obtain prior written consent from DCH before hiring or entering into an agreement with any subcontractor.

CareSource monitors subcontractor performance on a monthly basis and performs an annual comprehensive review as needed. The annual review includes, but is not limited to, a review of the program, policies and procedures, work plans, and random sample files aimed to assess the subcontractor's ability to provide services according to the standards of CareSource, applicable federal and state agencies, and accreditation requirements. The annual review may be performed on-site. In preparation for the audit, CareSource provides the subcontractor a list of documents and files to be audited ten (10) days prior to the audit. During the audit, the documentation and files are reviewed for areas where deficiencies and/or potential findings may exist. Upon completion of the audit, CareSource conducts a meeting where an overview of their findings is communicated with the subcontractor. A written report is provided to the subcontractor within ten (10) business days of completion of the audit.

Additionally, we noted the following key items when reviewing the Delegation Oversight template:

1. CareSource will request a CAP from a subcontractor that is not operating in accordance with their agreement and/or federal or state requirements.
2. The subcontractor has two (2) weeks to respond with a root cause analysis detailing how an infraction occurred; detailed action plan(s) for completion of the activities required by the CAP; expected and measurable results; and due date(s) for the completion of all CAP related action items.

3. The subcontractor is expected to resolve the CAP within thirty (30) days of receipt of written approval of the proposed CAP by CareSource. In some instances, an alternative completion period can be approved by CareSource, however, it must be in writing.
4. CareSource will monitor subcontractors on an ongoing basis to identify opportunities and/or areas for improvement.
5. CareSource is required to implement a compliance program that includes effective training and education for Subcontractors.
6. The Subcontractor's contract may be revoked in instances where CareSource or DCH determines that the Subcontractor has not performed satisfactorily, including by failing to implement a corrective action plan or quality improvement plan. CareSource can also terminate the Subcontractor's contract at any time for cause related to egregious deficiencies.
7. CareSource provided the CMO to Subcontractor contracts for Scion. The contract states that the subcontractor must comply and cooperate with CareSource and all applicable state and federal laws.

Additional Subcontractor Observations

- Scion has had no deficiencies since July.
- In Quarter 3 of 2017, CVS missed average speed of answer service level agreement (SLA). There was no CAP issued. CVS call center was monitored and have had no reoccurrences.
- 2018 Audit results indicate that a CAP was issued to Language Line (vendor) for missing the SLA for average speed of answer for Spanish interpreter services calls due to extenuating circumstances. The CAP remains open and is being monitored.

Myers and Stauffer determined CareSource's policies and procedures for subcontractor oversight were in accordance with the DCH contract.

Appendix H – Encounter Submissions and Payment Systems

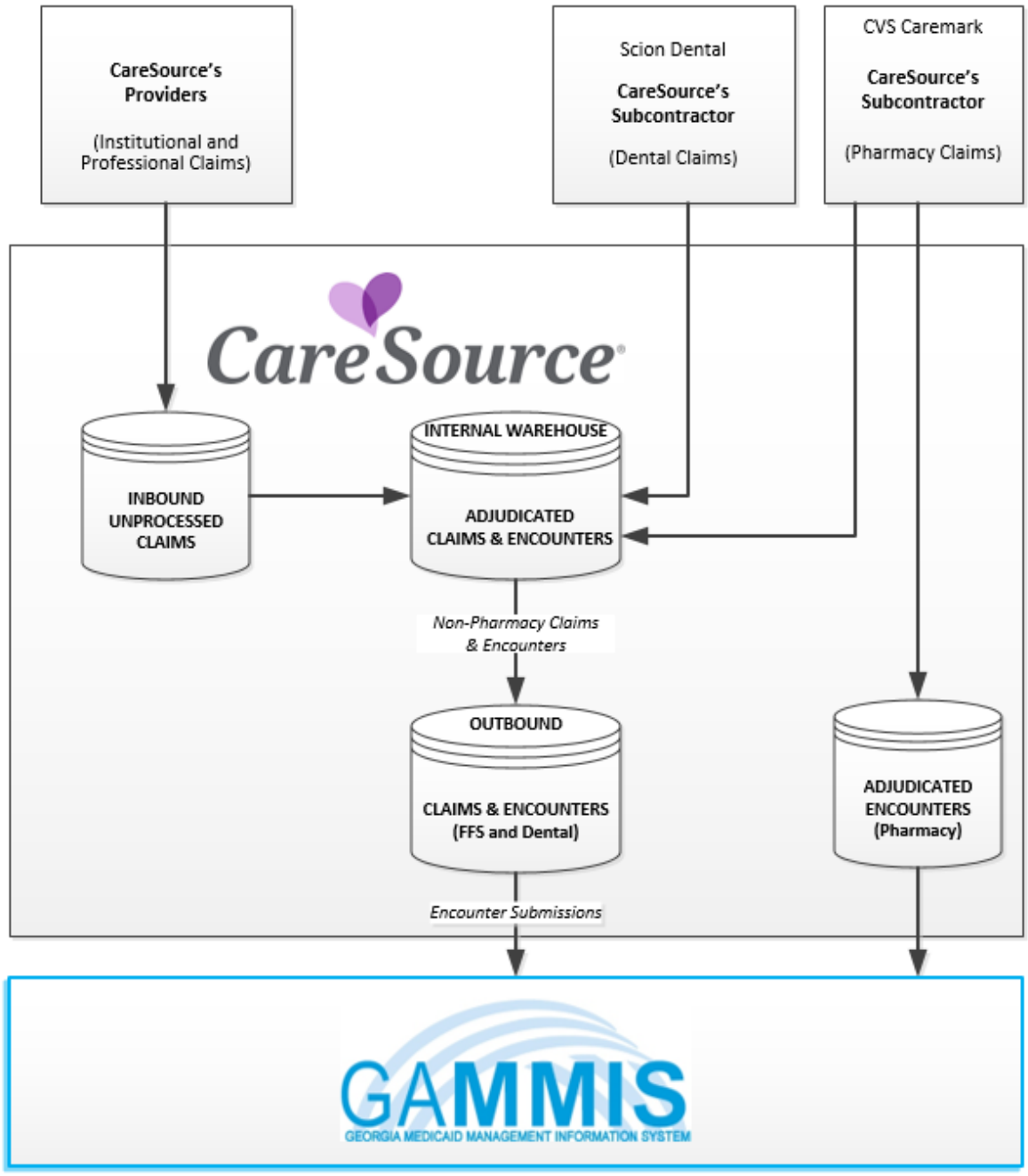
Overview of Encounter Submissions

Myers and Stauffer reviewed CareSource's encounter submission policies, procedures, and processes to ensure CareSource's policies are in compliance with the contract between DCH and CareSource. By contract, CareSource is required to provide timely, complete, and accurate encounter data to Georgia's MMIS. Myers and Stauffer reviewed CareSource's claims management system and the MMIS encounter data to determine if all claims for eligible members were included in the MMIS encounters, and claim data elements were accurately represented in the MMIS encounters.

Analysis of Encounter Submissions

Myers and Stauffer compiled encounter submission information from CareSource's policies and interviews with CareSource staff members in Dayton, Ohio and in Atlanta, Georgia. Staff members at CareSource provided descriptions, diagrams, and explanations of how each of their systems operate. This information supported our analysis model of CareSource's claims progression (i.e., flow of claims) through CareSource's claims management systems to the submission stage into the MMIS. Illustration 1 below is a representation of Myers and Stauffer's understanding of a high level flow of claims data in CareSource's system, including inbound receipt of un-adjudicated fee-for-service (FFS) claims from providers/clearinghouses, etc., adjudication of FFS claims, inbound receipt of adjudicated subcontractor encounters, and submission of FFS claims and subcontractor encounters to the MMIS. The flow of CVS Caremark claims is also represented in Illustration H.1 and differs from CareSource FFS claims and other subcontractor encounters. CVS Caremark adjudicates all pharmacy claims and prepares encounter data files for submission to the MMIS. CVS provides these files to CareSource, who submits the files directly to the MMIS as a pass-through.

Illustration H.1. Claims Systems Diagram – Myers and Stauffer's Interpretation



Myers and Stauffer developed this analysis model (Illustration H.1) to understand the flow of claims data within CareSource's internal claims management system and then to compare the existence of claims in CareSource's system to the encounters in Georgia's MMIS. Our methodology comparing the claims in CareSource's system to the encounters in Georgia's MMIS was to match claim lines at each of the different processing points in CareSource's claim management system and identify any potential missing claim lines in the MMIS encounters. We also identified any potential mismatching values or changes to claims data elements when comparing CareSource's claims data to the encounter data in the MMIS.

Based on the preliminary review of CareSource's claims management system, Myers and Stauffer requested CareSource submit a test sample data extract from multiple processing points in their claims system. CareSource staff prepared an initial data sample for delivery to Myers and Stauffer. Myers and Stauffer reviewed the initial extract and provided feedback to CareSource on the suitability of the format and content for the purpose of this analysis. This process was repeated for a second time and Myers and Stauffer provided additional clarification. A similar process was performed concurrently with CVS Caremark for pharmacy claims.

After establishing a suitable extract layout, Myers and Stauffer requested all Georgia Medicaid and PeachCare for Kids claims for the following two scenarios:

1. CareSource FFS claims and subcontractor encounter claims having a first date of service during the period September 1, 2018 through September 30, 2018.
2. CareSource FFS claims and subcontractor encounter claims having an adjudication (or payment) date during the period of October 1, 2018 through October 31, 2018.

The two extract scenarios were chosen to test different potential risk areas in the claims data flow through CareSource's systems. Each extract was reviewed independently and the results were combined for presentation in this report.

Myers and Stauffer reviewed all requested processing points in CareSource's claims system when comparing CareSource FFS claims and subcontractor encounters to their corresponding MMIS encounters. When claim data element values were unavailable in the CareSource extracts for a given processing point, Myers and Stauffer relied on remaining processing points where data was available.

The analyses of encounter submissions were divided into:

- **Section A**: Existence of CareSource FFS claims and subcontractor encounter claims as encounters in the MMIS.
- **Section B**: A comparison of CareSource FFS claim and subcontractor encounter claim data elements to the MMIS encounter data elements.

Section A: Existence of CareSource FFS Claims and Subcontractor Encounters as Encounters in the MMIS

Analysis of Claims in Data Extracts and the MMIS

Myers and Stauffer compared CareSource FFS claims and subcontractor encounters in the CareSource data extracts to MMIS encounters to determine the existence of claims in both data sources. The analysis was limited to claims and encounters in the CareSource data extracts with a service date in September 2018 or a paid date in October 2018 and MMIS CareSource encounters with a service date or paid date in those same months. MMIS CareSource encounters were further limited to those processed by the MMIS on or before April 8, 2019 based on Myers and Stauffer's receipt of the CareSource data extracts in late March 2019 and claim processing dates observed in the CareSource data extracts.

Additionally, Myers and Stauffer requested both accepted and rejected claims to be included in the data extracts for all processing points in CareSource's claims management system. Table H.1 below includes a summary of rejected inbound claim lines that were included in both the paid date and service date extracts. Rejected inbound claim lines are typically associated with HIPAA validation errors and/or missing member or provider information. Rejected inbound claim lines were not expected to be included in the MMIS encounters and were excluded from further analysis presented in this report. For CVS Caremark pharmacy, many of the rejection reason codes reported on inbound rejected claims could be interpreted as denials (for example: "product/service not covered" or "plan limitations exceeded"). These claims did not appear to be included in the MMIS. We would expect CVS Caremark to submit all claim lines to the MMIS that are billed for eligible members, except for rejection reasons related to HIPAA validation errors. The inclusion of these instances supports program integrity investigations, such as observing trends in multiple billing attempts for a given member/provider/service.

Table H.1. Number of rejected inbound claim lines excluded from analysis

Claim Type	Paid Date Sample		Service Date Sample	
	Claim Lines	% Inbound Claim Lines	Claim Lines	% Inbound Claim Lines
Institutional	17,980	9.3%	14,750	12.0%
Professional	1,307	0.3%	4,083	1.2%
Pharmacy	54,144	23.1%	45,874	23.7%

Myers and Stauffer mapped the flow of claims through CareSource's systems and into the MMIS by linking related claim lines at the different processing points in the CareSource data extracts and in the MMIS. Claim lines were linked using a combination of unique data fields, where available and populated:

- CareSource internal claim ID
- Georgia MMIS claim ID
- Patient account number
- Medical record number
- Prescription number
- Member ID
- Provider ID
- Claim adjudication and paid dates
- MMIS submission date
- Claim sequence number
- Dates of service
- Procedure codes
- Revenue codes

Myers and Stauffer made a best attempt to differentiate between multiple versions and adjustments of a claim using the data elements listed above. There were likely instances in this analysis where claim versions were not properly identified.

Approximately 280 claim lines in the CareSource data extracts appeared to have been in the process of being adjudicated or being submitted to the MMIS when the extracts were created. These claim lines were not expected to exist within the universe of MMIS encounters processed on or before April 8, 2019 and were excluded from this review.

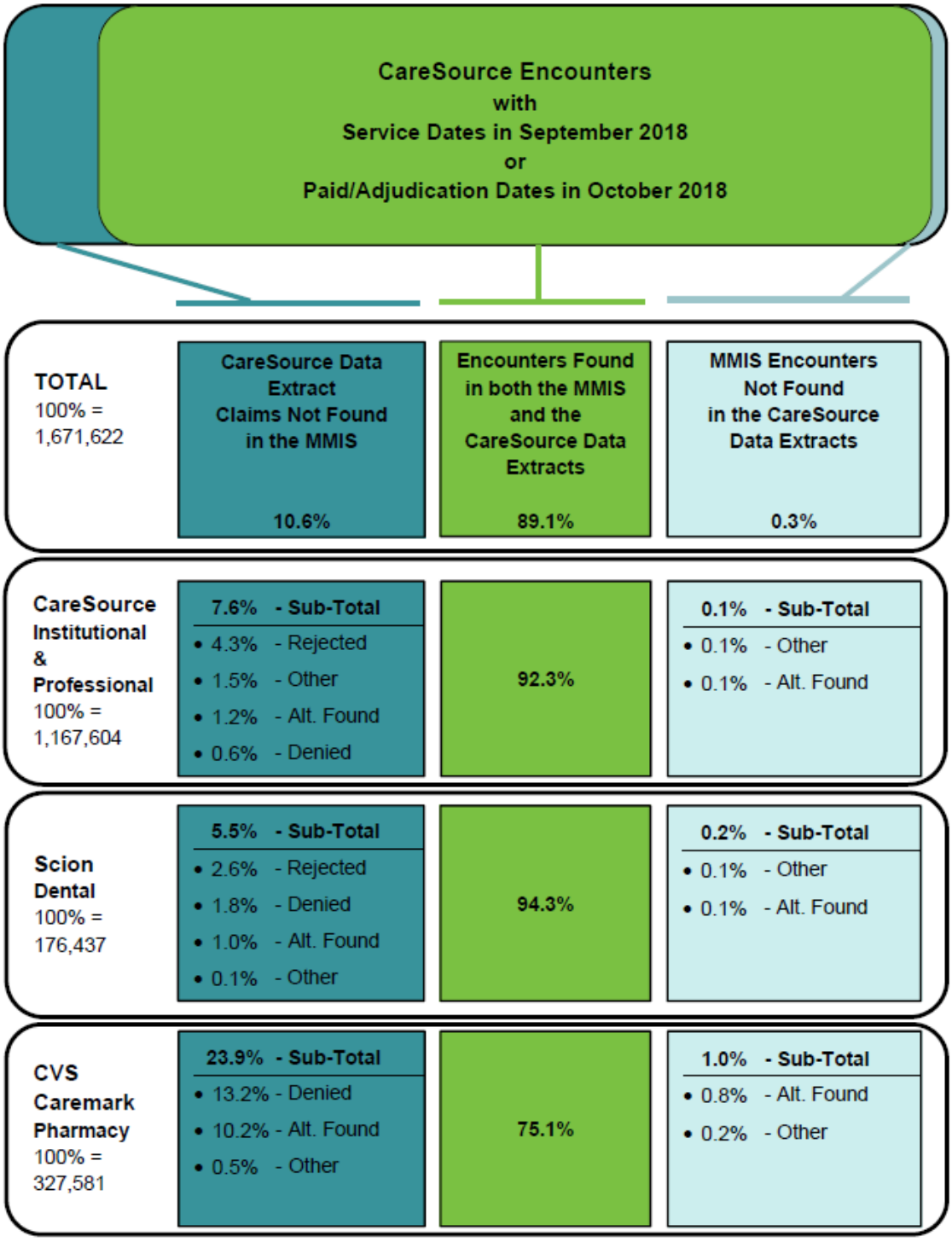
Summary of CareSource Claims in the MMIS

A summary of the existence of claims in both the CareSource data extracts and the MMIS is presented in Diagram H.1 below. Diagram H.1 shows the percentage of CareSource FFS claims and subcontractor encounter claims falling into one of three categories:

1. CareSource FFS claims and subcontractor encounter claims existing in the CareSource data extracts but absent from the MMIS.
2. CareSource FFS claims and subcontractor encounter claims existing in both the CareSource data extracts and the MMIS.
3. CareSource and subcontractor encounters existing in the MMIS but absent from the CareSource data extracts.

A guide to the terminology used in Diagram H.1 is presented below the figure. Additional details for claim lines identified only in the CareSource extracts and encounter claim lines identified only in the MMIS are presented in the pages following Diagram H.1.

Diagram H.1. Comparison of CareSource Encounter Claim Lines Existing in the CareSource Data Extracts and the MMIS[2]



Guide to Terminology Used in Diagram H.1:

[2] Percentages are rounded and may not always add up to 100%.

Rejected MMIS Submission – A claim line marked as rejected by the MMIS in CareSource's extracts of outbound claims and encounters for submission to the MMIS.

Denied Claim – A claim line denied for payment by CareSource or its subcontractor during their claim adjudication process due to authorization, eligibility, limits issues, or other reasons.

Alternate (Alt.) Found – Claim lines in the CareSource data extracts that did not appear to exist in the MMIS, or encounter claim lines in the MMIS that did not appear to exist in the CareSource data extracts. A different version or adjustment of these claim lines was found in the opposing claims data source.

Other – A claim line or encounter claim line with insufficient information available to explain their absence.

Details of CareSource Claims Found Only in the Data Extracts or the MMIS

The following sections provide additional details for the percentages found in Diagram H.1, specifically the CareSource FFS claims and subcontractor encounter claims that did not appear to exist in the MMIS, and for MMIS encounters which did not appear to exist in the CareSource data extracts. Myers and Stauffer noted potential discrepancies and explanations for the absence of these claim lines from the opposing claims data source.

CareSource Data Extract Claims Not Found in the MMIS Encounters

CareSource Institutional and Professional

- **Rejected MMIS Submission** – Approximately 49,600 (4.3%) CareSource FFS institutional or professional claim lines in the CareSource data extracts appeared to be rejected by the MMIS when submitted as encounters. Although there were some instances of claim lines that appear to be rejected likely due to member ineligibility, a majority of these claim lines did not appear to exist in the MMIS and insufficient information was available in the CareSource data extracts to determine the reason for rejection.
- **Other** – Approximately 17,500 (1.5%) CareSource FFS institutional or professional claim lines in the CareSource data extracts did not appear to exist as encounters in the MMIS.
- **Alternate Found** – Approximately 14,400 (1.2%) CareSource FFS institutional or professional claim lines in the CareSource data extracts did not appear to exist in the MMIS; however, a different version or adjustment of the claim line was found in the MMIS. Approximately 5,200 (0.5%) of these claim lines were processed within seven days of the associated version or adjustment identified in the MMIS, and these records may represent in-cycle adjustments[3]. Many of these claim lines, approximately 1,900 (0.2%), had matching line payment amounts when compared to the associated version or adjustment identified in the MMIS.
- **Denied Claim** – Approximately 7,200 (0.6%) CareSource FFS institutional or professional claim lines appeared to be denied in the CareSource data extracts and did not appear to exist in the MMIS.

[3] **In-Cycle Adjustments**: For the purpose of this review, in-cycle adjustments are FFS claims or subcontractor encounters that are adjusted and replaced within a single encounter reporting cycle. These claims might be excluded from reporting if the reporting process only considers the most recent adjustment.

Scion Dental

- **Rejected MMIS Submission** – Approximately 4,500 (2.6%) Scion Dental claim lines in the CareSource data extracts appeared to be rejected by the MMIS when submitted as encounters. Although there were some instances of claim lines that appear to be rejected likely due to member ineligibility, a majority of these claim lines did not appear to exist in the MMIS and insufficient information was available in the CareSource data extracts to determine the reason for rejection.
- **Denied Claim** – Approximately 3,200 (1.8%) Scion Dental claim lines appeared to be denied in the CareSource data extracts and did not appear to exist in the MMIS.
- **Alternate Found** – Approximately 1,700 (1.0%) Scion Dental claim lines in the CareSource data extracts did not appear to exist in the MMIS; however, a different version or adjustment of the claim line was found in the MMIS. Approximately 1,600 (0.9%) of these claim lines were processed within seven days of the associated version or adjustment identified in the MMIS, and these records may represent in-cycle adjustments.
- **Other** – Approximately 200 (0.1%) Scion Dental encounter claim lines in the CareSource data extracts did not appear to exist as encounters in the MMIS.

CVS Caremark

- **Denied Claim** – Approximately 43,100 (13.2%) CVS Caremark pharmacy encounter claim lines appeared to be denied or voided in the CareSource data extracts and did not appear to exist as encounters in the MMIS. It appears CVS Caremark may not be submitting all denied or voided claim lines as encounters to the MMIS.
- **Alternate Found** – Approximately 33,400 (10.2%) CVS Caremark pharmacy encounter claim lines in the CareSource data extracts did not appear to exist as encounters in the MMIS; however, a different version or adjustment of the claim line was found in the MMIS. Approximately 33,200 (10.1%) of these claim lines were processed within seven days of the associated version or adjustment identified in the MMIS, and these records may represent in-cycle adjustments. Many of these claim lines, approximately 14,700 (4.5%), had matching line payment amounts when compared to the associated version or adjustment identified in the MMIS.
- **Other** – Approximately 1,600 (0.5%) CVS Caremark pharmacy encounter claim lines in the CareSource data extracts did not appear to exist as encounters in the MMIS.

MMIS Encounters Not Found in the CareSource Data Extracts

CareSource Institutional and Professional

- **Other** – Approximately 700 (0.1%) CareSource FFS institutional or professional encounter claim lines in the MMIS did not appear to exist in the CareSource data extracts.
- **Alternate Found** – Approximately 600 (0.1%) CareSource FFS institutional or professional encounter claim lines in the MMIS did not appear to exist in the CareSource data extracts; however, a different version or adjustment of the claim line was found in the extracts.

Scion Dental

- **Other** – Approximately 200 (0.1%) Scion Dental encounter claim lines in the MMIS did not appear to exist in the CareSource data extracts.
- **Alternate Found** – Approximately 40 (0.1%) Scion Dental encounter claim lines in the MMIS did not appear to exist in the CareSource data extracts; however, a different version or adjustment of the claim line was found in the extracts.

CVS Caremark

- **Alternate Found** – Approximately 2,600 (0.8%) CVS Caremark pharmacy encounter claim lines in the MMIS did not appear to exist in the CareSource data extracts; however, a different version or adjustment of the claim line was found in the extracts.
- **Other** – Approximately 600 (0.2%) CVS Caremark pharmacy encounter claim lines in the MMIS did not appear to exist in the CareSource data extracts.

Section B: Comparison of CareSource FFS Claim and Subcontractor Encounter Data Elements to the MMIS Encounter Data Elements

Myers and Stauffer compared claims data elements between related claim lines in the CareSource data extracts and encounter claim lines in the MMIS to determine if the information on the claims received from CareSource and its subcontractors matched the information reported to the MMIS. Myers and Stauffer evaluated and documented differences in claim element values, including missing values. Results were tallied for percent of matching values, broken out by vendor, claim type, and data element. Detailed results are available for review in *Exhibit B, Tables 1 through 4*.

Myers and Stauffer noted some significant issues related to the following data elements: claim header paid amount, claim receipt date, claim header interest amount, and institutional diagnosis codes.

Claim Header Paid Amount

- **CareSource Institutional Claims** – The claim header paid amount on approximately 43,800 (12.0%) institutional encounter claim lines in the MMIS encounters appeared to be missing the Georgia Medicaid hospital add-on payment. The Georgia Medicaid hospital add-on payment may not be reported on all MMIS encounters.

Claim Receipt Date

- **CareSource Institutional and Professional Claims** – The claim receipt date reported in the CareSource extracts for institutional and professional claim lines did not match the claim receipt date reported in the MMIS encounters. The claim receipt date reported in the MMIS institutional and professional encounters may represent the date CareSource paid the encounter, since the claim receipt date appears to be the same date as the encounter paid date.
- **Scion Dental Claims** – The claim receipt date reported in the CareSource extracts for Scion dental claim lines did not match the claim receipt date reported in the MMIS encounters. The claim receipt date reported in the MMIS Scion dental encounters may represent the date Scion paid the encounter, since the claim receipt date appears to be the same date as the encounter paid date.

Claim Header Interest Amount

- **CareSource Institutional and Professional Claims** – Provider interest payments do not appear to be reported in the MMIS institutional and professional encounter data. We would expect to see the interest paid amount identified with an encounter adjustment reason code in the MMIS encounters.

Institutional Diagnosis Codes

- Myers and Stauffer's review of institutional diagnosis codes was inhibited by limitations of Myers and Stauffer's MMIS encounter data warehouse as described in further detail in Exhibit B, Table 1. Nevertheless, no significant issues were identified that would indicate institutional diagnosis codes reported in the MMIS encounters are inaccurate

or incomplete. Myers and Stauffer reviewed the order of secondary diagnosis codes on claims in the CareSource extracts and they appeared to match the order of diagnosis codes reported in the MMIS encounters for over 99% of claims reviewed.

Appendix I – Timely Payment of Health Benefits

Overview

The Georgia Families contract between DCH and CareSource requires 97% of all clean claims be paid or denied within fifteen business days during a fiscal year. CareSource is required to pay interest on claims that are paid or denied after the fifteenth business day. Interest is calculated at a 12% annual rate starting from the fifteenth business day.

Myers and Stauffer reviewed MMIS encounters to estimate the percentage of clean claim submissions paid or denied within fifteen business days of receipt by CareSource. Interest payments were estimated for claim submissions paid more than fifteen business days following the claim receipt date.

Review of Timely Payment Compliance

This review considered MMIS encounters for CareSource institutional and professional claims with service dates in calendar year 2018. The CMO paid date was compared to the CMO claim receipt date to determine if an encounter was paid or denied within fifteen business days.

The CMO claim receipt date did not appear to be accurately captured in the CareSource MMIS encounters[4], so the receipt date was estimated from a Julian date embedded in CareSource's internal claim control number for each encounter. This derived date appears to reflect the date the claim was loaded into CareSource's claims processing system, which should typically occur on or after the actual claim receipt date. To validate the use of this estimated receipt date, we reviewed a month of claims data supplied by CareSource, which appeared to include valid information for the claim receipt date. Approximately 94.4% of encounters reviewed were marked as electronic claim submissions. The estimated receipt date for electronic claim submissions appeared to match CareSource's reported receipt date for 99.9% of claims. In contrast, approximately 5.6% of encounters reviewed were marked as paper claim submissions[5]. For paper claim submissions, there appeared to be a delay between the actual receipt date and the estimated receipt date. We attempted to adjust for this delay, however our analysis is likely under-predicting the occurrence of paper claim submissions which were paid or denied more than fifteen business days following the claim receipt.

[4] Further details and recommendations relating to the reporting of the claim receipt date in the MMIS encounters are included in the following sections of this report: Appendix H – Encounter Submissions and Exhibit B – Supporting Detail for Encounter Submissions and Payment Systems.

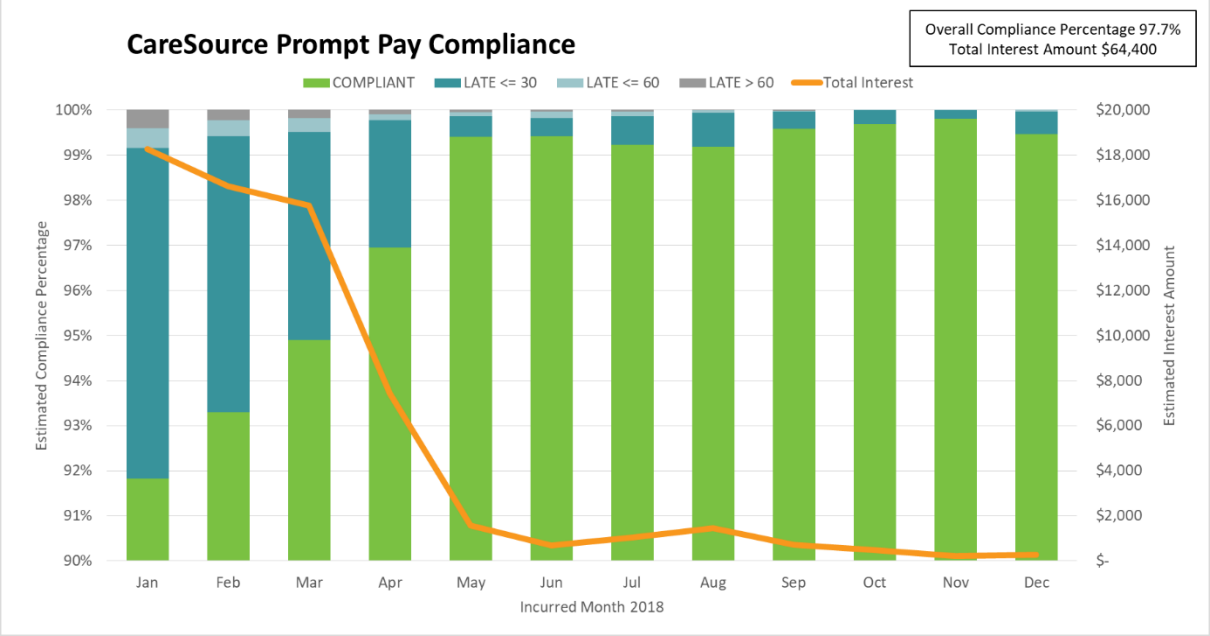
[5] The estimated percentage of paper claims calculated by Myers and Stauffer and reported here differs slightly from the paper claim percentage reported by CareSource and noted earlier in the report (4.3%). This is likely the result of differences in the time period considered when calculating the percentage.

This review was limited to original encounter submissions. Business days were calculated by excluding weekends and any weekdays that are observed as official State of Georgia holidays. Encounters were grouped into four categories based on the number of days past the compliance threshold:

- **Compliant** – *paid/denied within 15 business days*
- **Late <= 30** – *paid/denied between 1 and 30 calendar days following the 15th business day*
- **Late <= 60** – *paid/denied between 31 and 60 calendar days following the 15th business day*
- **Late > 60** – *paid/denied greater than 60 calendar days following the 15th business day*

Compliance percentages were calculated monthly and compared to the 97% compliance requirement outlined in the Georgia Families contract between DCH and CareSource. The interest amount was estimated based on a simple interest calculation at a 12% annual rate, calculated daily, and the difference in calendar days between the fifteenth business day and the claim paid date. Results are presented in Figure I.1 below. It appears that the percentage of compliant encounters was lower in early 2018, but rose to above 99% for May through the end of the year. The overall percentage of compliant encounters for 2018 was approximately 97.7%.

Figure I.1. CareSource Timely Payment Percentage and Estimated Interest for Services Incurred in 2018



Review of Timely Payment Interest Payments

Myers and Stauffer also reviewed interest payments on encounters paid after fifteen business days by comparing estimated interest amounts to the interest payments as reported in the claims data supplied by CareSource. The interest payment amount did not appear to be reported in the MMIS encounters[6], so we referenced the interest amounts reported in CareSource's cash disbursement journals (CDJ). We estimated total interest for original encounter submissions incurred in 2018 at approximately $64,400.

CareSource encounters for which Myers and Stauffer estimated an interest payment appeared to include an interest payment in the CareSource CDJs. The interest amount reported in the CDJs appeared to match the estimated interest amount for most encounters; however, we observed instances where it appeared CareSource was paying more interest than required by the Georgia Families contract.

Review of Encounters that Potentially Require Manual Adjudication

Myers and Stauffer was unable to reliably distinguish clean claim submissions from non-clean claim submissions from the available data, so all original encounter submissions were assumed to be clean claims. During on-site interviews, CareSource staff indicated the following conditions where claims were pended for manual review prior to finalizing adjudication and payment:

- Planning for Healthy Baby claims (P4HB)
- High-dollar billed claims
    - Professional claims billed greater than $20,000
    - Institutional claims billed greater than $70,000
- High-dollar paid claims
    - Claims adjudicated to pay greater than $40,000

We reviewed claims for each of these conditions to determine if there was a higher occurrence of payments or denials processed after fifteen business days from receipt of the claim. We identified approximately 47,700 P4HB encounters (2.3%) for the review period and approximately 98.6% of these were paid or denied within 15 business days. High-dollar billed encounters and high dollar paid encounters both had a lower percentage paid or denied within fifteen business days compared to the universe of original encounter submissions incurred in 2018, with approximately 90.2% and 94.8% respectively. However, these claims represented a very small subset of encounters at approximately 2,100 high dollar billed encounters (0.10%) and 440 high dollar paid encounters (0.02%).

[6] Further details and recommendations relating to the reporting of interest payments in the MMIS encounters are included in the following sections of this report: Appendix H – Encounter Submissions and Exhibit B – Supporting Detail for Encounter Submissions and Payment Systems.

Appendix J – Findings and Recommendations

The findings and recommendations identified during this engagement are based on the data and documentation provided by CareSource and the information obtained during on-site interviews conducted related to the following functional areas: call center operations; claims management; compliance plan; grievances and appeals; member and provider data maintenance; program integrity; provider complaints; quality improvement; subcontractor oversight; and utilization management. The table below summarizes the findings and recommendations.

Entity	Functional Area	Finding	Recommendation
DCH	Call Center Operations	Two (2) out of the three (3) live member calls CareSource demonstrated during the on-site yielded unsatisfactory results. According to CareSource, both member call center representatives were taken off the phones and coached. The first representative was coached on tone of voice; listening skills; empathy; and misuse of repetitive confirmation of the issue being expressed by the member. The second representative was coached on tone of voice; listening skills; empathy; escalation procedure; and subrogation case handling.	Due to the repeated issues with call center demonstrations, DCH may wish to develop a tool for auditing calls, which shall include components to be audited and a scoring methodology.
DCH	Program Integrity	At the time of this engagement, CareSource reported 25 cases of potential fraud and/or abuse. As of Quarter 2, 2019, three cases had been closed, ten cases were placed on closed network/auto denials of all claims, and six cases had approved overpayments totaling $185,734.08. However, only one case of $2,508.81 was recovered.	We recommend that DCH require CareSource to recover payments that were not appropriate and take actions to prevent and expedite the resolution and recovery of future such payments.

Entity	Functional Area	Finding	Recommendation
DCH	Provider Complaints	We found that CareSource can take up to thirty (30) days to provide resolution to a non-claim related provider complaints. However, we did not identify a policy related to provider complaints concerning non-claims issues.	We recommend that DCH update the contract to address this topic. As an example, the Florida Medicaid Managed Care Contract states, "For provider complaints concerning non-claims issues, the Managed Care Plan shall: (1) Allow providers forty-five (45) days to file a written complaint for issues that are not about claims; (2) Within three (3) business days of receipt of a complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution; (3) Document why a complaint is unresolved after fifteen (15) days of receipt and provide written notice of the status to the provider every fifteen (15) days thereafter; and (4) Resolve all complaints within ninety (90) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution."
DCH	Quality Improvement	According to the on-site interviews, CareSource has Member incentives higher than the policy limits, "Member incentives must be of nominal value ($10.00 or less per item and $50.00 in the aggregate on an annual basis per Member).	DCH should review this policy with CareSource then determine if an update to the policy or an adjustment to CareSource's policy needs to be made.
CareSource	Call Center Operations	CareSource does not have standard claim resolution scripts to assist provider service representatives with claim related calls.	We recommend that CareSource create a claim resolution reference document to assist call center representatives in providing adequate information to providers regarding claim status, payments, and denials.

Entity	Functional Area	Finding	Recommendation
CareSource	Call Center Operations	A CareSource Call Center Advocate (CCA) took a call from the parent of a member who had been in an accident and was unable to speak. The parent was requesting the dollar amount that Medicaid paid on claims relating to the accident on the member's behalf. The CCA did not provide the member's mother with the information; sounded irritated with the mother; and seemed to have no knowledge of the Subrogation Unit as she did not offer to transfer the call to that unit. According to CareSource, the call CCA was taken off the phones and coached on tone of voice; listening skills; empathy; escalation procedure; and subrogation case handling.	We recommend that CareSource increase the number of calls that are monitored for quality assurance. It is recommended that CareSource include training on the Subrogation Unit's purpose and when to send a member to that unit for additional assistance. Additionally, special emphasis should be placed on the effective use of people skills such as listening, empathy, and tone of voice.
CareSource	Call Center Operations	A CareSource Call Center Advocate (CCA) took a call from a member with a billing issue. She had gone to the hospital and the hospital was sending her a bill. The Call Center Advocate advised the member that it was her responsibility to give her Medicaid information to the hospital with a condescending tone of voice. He kept repeating the same thing to the member without offering her a solution. After going back and forth with the member, the CCA advised that he would have the Field rep reach out to the hospital and provide them with her Medicaid information for billing purposes. According to CareSource, the CCA was taken off the phones and coached on tone of voice; listening skills; empathy; and misuse of repetitive confirmation of the issue being expressed by the member.	We recommend that CareSource increase its number of calls that are monitored for quality assurance. Additional education should be provided to all call center representatives on handling balance billing issues. Additionally, special emphasis should be placed on the effective use of people skills such as listening, empathy, and tone of voice.
CareSource	Claims Management	CareSource has a high volume of manually priced claims. One reason is a configuration issue between the fee schedule and certain procedure codes. This configuration issue results in some claims being suspended for manual review.	CareSource should configure their claim system to recognize the fee schedule and correctly link rates to the appropriate procedure codes.

Entity	Functional Area	Finding	Recommendation
CareSource	Claims Management	According to CareSource personnel, every claim with a status of eleven (11) or fifteen (15) is held for manual pricing and review.	CareSource should reconfigure their claim system to correctly link its status eleven (11) and fifteen (15) claims to the appropriate fee schedule eliminating the need for manual pricing.
CareSource	Claims Management	During the on-site interviews, it was revealed that all ambulance claims are held for manual pricing in order to include payment for additional miles above the first ten (10) miles that are covered.	CareSource should reconfigure its ambulance claims to recognize additional miles billed after the first 10 miles eliminating the need for manual pricing.
CareSource	Claims Management	The Healthy Baby (P4HB) claims suspend to ensure that the diagnosis codes and procedure codes used are allowable codes for the Healthy Baby program criteria. CareSource reviewers use a list of preset codes to manually determine if the diagnosis and procedure codes are allowed.	CareSource should reconfigure its P4HB claims to automatically recognize all of the procedure and diagnosis codes allowed for the program. This should eliminate the need for manual processing and allow for timely adjudication of this claim type.
CareSource	Claims Management	According to CareSource personnel, Coordination of Benefit claims suspend for manual review in order to validate primary insurance and to ensure that CareSource is improperly paying the claim.	CareSource should reconfigure their claim system to correctly identify and apply coordination of benefits amounts to claims allowing for proper adjudication and payment when CareSource is identified as the secondary payer, reducing or eliminating the need for manual pricing.
CareSource	Claims Management	During the on-site interviews, CareSource advised that any claim with a payout greater than $40,000 would suspend for analyst (manual) review. It was noted that the reason the claims are being suspended is due to incorrect DRG weight configurations.	We recommend that CareSource correct its DRG weight configuration issues which will reduce the need for manual review. In addition, CareSource should also review existing claims processing procedures to require high dollar claims to suspend only in the event there is an issue with the claim.
CareSource	Claims Management	CareSource policy states that “CareSource will suspend claims that do not meet Clean Claim requirements no later than fifteen (15) business days after the receipt of the provider’s claim but does not address what happens if an unclean claim is suspended for longer than fifteen (15) business days.	Myers and Stauffer recommends that CareSource update this policy to clarify the resolution of the claim such providing a notice denying it, in whole or in part giving the reasons for such denial, if sufficient information is not provided within the 15 business days.

Entity	Functional Area	Finding	Recommendation
CareSource	Claims Management	During the on-site interviews, it was explained that the indicator in *Facets* for a COB/TPL is entering "new" on the line with the claim identification number. No other indicator for a COB/TPL claim was discussed and COB/TPL policies and procedures did not reference an indicator for *Facets*.	Myers and Stauffer recommends that CareSource review existing policies and procedures related to claims management and perform updates to include procedures for processing COB/TPL claims. The update should reference the field(s) in Facets that will serve as indicators, identifying the claim as COB/TPL.
CareSource	Compliance Plan	The CareSource process for tracking completed and pending HS&R report requests involves checking the designated HS&R mailbox used for the incoming report requests from providers. They do not have a tool to log and track report completion; validate the accuracy of the data contained within the report and verify that the report is in the DCH approved format.	We recommend that CareSource develop a tool to log and track HS&R report requests as they are received in addition to monitoring the report progress.
CareSource	Compliance Plan / Facility Tour	The Myers and Stauffer team observed a potential risk to the physical security of employees, visitors, and information in the workspace in Canton, Ohio. All employees must enter the building via badge access, however, visitors or those employees without badges are "buzzed in". There is no security protocol in place to keep a random individual from following an employee into the workspace without being "buzzed in". Furthermore, the visitor or random individual has access to all floors and entry ways upon entering the building.	Based on the current layout of the entry and lobby, we recommend that security access devices are added to each door that can be entered via the back stairways. This action will restrict individuals without a badge and those who may have entered the building from gaining access to employees and sensitive information.
CareSource	Compliance Plan / Internal Audit	The interview of the Internal Audit department revealed that there is not a designated internal audit group for the GA Market. Additionally, there is not a solid process for auditing and monitoring the different internal departments in order to identify discrepancies in a timely manner.	Myers and Stauffer recommends that CareSource establish and maintain an internal audit function, which is responsible for performing audits of all departments in order to fulfil the contractual obligations of the GA market contract.

Entity	Functional Area	Finding	Recommendation
CareSource	Encounter Submissions	Myers and Stauffer observed potentially missing encounters in the MMIS, particularly related to denied[1] CVS pharmacy encounters, paid Scion dental encounters, and paid CareSource FFS claim lines that appear to be included in the CareSource submitted claims extracts.	CareSource and its subcontractors should review processes and policies for the reporting of encounters to the MMIS and adjust their processes as necessary to ensure reliable reporting of claim lines.
CareSource	Encounter Submissions	Myers and Stauffer observed mismatching claim data elements between the CareSource FFS claims and subcontractor encounters extracts and the MMIS encounters. There may be instances of potential missing information for the following claim data elements: • Claim receipt date • Interest payments • Georgia Hospital Add-on payments • Units allowed • Operating provider NPI • Professional line diagnosis codes • Pharmacy header billed amounts	CareSource and CVS Caremark should review their policies and procedures for the reporting of encounters to the MMIS and adjust their processes as necessary to ensure reliable reporting of claim data elements.
CareSource	Program Integrity	CareSource has limited oversight of FWA investigations as it pertains to CVS Pharmacy. CVS conducts its own FWA investigations. CareSource uses a tracking system to monitor the investigations conducted by CVS.	Myers and Stauffer recommends that CareSource utilize its access to CVS data to conduct its own FWA audit and they should investigate any discrepancies between their findings and what CVS reports.
CareSource	Program Integrity	At the time of this engagement, CareSource reported 25 cases of potential fraud and/or abuse. As of Quarter 2, 2019, three cases had been closed, ten cases were placed on closed network/auto denials of all claims, and six cases had approved overpayments totaling $185,734.08. However, only one case of $2,508.81 was recovered.	We recommend that CareSource recover payments that were not appropriate and take actions to prevent and expedite the resolution and recovery of future such payments.

Entity	Functional Area	Finding	Recommendation
CareSource	Program Integrity	We noted that when the daily prepayment review conducted with the commercial off-the-shelf software identifies certain outlier claims based on a specific score, the outlier claims are manually reviewed by CareSource staff members. The CareSource team will review as many claims as possible in a day; however, if some outlier claims that were identified have not been reviewed that day, the claims proceed through the normal adjudication process. The limitation of manual review of claims to those than can be reviewed in a single day with available resources may be a potential risk area. This could result with CareSource potentially missing problematic claims on days with particularly high-volume or a high occurrence of potentially problematic claims.	Myers and Stauffer recommends that CareSource set a daily threshold percentage to trigger manual review.
CareSource	Provider Complaints	CareSource disclosed that any issue or complaint from a provider that requires an educational response, is responded to via email and is not logged in the Service Now tool or by any other method.	We recommend that CareSource began logging all provider issues, including those requiring a training and education, in their Service Now tool. This will allow ease in tracking the provider's experience for all CareSource staff.
CareSource	Provider Complaints	The issue resolution tools utilized by the call center and those utilized by health partners for communicating and consolidating provider complaints are separate. The call center representatives and the health partners do not have access to both tools; therefore, one cannot see what the other has documented.	We recommend that CareSource began logging all provider contacts in their Service Now tool. This will allow ease in tracking the provider's experience for all CareSource staff.
CareSource	Provider Network Management	Provider requests for claims training are forwarded from the Health Partner to the corporate office in Dayton to create the training requested.	Myers and Stauffer recommends that Health Partners are able to assist providers with complex billing and claims processing questions, including training on claims submission. CareSource should develop and train the Health Partners the claims system submission process to the Health Partners. This would alleviate providers from waiting on resolution of claims issues.

Entity	Functional Area	Finding	Recommendation
CareSource	Provider Network Management	During the on-site interviews, it was revealed no written policy or procedure exists detailing the processes used for logging, tracking and monitoring provider complaints, inquiries, etc.	We recommend that CareSource create written policies and procedures for the Health Partners outlining the process for logging, tracking, and monitoring provider encounters. This should also include resolution of provider inquiries.
CareSource	Provider Network Management	During the on-site interviews, it was revealed no written policy exists outlining how management monitors field staff to be sure that the work reported is actually being performed i.e. number of visits, quality of visits, provider satisfaction, etc.	CareSource should develop policies and procedures for oversight and monitoring of the Health Partners to include the number of visits, quality of visits, provider satisfaction, etc.
CareSource	Provider Network Management	During the on-site interviews, we were told that providers are advised that it takes approximately 45 days for contracts to be loaded into CareSource's system which differs from contract requirement of 30 calendar days.	We recommend CareSource review their existing procedures for loading provider contracts then identify the steps that potentially cause the process to extend beyond thirty (30) calendar days. Health Partners should be made aware of the contractual requirements for processing and loading provider contracts.
CareSource	Subcontractor Oversight	We found that CareSource does not have a standard process of tracking issues for its delegated vendors. There is a tracking log for CVS but not one for Scion.	We recommend that CareSource create an issue log for tracking and monitoring all subcontractor issues to ensure they are resolved in a timely manner.
CareSource	Utilization Management	Network Providers may participate in Utilization Review activities to the extent that there is not a conflict of interest. The Utilization Management Policies and Procedures do not clearly define when such a conflict may exist.	Myers and Stauffer recommends that CareSource review and update existing UM policies and procedures to include language or examples of conflicts of interest as it pertains to UM review activities.
CVS Caremark	Encounter Submissions	Myers and Stauffer observed a high occurrence of CVS Caremark inbound rejected claim lines which did not appear to be included in the MMIS. The rejection reasons on many of these pharmacy claim lines could be interpreted as denials (for example: "product/service not covered" or "plan limitations exceeded"). We would expect CVS Caremark to submit all claim lines to the MMIS that are billed for eligible members, except for rejection reasons related to HIPAA validation errors. The inclusion of these instances	We recommend CareSource and CVS Caremark should review processes and policies for the reporting of pharmacy encounters to the MMIS and adjust their processes as necessary to ensure reliable reporting of claim lines.

Entity	Functional Area	Finding	Recommendation
		supports program integrity investigations, such as observing trends in multiple billing attempts for a given member/provider/service.	
CVS Caremark	Program Integrity	Myers and Stauffer observed that CVS Caremark also performs FWA detection analyses at the national level and across all CVS Caremark markets. There may be a potential risk that FWA allegations in the CareSource Georgia market are not identified when compared to the FWA allegations that are identified as outliers and bigger risks at the national level.	Myers and Stauffer recommends CareSource and CVS Caremark review CVS Caremark's and CareSource's respective FWA detection analysis processes to ensure that sufficient FWA detection analyses is conducted for the CareSource Georgia market.
CVS Caremark	Encounter Submissions	Myers and Stauffer observed mismatching claim data elements between the CareSource FFS claims and subcontractor encounters extracts and the MMIS encounters. There may be instances of potential missing information for the following claim data elements: • Claim receipt date • Interest payments • Georgia Hospital Add-on payments • Units allowed • Operating provider NPI • Professional line diagnosis codes • Pharmacy header billed amounts	CareSource and CVS Caremark should review processes and policies for the reporting of encounters to the MMIS and adjust their processes as necessary to ensure reliable reporting of claim data elements.
Scion Dental SKYGEN USA	Member and Provider Data Maintenance	Scion Dental/SKYGEN USA named a provider data file the same as an existing data file creating two (2) files with identical names. The file naming issue went unnoticed for an unknown amount of time.	Myers and Stauffer recommends that Scion implement a process to routinely audit its provider data files to ensure the provider files are being properly named and processed without error.

Interviews with CareSource

In order to gain a better understanding of CareSource's policies and procedures for contract compliance, program integrity, encounter submissions, and subcontractor oversight, Myers and Stauffer interviewed the individuals listed in the table below on the dates and at the locations indicated.

Date	Interviewees	Title	Location
10/29/2018	Taura White	Director, JobConnect	Atlanta, GA
10/29/2018	Bobby Jones	President, Georgia Market	Atlanta, GA
10/29/2018	Seema Csukas	Medical Director	Atlanta, GA
10/29/2018	Margaux Frazee	Director, Compliance	Atlanta, GA
10/29/2018	Andrea Hundley	Director, Regulatory	Atlanta, GA
10/29/2018	Lora Jones	Manager, SIU	Atlanta, GA
10/29/2018	Deidra Wells	Manager, Compliance and Delegation Oversight (Optional)	Atlanta, GA
10/29/2018	Alexis Johnson	Manager, Program Integrity (Optional)	Atlanta, GA
10/29/2018	Erika Lawrence	Manager, Regulatory Contract	Atlanta, GA
10/29/2018	Annette Johnson	Manager, Clinical Quality Monitoring and Accreditation	Atlanta, GA
10/29/2018	Tiffany Parr	QI Strategic Planner & Interim Director, Quality Improvement	Atlanta, GA
10/29/2018	Latricia Whatley	Specialist, Clinical Quality	Atlanta, GA
10/29/2018	Viane Bello	QI Specialist, EPSTD	Atlanta, GA
10/29/2018	Juan Abreu	Director, Utilization Management	Atlanta, GA
10/29/2018	Tracy Leslie	Manager, Utilization Management GA	Atlanta, GA
10/29/2018	Dr. Mary Gregg	Medical Director	Atlanta, GA
10/30/2018	Helisa Jefferson	Manager, HP Contracting	Atlanta, GA
10/30/2018	Pascale Cadet-Dantes	Manager, HP Contracting	Atlanta, GA
10/30/2018	Tonia Davis	Director, Network Development	Atlanta, GA
10/30/2018	Chastidy Harvey	Ombudsman Coordinator	Atlanta, GA
10/30/2018	Candice Green	Ombudsman Liaison	Atlanta, GA
10/30/2018	Steve Beauford	Manager, Customer Care Advocacy	Atlanta, GA
10/30/2018	Michelle Jackson	Member Services Coach	Atlanta, GA
10/30/2018	Bradford Paschal	Manager, Service Center	Atlanta, GA
10/30/2018	Ariel Esteves	Director, Care4U	Atlanta, GA
10/30/2018	Alexis Johnson	Manager, Program Integrity	Atlanta, GA
10/30/2018	Lora Jones	Manager, SIU	Atlanta, GA
10/30/2018	Teresa Berger	Team Lead, Pharmacy Lock-in Program	Atlanta, GA

Date	Interviewees	Title	Location
10/30/2018	Ty Bracken	Fraud Examiner	Atlanta, GA
10/31/2018	Steve Beauford	Manager, Customer Care Advocacy	Atlanta, GA
10/31/2018	Bradford Paschal	Manager, Service Center	Atlanta, GA
10/31/2018	Kikela Roberts	Customer Care Advocate	Atlanta, GA
10/31/2018	Melvin Moultrie	Customer Care Advocate III	Atlanta, GA
11/12/2018	Margaux Frazee	Director, Compliance	Dayton, OH
11/12/2018	Lisa Arms	Manager, Claims	Dayton, OH
11/12/2018	Dexter Thomas	Director, Claims	Dayton, OH
11/12/2018	Denise Craven	Manager, Claims Ops Integrity	Dayton, OH
11/12/2018	Tamara Johnson	Senior Analyst, Claims	Dayton, OH
11/12/2018	Theresa Moser	Analyst, Claims	Dayton, OH
11/12/2018	Christie Kesler	SIU	Dayton, OH
11/12/2018	Dale Hockenbury	SIU	Dayton, OH
11/12/2018	Ryan Shafer	Manager, Payment Integrity	Dayton, OH
11/12/2018	Deidra Wells	Manager, Compliance and Delegation Oversight	Dayton, OH
11/12/2018	Kristen Halsey	Director, Vendor Risk Management and Oversight	Dayton, OH
11/12/2018	Valerie Dubuc	Manager, Vendor Oversight	Dayton, OH
11/12/2018	Deborah Hatton	Director, HP Operations Support	Dayton, OH
11/12/2018	Caitlin Secord	Senior Manager, Vendor Oversight	Dayton, OH
11/12/2018	Maitila Arasu	Manager, Compliance and Delegation Oversight	Dayton, OH
11/12/2018	Sheranita Hemphill	Manager, Compliance and Delegation Oversight	Dayton, OH
11/12/2018	Elizabeth Shambaugh	Associate, Op Excellency Analyst	Dayton, OH
11/12/2018	Issac Davidi	Director, Health Plan Performance Reporting	Dayton, OH
11/12/2018	Rachel Angrignon	Manager, IT Applications Management	Dayton, OH
11/12/2018	Chelsi McManus	Team Lead, Claims Encounter Data	Dayton, OH
11/12/2018	Teana Nichol	Manager, Claims Encounter Data	Dayton, OH
11/12/2018	Cathleen Athmer	Manager, Internal Audit	Dayton, OH
11/12/2018	Cathy Bordelon	Manager, Internal Audit	Dayton, OH
11/12/2018	Kristen Selvari	Manager, Claims eBusiness	Dayton, OH
11/12/2018	Joshua Nichols,	Analyst, Business Ops	Dayton, OH
11/12/2018	Donna McIntosh	Team Lead, Grievances and Appeals	Dayton, OH
11/12/2018	Amber Jones	Manager, Grievances and Appeals	Dayton, OH
11/12/2018	Melissa Mougey	Director, Grievances and Appeals	Dayton, OH
11/13/2018	Elizabeth Hilton	Director, Enrollment	Dayton, OH
11/13/2018	Mike Spivey	Manager, Enrollment	Dayton, OH
11/13/2018	Johnnetta Shaw	Team Lead, Enrollment	Dayton, OH
11/13/2018	Ariel Esteves	Director, Care4U	Dayton, OH
11/13/2018	Jared Preece	Director, IT Georgia Market	Dayton, OH

Date	Interviewees	Title	Location
11/13/2018	Joneece Arnold	Provider Database Specialist	Dayton, OH
11/13/2018	Janelle Bluser,	Team Lead, HPLC Market Relations	Dayton, OH
11/13/2018	David Hartzell	Director, Clinical Initiatives	Dayton, OH
11/13/2018	Jared Preece	Director, IT Georgia Market	Dayton, OH
11/13/2018	Angela Roberts	Manager, Health Information Exchange	Dayton, OH
11/13/2018	Lauren Hampshire	Director, Corporate Clinical Quality	Dayton, OH

Interviews with Subcontractors

Scion Dental (SKYGEN USA)

Scion Dental provided dental services to CareSource members. The functions delegated to Scion include:

- Call Center Operations;
- Claims Processing; and
- Utilization Management.

The Myers and Stauffer engagement team met with Scion Dental personnel on December, 3 2018 at the office located in Menomonee Falls, Wisconsin. We interviewed the individuals listed in the table below on the dates indicated.

Date	Interviewees	Title
12/3/2018	Crystal Seng	Service Manager
12/3/2018	Shelly Grainger	Account Manager
12/3/2018	David Tulbert	Director, Compliance
12/3/2018	Steve Giuntoli	Director, Quality Improvement
12/3/2018	Kathy Lotz	Manager, Quality Improvement
12/3/2018	Marcel Tetzlaff	Vice President, Dental Benefits Management
12/3/2018	Patrick Ruesch	Director, Provider Services
12/3/2018	Tony Jossart	Manager, Provider Services
12/3/2018	Ruslan Ahunov	Senior Analyst, EDI
12/3/2018	Artur Khachikyan	Senior Analyst, EDI
12/3/2018	Jim Zeisler	Director, Client Information Services

CVS Health (CVS)

CVS Health provided pharmacy services to CareSource members. The functions delegated to CVS include:

- Call Center Operations;
- Claims Processing;
- Credentialing;
- Dispensing Drugs;
- Drug Recalls;
- OIG/GSA Excluded Provider Management;
- Pharmacy Network Management; and
- Rebate Management.

The Myers and Stauffer engagement team interviewed CVS Health personnel on January 30, 2019 via teleconference from our office in Atlanta, GA. We interviewed the individuals listed in the table below on the date indicated.

Date	Interviewees	Title
1/30/2019	Randi Thomas	CVS - Strategic Account Executive
1/30/2019	John Stone	CVS - Strategic Account Director
1/30/2019	Cody Harris	CVS - Strategic Account Advisor
1/30/2019	Jasmine Kuylen	CVS - Senior Manager, Regulatory Affairs
1/30/2019	Amanda Buchmann	CVS - Senior Manager, Rebate Reporting
1/30/2019	Kim Sommers	CVS - Senior Manager, Rebate Reporting
1/30/2019	Alvin L. Ehrhards, Jr.	CVS - Senior Advisor, Product and Product Innovation and Management
1/30/2019	Sheilla Sagun	CVS - Pharmacist, Professional Product
1/30/2019	Lauren Grosso	CVS - Manager, Network Performance
1/30/2019	Kelly Lyscio	CVS - Manager, Contracting
1/30/2019	Andy Hinson	CVS - Lead Coder, Professional Practice
1/30/2019	Shawn Smith	CVS - Director, Network Operation
1/30/2019	Christopher Robinson	CVS - Director, Clinical Services
1/30/2019	Casey Dennis	CVS - Clinical Advisor
1/30/2019	Andrew Long	CVS - Advisor, Client Audit
1/30/2019	Natalia Tirums	CVS - Advisor, Client Audit
1/30/2019	Duane Greene	CVS - Advisor, Client Audit
1/30/2019	Austin Crippes	CVS - Account Manager
1/30/2019	Teresa Berger	CareSource - Team Lead, Pharmacy Lock-in Program
1/30/2019	Andrea Enterline	CareSource - Pharmacy Formulary RPH
1/30/2019	Lora Jones	CareSource - Manager, SIU
1/30/2019	Erika Lawrence	CareSource - Manager, Regulatory Contract
1/30/2019	Alexis Johnson	CareSource - Manager, Program Integrity
1/30/2019	Shannon Steele	CareSource - Manager, Pharmacy Formulary

Date	Interviewees	Title
1/30/2019	Allison Hertzog	CareSource - Manager, Pharmacy Accreditation and Quality
1/30/2019	Geri Ellington	CareSource - Manager, Compliance and Delegated Oversight
1/30/2019	Shane Sturgeon	CareSource - Manager, Application Development
1/30/2019	Amy Wendell	CareSource - Liaison, SIU
1/30/2019	Jessica Hatton	CareSource - Liaison, Pharmacy Market
1/30/2019	Turkesia Robertson-Jones	CareSource - Director, GA Pharmacy Market
1/30/2019	Andrea Hundley	CareSource - Director, Regulatory
1/30/2019	Owen Neff	CareSource - Director, Pharmacy Compliance
1/30/2019	Dave Hartzell	CareSource - Director, Pharmacy Clinical Initiatives
1/30/2019	Jeff Severino	CareSource - Director, Application Engineering
1/30/2019	Thomas Wall	CareSource - Director, Application Development
1/30/2019	Rama Gudimetla	CareSource - Business Analyst, IT Application Development (Enrollment)

Supporting Detail: Comparison of CareSource FFS Claim and Subcontractor Encounter Data Elements to the MMIS Encounter Data Elements

Myers and Stauffer requested specific claim data elements to be included in the CareSource data extracts for comparison to the MMIS encounters. Claim details vary by claim type (e.g. surgical procedure codes were only assessed for institutional claims). For all CareSource FFS claims and subcontractor encounters found to exist in both the CareSource data extracts and the MMIS encounters, Myers and Stauffer measured the percentage of such claims where the data element value in the CareSource data extracts exactly matched the value in the MMIS encounters. Results of the comparison were presented in four tables, broken out by claim type and vendor as:

- CareSource Institutional and Professional Claims
  - Exhibit B, Table 1 - Institutional (837I / UB-04)
  - Exhibit B, Table 2 - Professional (837P / CMS-1500)

- Scion Dental Encounters
  - Exhibit B, Table 3 - Dental (837D / ADA)

- CVS Caremark Pharmacy Encounters
  - Exhibit B, Table 4 - Pharmaceutical (NCPDP)

The following tables include a listing of all claim data elements assessed for each claim type and vendor. For each data element, there is a percentage indicating the portion of CareSource's claims or their subcontractors' encounters with matching values between processing points in CareSource's claims management system and on the MMIS encounters. Percentages greater than or equal to 99.95% and less than 100% were truncated to 99.9%.

Percentages below 99% were reviewed more in-depth. Observations and findings were included for some scenarios of missing or mismatching data values between the CareSource data extracts and MMIS encounters.

Exhibit B, Table 1 - CareSource Institutional Claims (837I/UB-04) Claim Lines Reviewed = 366,234			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to CMO by Provider	0.0	The claim receipt date reported in the CareSource extracts for institutional claim lines did not match the claim receipt date reported in the MMIS encounters. The claim receipt date reported in the MMIS institutional encounters may represent the date CareSource paid the encounter, since the claim receipt date appears to be the same date as the encounter paid date.
2	Date Paid	99.9	
3	Amount Paid - Claim Header	88.0	The claim header paid amount on approximately 43,800 (12.0%) institutional encounter claim lines in the MMIS encounters appeared to be missing the Georgia Medicaid hospital add-on payment.
4	Amount Paid - Claim Detail Lines	96.7	Approximately 4,800 (1.3%) institutional encounter claim lines with $0 header paid amounts appeared to have non-zero line paid amounts reported in the MMIS encounters. The claim line paid amount on approximately 4,000 (1.1%) institutional encounter claim lines in the MMIS encounters appeared to be different due to the Georgia Medicaid hospital add-on payment included in the claim line paid amount in the CareSource extracts. Approximately 1,200 (0.4%) line paid amounts, when totaled with other line paid amounts for the same claim, resulted in a paid amount less than the claim header payment amount reported in both the CareSource extracts and in the MMIS encounters. Similarly, approximately 1,000 (0.3%) line paid amounts, when totaled with other line paid amounts for the same claim, resulted in a paid amount greater than the header payment amount reported in both the CareSource extracts and in the MMIS encounters.
5	Interest Paid - Claim Header	0.0	Provider interest payments do not appear to be reported in the MMIS institutional encounter data. We would expect to see the interest paid amount identified with an encounter adjustment reason code in the MMIS encounters.
6	Amount Billed - Claim Header	100.0	

Exhibit B, Table 1 - CareSource Institutional Claims (837I/UB-04) Claim Lines Reviewed = 366,234			
	Claim Data Element	**% Match**	**Notes**
7	Amount Billed - Claim Detail Lines	100.0	
8	Member Medicaid ID	99.8	
9	Rendering Provider NPI	92.4	The rendering provider NPI on approximately 27,500 (7.5%) institutional encounter claim lines in the MMIS encounters appeared to be an older provider NPI associated with the Georgia Medicaid provider ID reported on the MMIS encounter. The rendering provider NPI reported in the CareSource extracts for these encounters appeared to be the most recent NPI associated with the Medicaid provider ID.
10	Attending Provider NPI	99.7	
11	Operating Provider NPI	0.0	The Operating Provider NPI does not appear to be reported in the MMIS encounters.
12	Admission Date	100.0	
13	Discharge Date	99.8	
14	First Date of Service – Claim Header	99.8	
15	Last Date of Service – Claim Header	98.5	For approximately 5,500 (1.5%) claim lines, the claim discharge date appears to be reported as the claim header last date of service in the MMIS encounters and later stages of the CareSource extracts.
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	100.0	
19	Units Billed	100.0	
20	Units Allowed	0.0	The allowed units reported in the MMIS encounters appear to be set as 0 for all institutional encounters reviewed. The allowed units do not appear to be reported accurately in the MMIS encounters.
21	Revenue Code	100.0	

Exhibit B, Table 1 - CareSource Institutional Claims (837I/UB-04) Claim Lines Reviewed = 366,234			
	Claim Data Element	**% Match**	**Notes**
22	NDC	89.9	There appeared to be an error in the extract process used by CareSource to provide Myers and Stauffer with inbound claims data from their claim processing system. It appeared the NDCs may have been assigned to incorrect line numbers on the claims in the data extracts. Therefore, we could not compare these values to the MMIS encounters; however, the NDC reported in extracts from later stages in CareSource's claims processing system did not appear to have the same potential extract error and the values appeared to match the NDCs reported in the MMIS encounters.
23	DRG Code	99.9	

Exhibit B, Table 1 - CareSource Institutional Claims (837I/UB-04) Claim Lines Reviewed = 366,234			
	Claim Data Element	**% Match**	**Notes**
24	Diagnosis Codes	92.5	Approximately 2,009,000 diagnosis codes were reviewed for the 366,234 CareSource institutional claim lines reviewed. Myers and Stauffer receives a data extract of MMIS encounters from the Georgia Medicaid Fiscal Agent Contractor on a weekly basis and maintains an internal data warehouse of MMIS encounters. This data warehouse was the source for the MMIS encounter data used in this review. The number of diagnosis codes provided to Myers and Stauffer in the MMIS extracts is limited to 11 total codes; however, the Georgia MMIS maintains additional codes in their system. Due to the limited number of diagnosis codes in Myers and Stauffer's MMIS data warehouse, approximately 150,100 (7.5%) diagnosis codes in the CareSource extracts did not appear in the data warehouse of MMIS encounters, but were associated with encounters where all 11 diagnosis codes listed in the data warehouse of MMIS encounters matched to other diagnosis codes reported in the CareSource extracts for the same claim. These missing diagnosis codes are likely explained by the limitation on the number of diagnosis codes in Myers and Stauffer's data warehouse. In addition to comparing diagnosis code values between the CareSource extracts and the MMIS encounters, Myers and Stauffer compared the order of secondary diagnosis codes between the two data sources. The order of secondary diagnosis codes matched for over 99% of diagnosis codes reviewed.
25	ICD Surgical Procedure Codes	100.0	
26	Procedure Code	99.9	
27	Procedure Code Modifier 1	100.0	
28	Procedure Code Modifier 2	100.0	
29	Procedure Code Modifier 3	100.0	
30	Procedure Code Modifier 4	100.0	
31	Type of Bill	99.9	

Exhibit B, Table 2 - CareSource Professional Claims (837P/CMS-1500) Claim Lines Reviewed = 711,014			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to CMO by Provider	0.0	The claim receipt date reported in the CareSource extracts for professional claim lines did not match the claim receipt date reported in the MMIS encounters. The claim receipt date reported in the MMIS professional encounters may represent the date CareSource paid the encounter, since the claim receipt date appears to be the same date as the encounter paid date.
2	Date Paid	99.9	
3	Amount Paid - Claim Header	99.9	
4	Amount Paid - Claim Detail Lines	98.9	Approximately 2,500 (0.4%) line paid amounts, when totaled with other lines for the same claim, resulted in a paid amount greater than the claim header payment amount reported in both the CareSource extracts and in the MMIS encounters. Approximately 2,200 (0.3%) professional encounter claim lines for claims where the line paid amount was $0 for all claim lines appeared to have non-zero header paid amounts reported in the MMIS encounters. Approximately 2,000 (0.3%) professional encounter claim lines with $0 header paid amounts appeared to have non-zero line paid amounts reported in the MMIS encounters.
5	Interest Paid - Claim Header	0.0	Provider interest payments do not appear to be reported in the MMIS professional encounter data. We would expect to see the interest paid amount identified with an encounter adjustment reason code in the MMIS encounters.
6	Amount Billed - Claim Header	100.0	
7	Amount Billed - Claim Detail Lines	99.9	
8	Member Medicaid ID	99.8	

Exhibit B, Table 2 - CareSource Professional Claims (837P/CMS-1500) Claim Lines Reviewed = 711,014			
	Claim Data Element	**% Match**	**Notes**
9	Rendering Provider NPI	98.9	The rendering provider NPI on approximately 3,000 (0.4%) professional encounter claim lines in the MMIS encounters appeared to be an older provider NPI associated with the Georgia Medicaid provider ID reported on the MMIS encounter. The rendering provider NPI reported in the CareSource extracts for these encounters appeared to be the most recent NPI associated with the Medicaid provider ID.
10	Referring Provider NPI	100.0	
11	First Date of Service – Claim Header	99.9	
12	Last Date of Service – Claim Header	99.9	
13	First Date of Service – Claim Detail Lines	100.0	
14	Last Date of Service – Claim Detail Lines	100.0	
15	Claim Detail Line Number	99.9	
16	Units Billed	100.0	
17	Units Allowed	0.0	The allowed units reported in the MMIS encounters appear to be set as 0 for all professional encounters reviewed. The allowed units do not appear to be reported accurately in the MMIS encounters.
18	NDC	91.2	There appeared to be an error in the extract process CareSource used to provide Myers and Stauffer with inbound claims data from their claim processing system. It appeared the NDCs may have been assigned to incorrect line numbers on the claims in the data extracts. Therefore, we could not compare these values to the MMIS encounters; however, the NDC reported in extracts from later stages in CareSource's claims processing system did not appear to have the same potential extract error and the values appeared to match the NDCs reported in the MMIS encounters.

Exhibit B, Table 2 - CareSource Professional Claims (837P/CMS-1500) Claim Lines Reviewed = 711,014			
	Claim Data Element	**% Match**	**Notes**
19	Diagnosis Code 1	0.0	The first line diagnosis code reported in the MMIS encounters appeared to be hard-coded to point to the first diagnosis code listed on the encounter. The first line diagnosis code does not appear to be reported accurately in the MMIS encounters.
20	Diagnosis Code 2	0.0	The second line diagnosis code reported in the MMIS encounters appeared to be hard-coded to point to the second diagnosis code listed on the encounter. The second line diagnosis code does not appear to be reported accurately in the MMIS encounters.
21	Diagnosis Code 3	0.0	The third line diagnosis code reported in the MMIS encounters appeared to be hard-coded to point to the third diagnosis code listed on the encounter. The third line diagnosis code does not appear to be reported accurately in the MMIS encounters.
22	Diagnosis Code 4	0.0	The fourth line diagnosis code reported in the MMIS encounters appeared to be hard-coded to point to the fourth diagnosis code listed on the encounter. The fourth line diagnosis code does not appear to be reported accurately in the MMIS encounters.
23	Procedure Code	100.0	
24	Procedure Code Modifier 1	99.9	
25	Procedure Code Modifier 2	100.0	
26	Procedure Code Modifier 3	100.0	
27	Procedure Code Modifier 4	100.0	
28	Place of Service	100.0	

Exhibit B, Table 3 - Scion Dental Encounters (837D/ADA) Encounter Claim Lines Reviewed = 166,421			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Vendor by Provider	0.0	The claim receipt date reported in the CareSource extracts for Scion dental claim lines did not match the claim receipt date reported in the MMIS encounters. The claim receipt date reported in the MMIS Scion dental encounters may represent the date Scion paid the encounter, since the claim receipt date appears to be the same date as the encounter paid date.
2	Date Paid	99.9	
3	Subcontractor Amount Paid - Claim Header	99.9	
4	Subcontractor Amount Paid - Claim Detail Lines	99.7	
5	Interest Paid - Claim Header	100.0	
6	Amount Billed - Claim Header	99.8	
7	Amount Billed - Claim Detail Lines	99.9	
8	Member Medicaid ID	99.9	
9	Rendering Provider NPI	96.5	There appear to be approximately 4,900 (3.0%) Scion dental encounter claim lines in MMIS encounters that do not have the same rendering provider NPI as reported in the CareSource extracts. The rendering provider NPI on approximately 800 (0.5%) Scion dental encounter claim lines in the MMIS encounters appeared to be an older provider NPI associated with the Georgia Medicaid provider ID reported on the MMIS encounter. The rendering provider NPI reported in the CareSource extracts for these encounters appeared to be the most recent NPI associated with the Medicaid provider ID.
10	First Date of Service – Claim Header	99.9	
11	Last Date of Service – Claim Header	99.9	
12	First Date of Service – Claim Detail Lines	99.9	
13	Last Date of Service – Claim Detail Lines	99.9	

Exhibit B, Table 3 - Scion Dental Encounters (837D/ADA) Encounter Claim Lines Reviewed = 166,421			
	Claim Data Element	**% Match**	**Notes**
14	Claim Detail Line Number	99.0	Myers and Stauffer observed instances of denied Scion dental claim lines reported in the CareSource extracts which did not appear to exist in the MMIS encounters. These apparent missing claim lines resulting in a shifting of claim line numbers in the MMIS encounters, which appears to explain the observed discrepancy.
15	Units Billed	100.0	
16	Units Allowed	0.0	The allowed units reported in the MMIS encounters appear to be set as 0 for all dental encounters reviewed. The allowed units do not appear to be reported accurately in the MMIS encounters.
17	Procedure Code	99.9	
18	Procedure Code Modifier 1	100.0	
19	Procedure Code Modifier 2	100.0	
20	Procedure Code Modifier 3	100.0	
21	Procedure Code Modifier 4	100.0	
22	Tooth Number	99.9	
23	Tooth Surface Values	99.9	
24	Place of Service	100.0	

Exhibit B, Table 4 – CVS Caremark Pharmaceutical Encounters (NCPDP) Encounter Claim Lines Reviewed = 246,092			
	Claim Data Element	**% Match**	**Notes**
1	Date Filled	100.0	
2	Date Paid	99.9	
3	Subcontractor Amount Paid – Claim Header	99.9	
4	Amount Billed - Claim Header	0.4	The claim billed amount reported in the MMIS encounters for CVS Caremark pharmacy encounters did not match the billed amount reported in the CareSource extracts. Additionally, in the MMIS encounters, the billed amount reported appeared to be the same as the claim paid amount or was $0.50 greater than the claim paid amount. It is possible that the billed amount reported in the MMIS encounters is the amount CareSource paid CVS Caremark instead of the amount the pharmacy billed.
5	Member Medicaid ID	99.9	
6	Rendering Provider NPI	97.2	The rendering provider NPI on approximately 6,800 (2.8%) CVS Caremark pharmacy encounter claim lines in the MMIS encounters appeared to be an older provider NPI associated with the Georgia Medicaid provider ID reported on the MMIS encounter. The rendering provider NPI reported in the CareSource extracts for these encounters appeared to be the most recent NPI associated with the Medicaid provider ID.
7	Prescribing Provider	99.9	
8	Prescription Number	100.0	
9	Refill Number	100.0	
10	NDC	99.9	
11	Dispensed Units	100.0	
12	Days' Supply	99.9	

Attachment A – Agreed-Upon Procedures

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

1. We will request that CareSource and its subcontractors identify and provide their policies and procedures related to Contract Compliance in the areas of Compliance Plan, Program Integrity, Subcontractor Oversight, Utilization Management, Quality Improvement, Member Services, Provider Network, Member and Provider Data Maintenance, Grievances and Appeals, Provider Complaints, Claims Management including Third Party Liability, and Call Center Operations. The following procedures will be performed:
    a. We will review then determine if the policies are in accordance with the contract between DCH and CareSource.
    b. We will review the information provided during the on-site interviews then determine if responses are in accordance with the contract between DCH and CareSource.

2. We will request that CareSource and its subcontractors identify and provide their policies and procedures related to Encounter Submissions. We will also request claims data for analyses. The following procedures will be performed:
    a. We will review then determine if the policies are in accordance with the contract between DCH and CareSource.
    b. We will review the information provided during the on-site interviews then determine if responses are in accordance with the contract between DCH and CareSource.
    c. We will analyze the encounter workflows and processes within CareSource, the subcontracted vendors, and between the subcontractors and CareSource.
    d. We will assess the effectiveness of internal controls used to ensure complete, timely and accurate encounters are reported.
    e. We will select a sample of encounters submitted to the Department's Fiscal Agent Contractor and trace the reported information to CareSource's (and subcontractor's) payment system.
    f. We will research then determine the cause of any discrepancies.
    g. We will analyze the claims payment system and accuracy of claim pay dates, particularly on adjustments and voids.

3. We will request that CareSource and its subcontractors identify and provide their policies and procedures related to Program Integrity Oversight. The following procedures will be performed:
    a. We will review then determine if the policies are in accordance with the contract between DCH and CareSource.
    b. We will review the information provided during the on-site interviews then determine if responses are in accordance with the contract between DCH and CareSource.
    c. We will review CareSource and its subcontractor's program integrity programs and its overall effectiveness including implementing pre-payment and post-payment reviews, identifying, investigating, and referring all cases of fraud,

waste, and abuse cases to appropriate state and federal law enforcement, and other program integrity activities.

4. We will request that CareSource identify and provide their policies and procedures related to Subcontractor Oversight.
    a. We will review then determine if the policies are in accordance with the contract between DCH and CareSource.
    b. We will review the information provided during the on-site interviews then determine if responses are in accordance with the contract between DCH and CareSource.
    c. We will review corrective action procedures administered, if any, by CareSource as a result of contract non-compliance.