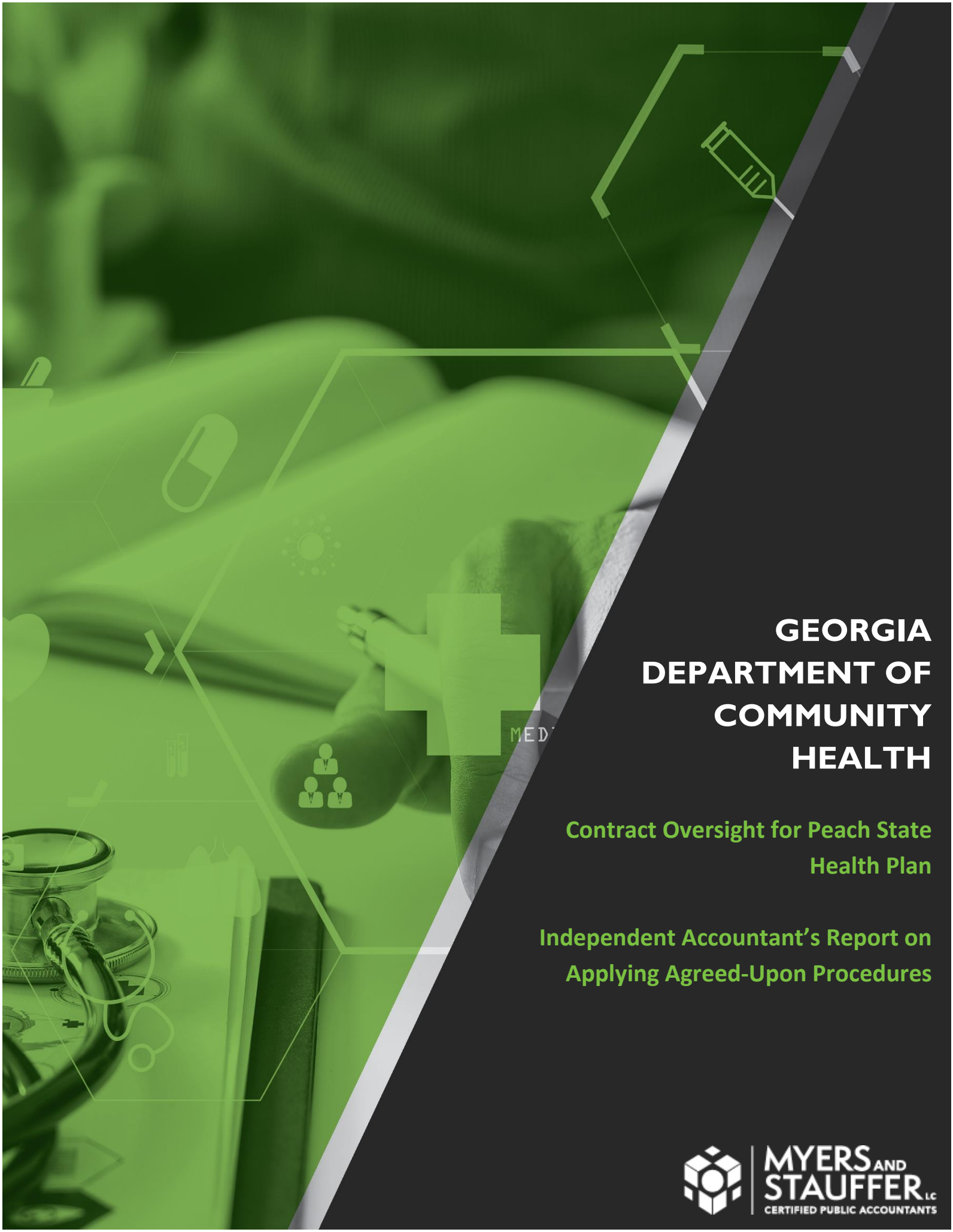

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Contract Oversight for Peach State Health Plan

Independent Accountant's Report on Applying Agreed-Upon Procedures

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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CERTIFIED PUBLIC ACCOUNTANTS

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

We have performed the procedures enumerated in Appendix B, which were agreed to by the Department of Community Health (DCH or the Department). We were asked to apply these procedures in order to evaluate Peach State Health Plan's (PSHP) contract compliance, program integrity oversight, subcontractor oversight, and encounter submissions. PSHP's management is responsible for compliance with the Department's policies and procedures, as well as the encounter submissions. DCH's management is responsible for the Department's policies and procedures, as well as vendor management functions. The sufficiency of these procedures is solely the responsibility of the Department. Consequently, we make no representation regarding the sufficiency of contract compliance, program integrity oversight, subcontractor oversight, or encounter submissions and payment systems policies and procedures established by the Department and PSHP for the purpose for which this report has been requested or for any other purpose. Our *Findings and Recommendations* section begins on page 110.

This agreed-upon procedures engagement was conducted 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, the objective of which would be the expression of an opinion or conclusion, respectively, on the accompanying *Findings and Recommendations* section. 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.

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

Myers and Stauffer LC

Myers and Stauffer LC
Atlanta, Georgia
December 16, 2021

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Project Background

PSHP is one of four Care Management Organizations (CMOs) providing 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 may be 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 their subcontractors in order to assess the effectiveness of contractually-mandated monitoring and operational requirements.

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

Methodology

Pre On-site

We prepared and submitted a data and information request to PSHP prior to initiating field work. This request was sent to PSHP on September 9, 2019. 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 PSHP.*
- *The requirements included in the contracts between PSHP and its subcontractors.*
- *The existing policies and procedures relative to contract compliance, PI, and subcontractor oversight for PSHP and each subcontractor.*
- *The encounter workflows and processes within PSHP, within the subcontracted vendors, and between the subcontractors and PSHP.*
- *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) PI; 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 and whether Myers and Stauffer had previously visited the vendors.*
- *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 PSHP and/or the appropriate subcontractor(s).*

On-site and Teleconferences

On-site activities at the PSHP office in Atlanta, Georgia, and the Centene corporate office in Clayton, Missouri, consisted of facility tours followed by Myers and Stauffer performing interviews of certain PSHP 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 PSHP personnel to interview and met and interviewed those individuals while on-site.

Myers and Stauffer, with DCH approval, determined that visits, teleconference calls, and interviews would be conducted with subcontractors Envolve Dental, Envolve Pharmacy, Envolve Vision, Nursewise, Nurtur, and One Source Therapy Review. Visits and interviews at each subcontractor location were performed in the same manner as those performed at the PSHP corporate and local offices, which included a facility tour. The claims and encounters sections of this engagement were conducted via teleconference.

On-site visits, teleconference calls, and interviews for this engagement began October 28, 2019 and ended December 17, 2019. The table below outlines the health plan, dates, the Myers and Stauffer and DCH team members, and locations for this engagement.

On-site Schedule and Details			
Health Plan	**Date**	**Myers and Stauffer Engagement Team**	**Location**
PSHP	10/28/2019 - 10/30/2019	**Myers and Stauffer:** Savombi Fields Nickie Turner Mitchell Keister Jillian Kuether Phoebe Chiem **DCH:** Sandra Middlebrooks Woody Dahmer	Atlanta, GA
Centene, Inc.	11/12/2019 - 11/14/2019	**Myers and Stauffer:** Savombi Fields Stephen Fader Mitchell Keister Phoebe Chiem Hailey Plemons	Clayton, MO
One Source Therapy Review, Inc.	11/14/2019	**Myers and Stauffer:** Vickie Bartlett	Duluth, GA

On-site Schedule and Details			
Health Plan	**Date**	**Myers and Stauffer Engagement Team**	**Location**
		Kathryn Striewe Kelly McNamara Nickie Turner	
Nurtur	11/20/2019 – 11/21/2019	**Myers and Stauffer:** Savombi Fields Vickie Bartlett Sue Hart	Dallas, TX
Envolve Dental	12/03/2019	**Myers and Stauffer:** Savombi Fields Nickie Turner	Tampa, FL
Envolve Pharmacy Solutions/RX Advance	12/04/2019	**Myers and Stauffer** Savombi Fields Nickie Turner	Orlando, FL
Nursewise	12/09/2019 – 12/10/2019	**Myers and Stauffer** Savombi Fields Kathryn Striewe Sue Hart	Tempe, AZ
Envolve Vision (and Dental)	12/16/2019 – 12/17/2019	**Myers and Stauffer** Savombi Fields Nickie Turner	Rocky Mount, NC
Envolve Dental	12/10/2019	**Myers and Stauffer** Stephen Fader Mitch Keister	Teleconference
Behavioral Health (PSHP)	12/16/2019	**Myers and Stauffer** Stephen Fader Mitch Keister	Teleconference
Envolve Vision	12/16/2019	**Myers and Stauffer** Stephen Fader Mitch Keister	Teleconference
Envolve Pharmacy Solutions	12/17/2019	**Myers and Stauffer** Savombi Fields Nickie Turner	Teleconference
PSHP	10/28/2019 - 10/30/2019	**Myers and Stauffer:** Savombi Fields Nickie Turner Mitchell Keister Jillian Kuether Phoebe Chiem **DCH:**	Atlanta, GA

On-site Schedule and Details			
Health Plan	**Date**	**Myers and Stauffer Engagement Team**	**Location**
		Sandra Middlebrooks Woody Dahmer	

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 PSHP.

Post On-site

Myers and Stauffer transcribed the interviews with PSHP, Centene, One Source Therapy Review, Nurtur, Envolve Dental, Envolve Pharmacy/RxAdvance, Nursewise, and Envolve Vision. 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.

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 PSHP 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 PSHP, Centene, Envolve Pharmacy Solutions/RxAdvance, Envolve Dental, Envolve Vision, Nursewise, and Nurtur.

6. We assumed data from PSHP's information systems operated as described in the documentation supplied by PSHP.

7. We assumed that claims data and claims payment information received was correct. Unless conflicting information was presented to the contrary, we accepted the claims data and claims payment information as accurate.

Contract Compliance

Myers and Stauffer interviewed PSHP staff members and reviewed PSHP's existing policies and procedures related to contract compliance in the areas of behavioral health; call center operations (member and provider); claims management (including third-party liability [TPL]); compliance plan; grievances and appeals; member and provider data maintenance; member services; PI; provider complaints; provider network; quality improvement; subcontractor oversight; and utilization management. We identify the key contract requirements and determine whether PSHP has policies and procedures consistent with the contract requirement(s) in the tables below.

Behavioral Health

We interviewed PSHP staff members and reviewed PSHP's existing policies and procedures in relation to behavioral health. In the table below, we identify the key contract requirements and whether PSHP has policies and procedures consistent with the contract requirement(s) for behavioral health.

Contract Requirements and Consistency of PSHP Policies and Procedures for Behavioral Health

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.5.4.3 For Medicaid children under twenty-one (21) years of age, the Contractor is required to provide Medically Necessary Services to correct or ameliorate physical and Behavioral Health disorders, a defect, or a condition identified during an EPSDT screening or preventive visit regardless of whether those services are included in the State Plan, but are otherwise allowed pursuant to 1905 (a) of the Social Security Act.	Yes
4.6.11.6 The Contractor shall permit all initial outpatient Behavioral Health (mental health and substance abuse) evaluation, diagnostic testing, and assessment services to be provided without Prior Authorization. The Contractor shall permit up to three (3) initial evaluations per year for Members younger than twenty-two (22) years of age without requiring additional Prior Authorization.	Yes

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.6.11.7 Following an initial evaluation, the Contractor shall permit up to twelve (12) outpatient counseling/therapy visits to be provided without Prior Authorization.	Yes
4.6.11.8 The Contractor shall promote the delivery of Behavioral Health services in the most integrated and person-centered setting including in the home, school or community, for example, when identified through care planning as the preferred setting by the Member. The delivery of home and community based Behavioral Health services may be incentivized by the Contractor for Providers who engage in this person-centered service delivery.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with PSHP personnel supported that these functions are occurring.
4.8.4.5 The Contractor will include Behavioral Health Homes in its Medical Home network. Behavioral Health Home providers do not need to provide all the services of a traditional Medical Home themselves, but must ensure that the full array of primary and Behavioral Health Care services is available, integrated and coordinated. The number of behavioral Health Homes proposed in the network should be responsive to the prevalence of members with severe and persistent mental illness or chronic behavioral health conditions. The proposed algorithm along with assignment of Behavioral Health Homes shall be included in a Medical Home implementation plan.	Awaiting guidance from DCH.
4.8.9.1 The Contractor shall include in its network the three tiers of community Behavioral Health Providers listed below that meet the requirements of the Department of Behavioral Health and Developmental Disabilities, provided they have been credentialed to participate in Medicaid for that provider type and agree to the Contractor's terms and conditions as well as rates.	Yes
4.8.9.1.1 Tier 1: Comprehensive Community Providers (CCP) 4.8.9.1.1.1 CCPs function as the safety net for the target population, serve the most vulnerable and respond to critical access needs. The standards and requirements for CCPs are found in CCP Standards for Georgia's Tier 1 Behavioral Health Safety Net, 01-200.	Yes
4.8.9.1.2 Tier 2: Community Medicaid Providers (CMPs)	Yes

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.8.9.1.2.1 CMPs provide Behavioral Health services and supports identified in the Medicaid State Plan for Serious Emotional Disturbance (SED) youth, young adults, Serious and Persistent Mental Illness (SPMI) Adults, and individuals with Substance Use Disorders (SUDs). CMPs must competently serve children, adolescents, emerging adults, and/or adults and have the capacity and infrastructure to provide all of the services in the core benefit package:	Yes
4.8.9.1.3 Tier 3: Specialty Providers (SPs) 4.8.9.1.3.1 SPs offer an array of specialty services including but not limited to: 4.8.9.1.3.1.1 Intensive Family Intervention providers for children who have mental illness/serious emotional disturbance (or similar diagnosis) and their families.	Yes
4.8.9.1.3.1.2 Certified Peer Specialists (CPS) with lived experience for both young adults and adults to include CPS-Parents who are associated with a Family Support Organization (i.e. Federation of Families), CPS-Addiction and CPS Whole Health and Wellness.	Yes
4.8.9.1.3.1.3 Care Management Entities to provide intensive, customized, complex Care Coordination for children, youth, and young adults who have mental illness/serious emotional disturbance (or similar diagnosis) and their families.	Yes
4.8.9.1.3.1.4 Assertive Community Treatment for adults with SPMI.	Yes
4.8.9.2 Additionally, the Contractor shall include in its Provider network Providers who are enrolled as psychologists under the State Plan.	Yes
4.8.9.3 The Contractor shall maintain copies of all letters and other correspondence related to the inclusion of Community Behavioral Health Providers in its network. This documentation shall be provided to DCH upon request.	Yes
4.9.2.1 The Contractor shall provide a Provider Handbook to all Providers. Upon request, the Contractor shall mail a hard copy to the Provider. The Provider Handbook shall serve as a source of	Yes

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
information regarding GF Covered Services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all Contract requirements are being met. At a minimum, the Provider Handbook shall include the following information: 4.9.2.1.10 Physical Health and Behavioral Health Coordination including the requirement for Behavioral Health Providers to send status reports to PCPs and PCPs to send status reports to Member's Behavioral Health Providers.	
4.11.8.2 The Contractor must develop and implement Care Coordination and Continuity of Care. Policies and procedures are designed to accommodate the specific cultural and linguistic needs of the Contractor's Members and include, at a minimum, the following elements:	Yes
4.11.8.4 The Contractor is encouraged to use Community Health Workers in the engagement of Members in Care Coordination activities. This includes: Transition of Care, Discharge Planning; Care Coordination, Coordination with Other Entities, Physical Health and Behavioral Health Integration, Disease Management and Case Management.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with PSHP personnel supported that these functions are occurring.
4.11.8.9.1 The Contractor shall develop an innovative approach to encourage PCPs, Behavioral Health Providers, and dental Providers to effectively and efficiently share behavioral and physical health clinical Member information, including how the Contractor will notify Behavioral Health Providers and PCPs after an inpatient mental health stay.	Yes
4.11.8.9.2 The Contractor must require Behavioral Health Providers to send initial and quarterly (or more frequently if clinically indicated) summary reports of a Member's behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Handbooks.	Yes
4.11.8.9.3 The Contractor shall submit an annual Health Coordination and Integration Report to the Department due June 30th of each calendar year for the prior calendar year beginning 2017. This report is subject to approval by the Department. At a minimum, this report	Yes

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
shall include: 4.11.8.9.3.1 Program Goals and Objectives 4.11.8.9.3.2 Summary of activities and efforts to integrate and coordinate behavioral and physical health; 4.11.8.9.3.3 Successes (e.g., exceeding performance targets) and opportunities for improvement; 4.11.8.9.3.4 Plans to implement initiatives to address identified opportunities for these improvements and to achieve expected outcomes; and 4.11.8.9.3.5 Roadmap of activities planned for the next reporting period.	
4.11.10.8 The Contractor must notify DCH of the specific Case Management programs it initiates (i.e. OB Case Management, Behavioral Health case management, etc.) and terminates and provide evidence, on an annual basis, of the effectiveness of such programs for its enrolled Members.	No. There was no specific reference to this section of the contract in the submitted policy documents.

Overview of Behavioral Health Management

PSHP policy indicates that the plan and its providers are responsible for an integrative approach to addressing their members' physical health care and behavioral health care services. The approach requires the sharing of behavioral health and physical health information between primary care physicians (PCPs), behavioral health providers, and dental providers, resulting in a collaborative approach to the member's care.

PCPs are assigned members for whom they coordinate, supervise, and provide primary care. Additionally, they coordinate specialty care, including behavioral health care. The PCP maintains the member's medical records, which include documentation of behavioral health and other specialty services. Peach State allows psychiatrists to serve as PCPs for members with a severe persistent mental illness as their primary diagnosis. The psychiatrist must be willing to perform all PCP responsibilities as outlined with their contract with PSHP.

Behavioral health providers are responsible for assessing, monitoring, and providing care to address the members' behavioral or mental health needs. Behavioral health providers include, but are not limited to: psychiatrists; psychologists; licensed master social workers (LMSW); advanced clinical practitioners (ACP); licensed professional counselors (LPC); and licensed marriage and family therapists (LMFT).

Behavioral health providers are required to send initial and quarterly summary reports on the member's behavior health status to the member's PCP. This reporting is done with the consent of the member or their legal guardian. PSHP's role in this reporting process is to notify behavioral health providers and PCPs when a member has had an inpatient hospital stay for mental health reasons. This allows for continuity of care and proper documentation as it relates to mental health diagnoses and provision of behavior health services.

The Behavioral Health Plan is structured so that each functional area has behavioral health as a part of its functionality. These functional areas collaborate with their behavioral health counterparts to ensure that behavioral health services are available and integrated for the PSHP member population requiring these services. Examples of this include utilization management (UM), case management (CM), disease management (DM), network management (NM), and quality management (QM).

- *UM is using evidence-based criteria or guidelines to assess the appropriateness of health care while managing the cost, on a case-by-case basis, prior to providing that care. Prior authorizations are used as a part of the UM function. PSHP's UM department includes functions and staffing for behavioral health services. The UM department has a dedicated team of licensed behavior health providers, which include licensed mental health providers and psychologists whose education, experience, and training corresponds with the reviews that they conduct.*

Prior authorizations are submitted by the provider requesting certain behavioral health services for their members. The request will be reviewed by Peach State Behavioral Health UM staff for appropriateness and for medical necessity. Prior authorizations can be submitted via a telephone call or a fax. Initial or primary reviews are conducted by UM staff. If the UM staff require additional support or the request does not meet *InterQual*® guidelines, the full time medical director will review the case with the UM staff. The prior authorization is approved if it is supported and meets *InterQual*® criteria. A denial is submitted if medical necessity is not met.

  - *The hours of operation for the PSHP UM department are Monday through Friday (excluding holidays) from 8:00 a.m. to 5:30 p.m. Clinical staff is also available after hours on weekdays and weekends to conduct clinical reviews and/or, if needed, to discuss urgent UM issues. UM staff can be reached via their toll-free number at (800) 947-0633.*

- *Per PSHP policy, their CM services focus on prevention, coordination of care, continuity of care, and integration of care. CM seeks to reduce hospitalizations and support member health and recovery while maintaining cost effectiveness. Peach State members can be referred to CM by physicians, providers, and case managers. Data mining is also performed in order to identify members eligible for CM. Criteria for behavioral health CM selection include but are not limited to: members in the emergency room (ER) for a mental health crisis; members with three (3) or more admittances in the past ninety (90) days to the ER; members with admittances to an In-patient psychiatric facility three (3) or more times in sixty (60) days; currently hospitalized or*

seeing a vendor or therapy provider for mental health related issues; members with a history of chronic mental and physical health conditions; children and adults with special healthcare needs; and toddlers with developmental delays or disabilities. Initially, the members are screened to identify their level of risk. Assessments are performed within the first thirty (30) days of the member being identified and screened. The member's current medical condition, clinical history, ER utilization, medication history, and cognitive and mental status are evaluated during the assessment. The assessment also looks at daily functions, evaluates care givers, and evaluates benefits for specific needs.

- *PSHP has specialized care management programs for members with behavioral and other mental health conditions. These care management programs include but are not limited to a DM program for depression, substance abuse, high risk, and chronic diseases. CM in general will follow up with members after every hospitalization to ensure effective transition of care. The goal is for the member to be seen within seven (7) days post discharge and no longer than thirty (30) days post discharge. Additionally, they outreach telephonically to members with major depression and/or substance abuse. Home visits are performed in the event the member cannot be reached telephonically.*
    - *PSHP submits quarterly reports to DCH that include specific CM data for the purpose of evaluating the effectiveness of the program. PSHP evaluates their CM program annually.*
- *The NM department contains a behavioral health contracting team. This team works with the PSHP network analysts who utilize geo-access reporting to determine network adequacy. Network adequacy is reviewed and determined on a monthly basis. Network adequacy reporting is used in recruiting efforts when feedback from behavioral health CM staff, behavioral health customer service staff, and PSHP members utilizing behavioral health services indicate that there may be a deficiency in the network. PSHP also uses data mining to look for gaps in provider coverage. According to PSHP staff, there were no areas of deficiency with geo-access at the time of our interviews.*
- *QM oversight for Behavioral Health is done within the QM department. In order to meet the quality standards for behavioral health, PSHP has specialized programs in place. They have two (2) specialized trainers who perform behavioral health training with providers either face-to-face or by webinar. They have developed an in-depth training on HEDIS (Healthcare Effectiveness Data and Information Set) measures, as well as trainings on other topics. These trainings are available on the PSHP website.*
    - *A HEDIS guide has been developed for behavioral health providers. PSHP provider representatives provide the guide and review it with behavioral health providers during their site visits. Additionally, care gap reports are given to the providers for the purpose of educating the members. Behavioral health providers do not typically identify care gaps, as this is a function of PCP providers. PCPs should cross reference against care*

provided by behavioral health providers in order to identify any behavioral health-related gaps in care.

Observations: Behavioral Health

- *Within the customer service unit, there are representatives who are specially trained to handle the unique needs of behavioral health members (e.g., the caller is in crisis and in critical need of assistance).*
- *PSHP has a 24/7 crisis line for behavior health member calls, and both the customer service line and nurse advice line can warm transfer to this line.*
- *InterQual® is an evidence-based clinical decision support tool used to make UM decisions that are clinically appropriate. PSHP uses InterQual® guidelines to make UM decisions for adult and pediatric members in both inpatient and outpatient settings.*
- *Behavioral health members may be locked into a single provider or go to a provider of their choice.*
- *PSHP has seen an increase in the number of providers who provide both physical and behavioral health within the same practice. Peach State provided an example of a pediatrician having a counselor in their practice.*
- *PSHP allows the use of telehealth services for outpatient services. Behavioral health is one of the highest utilizers of these services.*

Effective July 1, 2017, as part of the new contract between DCH and the CMOs, the Department implemented the behavioral health homes (BHH) requirement for all CMOs. PSHP has not initiated a formalized BHH program because the Department has asked them to wait until a statewide program can be developed.

Myers and Stauffer determined that some of PSHP's policies and procedures for the behavioral health program were in accordance with the DCH contract. PSHP should revisit the current contract with DCH and ensure that relevant policies and procedures address the following: promotion of the delivery of behavioral health services; community health workers in the engagement of members in care coordination activities; and the notification, utilization, and administration of CM programs. We also find that as DCH communicates its expectations of the BHH (contract section 4.8.4.5), PSHP's existing program should be assessed to ensure compliance.

Call Center Operations

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

Contract Requirements and Consistency of PSHP Policies and Procedures for Call Center Operations—Member

Contract Language (Member)	PSHP 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.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with PSHP personnel supported this did occur.
4.3.7.4 The call center must comply with Title IV of the Civil Rights Act. The call center shall be equipped to handle calls from non-English speaking callers, as well as calls from Members who are hearing impaired.	Yes
4.3.7.5 The Contractor shall fully staff the call center between the hours of 7:00 a.m. and 7:00 p.m. EST, Monday through Friday, excluding State holidays. The call center staff shall be trained to accurately respond to Member questions in all areas, including, but not limited to, Covered Services, the Provider Network, and Non-Emergency Transportation (NET). Additionally, 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	Yes

Contract Language (Member)	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
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.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.3.10.1 The Contractor shall provide oral interpretation services of information to any Member who speaks any non-English language regardless of whether a Member speaks a language that meets the threshold of a Prevalent Non-English Language. The Contractor shall notify its Members of the availability of oral interpretation services and to inform them of how to access oral interpretation services. There shall be no charge to the Member for interpretation services.	Yes

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

Contract Language (Provider)	PSHP 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.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with PSHP personnel supported this did occur.
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	Yes

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

Overview of Call Center Operations for Members and Providers

PSHP contractual obligations are applicable to both the member and provider call center to include the following:

- *Eighty percent (80%) of all calls answered within thirty (30) seconds.*
- *Abandoned call rate of less than five percent (5%).*
- *Blocked call rate of less than one percent (1%).*
- *Average hold time of less than one (1) minute with a ninety-nine percent (99%) adherence rate.*

- *One hundred percent (100%) of call center inquiries resolved and closed within seventy-two (72) clock hours.*

The call center representatives complete a four (4) week training which includes three (3) weeks of instruction and one (1) week of on the job training. The type of calls received by the representatives include claim inquiry, eligibility inquiry, claim status, UM history inquiry, prior authorizations, and provider inquiry.

All calls are recorded and monitored for the purposes of performance feedback and reporting metrics. All customer service representative (CSR) calls are monitored weekly. The quality specialists, who perform the monitoring, are required to monitor a minimum of two (2) calls per week and a total of ten (10) calls monthly. The CSRs are provided feedback on all monitored calls and must maintain a quality score of 90%.

Observations: Call Center Operations for Members and Providers

Myers and Stauffer listened to three (3) calls while on-site, of which one call required follow-up. For this call, the call center representative was not able to provide resolution due to the provider disconnecting the call while placed on hold. PSHP reached out to the provider for resolution. The PSHP follow-up response stated:

> *"During the live monitoring session with Myers and Stauffer/DCH, a provider contacted the call center regarding an $86K claim that was denied. The provider hung up before the CSR could research the issue. The CSR placed a follow up call to the provider's office to complete the call however she received the provider's voicemail."*
>
> *"After researching the claim, it was determined that the claim was resubmitted and rejected again due to the incorrect authorization being submitted by the provider. We then engaged our Provider Relation (PR) team to conduct further outreach to the provider. The provider re-submitted both claims on October 31, 2019. The claims were denied again for failure to submit medical records. The provider was instructed to submit a Provider Adjustment with medical records to have the claim reprocessed."*

Overall, Myers and Stauffer determined PSHP's policies and procedures for member and provider call center operations were in accordance with the DCH contract with the exception of contract sections 4.3.7.7 and 4.9.5.7 related to remote phone monitoring capabilities for at least ten (10) DCH staff. PSHP should update policies and procedures to address this contract requirement.

Claims Management including Third Party Liability

We interviewed PSHP staff members and reviewed their existing policies and procedures in relation to claims management, including TPL. In the table below, we identify the key contract requirements and whether PSHP has policies and procedures consistent with the contract requirement(s).

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

Contract Language	PSHP 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), real-time 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	Yes

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
electronic funds transfer (EFT) of Claims payments.	
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
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	Yes

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
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.	
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.	Yes
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.	Yes
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.	Yes
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.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with PSHP personnel supported that

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
	this requirement is being met.
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
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.	No. There was no specific reference to this section of the contract in the submitted policy documents.
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.	No. There was no specific reference to this section of the contract in the submitted policy documents.
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

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
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.	No. There was no specific reference to this section of the contract in the submitted policy documents.
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 provided but may not recover any payment made to the Provider; and	No. There was no specific reference to this section of the contract in the submitted policy documents.
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.	No. There was no specific reference to this section of the contract in the submitted policy documents.
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.	No. There was no specific reference to this section of the contract in the submitted policy documents.

Overview of Claims Management including Third Party Liability

Claims Management

PSHP's provider manual states that initial claims must be received within 180 days from the date of service. PSHP accepts both paper and electronic claims; however, electronic submission is the preferred format. PSHP encourages providers to submit claims electronically.

Claims filed that meet the definition of a "clean" claim will pay or deny within fifteen (15) business days of receipt. Non-clean claims will be adjudicated (finalized as paid or denied) within thirty (30) business days from the date of the original submission. Non-clean claims will be adjudicated (finalized as paid or denied) within thirty (30) days of receipt of the electronic claim. No later than the fifteenth (15th) business day after the receipt of a provider claim that does not meet "clean" claim requirements, PSHP will suspend the claim and request additional information through the PSHP website or explanation of benefits for all outstanding information such that the claim can be deemed "clean." Upon receipt of all the requested information from the provider, PSHP will complete processing of the claim within fifteen (15) business days.

For all claims initially denied or underpaid by PSHP but eventually determined or agreed to have been owed to a provider of health care services, PSHP 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.

Third-Party Liability

TPL refers to the legal obligation of any other health insurance plan, 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.

PSHP works with Health Management Systems (HMS) to update TPL information. HMS takes the PSHP member information and checks it against 1200 other commercial carriers to find matches. If a match is found, HMS sends a bill out to the primary commercial carrier letting them know that PSHP paid a claim and is requesting repayment. Once a payment is received from the primary carrier, it is posted to the system. Anything HMS has been able to verify by speaking to the other insurance carrier is referred to as the cost avoidance record. The record is loaded into the system to assure any future claims will not be paid until PSHP gets an EOB from the primary carrier.

PSHP uses another vendor, Rawlings, to handle pay and chase or recovery cases. These are often referred to as subrogation cases because they involve an accident. In these cases, PSHP has already paid the claims and is seeking recoupment from the primary insurance carrier.

Observations: Claims Management including Third Party Liability

- *HMS provides TPL cost avoidance reports to PSHP on a monthly basis.*
- *High-dollar claims will automatically pend if the allowable amount is $50,000 or greater for inpatient and $10,000 or greater for outpatient.*
- *An estimated 92% of PSHP claims are auto adjudicated.*

After review of PSHP policies and procedures for claims management, including TPL, we did not identify policies or standard operating procedures for some contract sections. Those sections include policy on the following: functionally equivalent to the web site; DCH notification when unsuccessful in obtaining necessary cooperation from a member to identify potential third-party resources; coordinating with the other responsible payer and not recouping funds directly from the provider; withholding payment for services provided to a member if TPL cannot be determined or if payment will not be available within sixty (60) calendar days; pursuing a cause of action against any person who was responsible for payment of the services; proper TPL payments to the provider; and responsible party billing for the provider. We recommend that PSHP, in accordance with their contract with DCH, create policies to address the contract requirements outlined in these areas.

Compliance Plan

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

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

Contract Language	PSHP 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

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.13.2.1.3 Policies to ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's Fraud, Waste and Abuse compliance plan;	Yes
4.13.2.1.4 Policies to establish a compliance committee that meets quarterly and reviews Fraud, Waste and Abuse compliance issues;	Yes
4.13.2.1.5 Policies to ensure that any individual who reports CMO violations or suspected Fraud, Waste and Abuse will not be retaliated against;	Yes
4.13.2.1.6 Policies of enforcement of standards through well-publicized disciplinary standards;	Yes
4.13.2.1.7 Provision of a data system, resources and staff to perform the Fraud, Waste and Abuse and other compliance responsibilities;	Yes
4.13.2.1.8 Procedures for the detection of Fraud, Waste and Abuse that includes, at a minimum, the following: 4.13.2.1.8.1 Prepayment review of claims; 4.13.2.1.8.2 Claims edits; 4.13.2.1.8.3 Post-processing review of Claims; 4.13.2.1.8.4 Provider profiling; 4.13.2.1.8.5 Quality Control; and 4.13.2.1.8.6 Utilization Management.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with PSHP personnel supported that these functions are occurring.
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.	No. There was no reference to this section of the contract in the submitted policy documents; however, interviews with PSHP

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
	personnel supported that procedures are in place.

Overview of Compliance Plan

PSHP has a Compliance Plan and a Compliance Program in place. The Compliance Plan is updated annually or more frequently to incorporate changes. Per PSHP policy, the purpose of the PSHP Compliance Program is to: (a) prevent, detect, and correct violations of law and company policy and procedures; (b) assure the establishment of compliance-related policies and procedures for business operations; (c) assure development of training and other programs designed to educate employees regarding applicable policies, procedures, and standards; (d) implement a mechanism to evaluate the effectiveness of essential elements of the Compliance Program; (e) implement a mechanism for internal reporting of questionable or inappropriate activities to enable timely investigation and resolution; and (f) assure appropriate corrective action is taken to prevent recurrence of misconduct.

The Compliance Program incorporates guidance from the Department of Health and Human Services' Office of the Inspector General, and is coordinated by the PSHP compliance officer who works with compliance representatives throughout the organization**.** PSHP also has a compliance committee that meets on a quarterly basis. The committee reviews metrics, discusses new initiatives, and conducts the annual approval of the Compliance Plan.

Annual fraud, waste, and abuse (FWA) training is mandatory for all employees. The training is presented in conjunction with the annual ethics and compliance training. New employees receive the training as part of the on-boarding process. Employees complete the tasks inside each training module. The scoring method may vary. For example, for 2019, test questions were included throughout; whereas the previous year included an exam at the end.

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

Grievances and Appeals

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

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

Contract Language	PSHP 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

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.14.1.6.1 An Appeal of a denial that is based on lack of Medical Necessity;	Yes
4.14.1.6.2 A Grievance regarding denial of expedited resolutions of an Administrative Review; and	Yes
4.14.1.6.3 Any Grievance or Administrative Review that involves clinical issues.	Yes
4.14.3.1 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

PSHP's grievances and appeals (G&A) department is responsible for receiving, tracking, resolving, and reporting member and provider grievances and appeals. The department is made up of one medical director, two senior managers, seven non-clinical case coordinators, and one intake coordinator.

Grievances

Grievances are submitted orally via the *Omni* Customer Relationship Management (CRM) system or in writing. This information is also tracked in SharePoint, the internal system used to record the intake of grievances and appeals. PSHP receives the majority of grievances through oral submission. Some grievance classifications include quality of care, access to care, billing, and financial.

The process begins when the grievance is received in the Prime system, which is used to track, investigate, and record grievance resolutions. Once the complaint is received by the G&A intake coordinator, it is classified and distributed to the appropriate G&A case coordinator. The grievance coordinator is responsible for sending an acknowledgement letter to the member within 10 calendar days of receipt. The case coordinator investigates, as well as collaborates with other departments to ensure timely resolution and documents the grievance in the system. The G&A department's internal process is to resolve the case within 45 calendar days; however, the contractual requirement is 90 calendar days. Certain cases deemed clinically urgent by the medical director will be expedited and resolved within three business days of receipt. If members disagree with the grievance disposition, they can submit an appeal to PSHP within 15 calendar days of the Notice of Disposition letter. This appeal will be processed by the G&A team within 30 calendar days following the same grievance process.

Appeals

Appeals can be received via mail, phone, or fax. PSHP receive the majority of appeals via fax in the *Faxcom* system. Appeals can be submitted by the member, an authorized representative, or the provider on behalf of the member. Once the appeal is received, the intake coordinator will classify the appeal in the *Truecare* system as standard or expedited. Standard appeals are processed within 30 calendar days while expedited cases are processed within 72 hours of receipt. If the appeal is a hard copy, the document will be uploaded to the *Faxcom* system and shredded once complete. The documents within the *Faxcom* system are routed to the non-clinical case coordinator queues for processing.

The case is then distributed to the non-clinical case coordinator, who acknowledges the case and sends the acknowledgement letter to the member within 10 calendar days. They also begin the preliminary review to ensure all necessary information is received to include the notice of action, written request, supporting documents or medical records, and member consent for appeals submitted by the provider on behalf of the member. After these elements are received, the case is uploaded to the appeal summary tab in the *Truecare* system as one appeal packet and transferred to a clinician within the UM Department for review. The medical director will review the case and make a determination. Once a determination has been made, the medical director routes the case back to the non-clinical case coordinator in *Truecare*. The case coordinator will then generate the resolution letter to all involved parties and close the case.

If the adverse action is upheld, the member has the right to an administrative law hearing if requested in writing within 120 calendar days from the appeal resolution notification. This process is handled by the compliance team. A continuation of benefit request can be submitted by the member within 10 calendar days from the appeal resolution notification while the administrative law hearing is pending.

If the appeal is overturned, the case is automatically routed to the claims department for further action. PSHP's case coordinator will reach out to the vendor coordinators directly for overturned pharmacy,

dental, and *NIA* (National Imaging Association) appeals. The case coordinator is responsible for resolution and closing out the case.

Observations: Grievances and Appeals

- *According to PSHP representatives, the volume of Medicaid grievances and appeals averages 20 per day.*
- *When asked to provide the percentage of overturned medical necessity appeals for Q2 2019, we were advised that the percentage was 28.7%. The target is ≤ 30%.*

Myers and Stauffer found the contract provisions related to grievances and appeals were addressed in current policies and procedures.

Member and Provider Data Maintenance

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

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

Contract Language	PSHP 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.	Yes
4.17.1.1.1 Contractor shall have information management processes and information Systems that enable it to retain and maintain access to Provider's historical information for the purpose of claims processing and Provider inquiries for a period of up to five (5) years.	No. There was no specific reference to this section of the contract in the submitted policy documents.
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.	Yes

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.17.1.3 The Contractor shall provide a Web-accessible system hereafter referred to as the DCH Portal that designated DCH and other state agency resources can use to access Quality and performance management information as well as other system functions and information as described throughout this Contract. Access to the DCH Portal shall be managed as described in the System and Data Integration Requirements below.	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 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.	Yes
4.17.1.7 The Contractor is responsible for all costs associated with the Contractor's Systems refresh plan.	No. There was no specific reference to this section of the contract in the submitted policy documents.

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.17.2.1 The Contractor shall have in place or develop initiatives towards implementing electronic health information exchange and health care transparency to encourage the use of Qualified Electronic Health Records and make available to Providers and Members increased information on cost and Quality of care through health information technology.	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.	Yes
4.17.2.3 The Contractor shall participate in the Georgia Health Information Network (GaHIN) as a Qualified Entity (QE).	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.17.2.3.1 If not already participating in the GaHIN, the Contractor shall sign and execute all required GaHIN participation documentation within ten (10) Calendar Days of the Contract Effective Date (or an alternative date approved in writing by DCH) and shall adhere to all related policy and process requirements as a QE in the GaHIN. Such application process shall include successful completion of the GaHIN accreditation process;	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.17.2.3.2 The Contractor shall make business and technology resources available to work with the GaHIN technology vendor to develop, implement and test technical interfaces and other interoperability services as deemed necessary by DCH;	No. There was no specific reference to this section of the contract in the submitted policy documents.
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	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.17.2.3.4 Costs incurred by the Contractor to establish interoperability with the GaHIN shall be the sole responsibility of the Contractor.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.17.2.4 The Contractor shall make Member health information accessible to the GaHIN.	No. There was no specific reference to this section of the contract in the submitted policy documents.

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.17.2.4.1.1 Member-specific information including, but not limited to name, address of record, date of birth, race/ethnicity, gender and other demographic information, as appropriate;	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.17.2.4.1.2 Name and address of each Member's PCP;	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.17.2.4.1.3 Acquisition and retention of the Member's Medicaid ID;	No. There was no specific reference to this section of the contract in the submitted policy documents.
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. There was no specific reference to this section of the contract in the submitted policy documents.
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. There was no specific reference to this section of the contract in the submitted policy documents.
4.17.2.4.1.6 Record of future scheduled service appointments, if available, and referrals;	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.17.2.4.1.7 Complete record of all immunizations;	No. There was no specific reference to this section of the contract in the submitted policy documents.
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. There was no specific reference to this section of the contract in the submitted policy documents.
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. There was no specific reference to this section of the contract in the submitted policy documents.

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.17.2.5 The Contractor shall access the GaHIN to display Member health information within their system for the purpose of Care Coordination and management of the Members.	No. There was no specific reference to this section of the contract in the submitted policy documents.
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.	Yes
4.17.2.8 The Contractor shall encourage contracted Providers' participation in the GAHIN as well.	Yes

Overview of Member Data Maintenance

The member data maintenance process begins with PSHP receiving a daily enrollment file from the State via an 834 member data file transfer. The 834 files are downloaded to a secured file transfer protocol (FTP) site and translated by Peach State's corporate partners. Upon completion of file translation, the member data is housed in their *UMV (Unified Member View)* system. The member enrollment team uses *UMV* to review the member files with the primary goal of ensuring that there are no discrepancies and that errors are identified, reviewed, and corrected.

On a monthly basis, Peach State receives an audit file of full membership. These files are used to compare and reconcile their membership data to the State's membership data. PSHP does not make updates by overwriting member data from the State; instead, it is saved as alternative contact information.

Observations: Member Data Maintenance

- *Peach State processing time for a daily file is four (4) hours.*
- *Peach State processing time for a monthly audit file is eight (8) to ten (10) hours.*
- *Members with retroactive eligibility are typically seen on daily files for the first (1st) and the fifteenth (15th) of each month.*

Overview of Provider Data Maintenance

The provider data maintenance process begins with *Portico*, PSHP's demographic system. *Portico* is a single-source system which feeds information to all other systems that need to be updated, such as

Amisys. Amisys acts as the claims payment system, as well as the online provider directory. The updates into *Portico* are not automated. The process requires an interface which runs daily and constantly. Centene has ownership of the interface and monitors it constantly to ensure that provider data loads are complete. In the event an error occurs while running the interface, an interface error report is run which tells where the data did not interface. The interface errors are isolated on the provider level based on the provider identification number. Once errors are identified, they are corrected with the next interface run.

PSHP receives provider data in one of two ways. The first consists of receiving a daily provider data file from the State via a 7400 data file. A batch load of the daily 7400 data file is then performed. A full scan of the 7400 file is performed weekly and only providers who are participating with PSHP are loaded. The data analytics team performs a comparison of the 7400 provider file data against the provider contracts. The second way PSHP receives provider data is from delegated provider groups. Delegated provider groups perform their own credentialing and submit provider information to PSHP on spreadsheets in an approved roster template. These provider updates are typically submitted to the provider data maintenance department by provider relations representatives.

Observations: Provider Data Maintenance

- *PSHP receives provider data to be added, modified, and/or deleted on a monthly basis.*
- *Reviews of the provider roster are performed quarterly. Recommendations for provider terminations may result from this review and be sent to DCH for approval.*

After review of PHSP's policies and procedures for member and provider data maintenance, we did not identify policies or standard operating procedures for several contract sections. We recommend that PSHP, in accordance with their contract with DCH, create policies to address the contract requirements outlined in these areas.

Member Services

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

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

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.3.1.1 The Contractor shall ensure that Members are aware of the following: 4.3.1.1.1 Member rights and responsibilities	Yes
4.3.1.1.2 The role of PCPs and Dental Home	Yes
4.3.1.1.3 The role of the Family Planning Provider and PCP (for IPC P4HB Participants only)	Yes
4.3.1.1.4 How to obtain care	Yes
4.3.1.1.5 What to do in an emergency or urgent medical situation (for P4HB participants information must address what to do in an emergency or urgent medical situation arising from the receipt of Demonstration related Services)	Yes
4.3.1.1.6 How to request a Grievance, Appeal, or Administrative Law Hearings	Yes
4.3.1.1.7 How to report suspected Fraud and Abuse	Yes
4.3.1.1.8 Providers who have been terminated from the Contractor's network	Yes
4.3.1.2 The Contractor must be prepared to utilize all forms of population-appropriate communication to reach the most Members and engender the most responses. Examples of communications include but are not limited to telephonic; hard copy via mail; social media; texting; and email that allow 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
4.3.6.1 The Contractor shall mail via surface mail a Member ID Card to all new Members according to the following timeframes: 4.3.6.1.1 Within seven (7) Calendar Days of receiving the notice of Enrollment from DCH or the Agent for Members who have selected a CMO and a PCP.	Yes
4.3.6.3 The Contractor shall reissue the Member ID Card within seven (7) Calendar Days of notice if a Member reports a lost card, there is a Member name change, the PCP changes, or for any other reason that results in a change to the information disclosed on the Member ID Card.	Yes
4.3.6.4 The Contractor shall submit a front and back sample Member ID Card to DCH for initial review and approval, within sixty (60) Calendar Days of the Contract Effective Date and approval and as updated thereafter.	Yes

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.3.6.5 The Contractor shall mail via surface mail a P4HB participant ID Card to all new P4HB participants in the Demonstration within Seven (7) Calendar Days of receiving the notice of Enrollment from DCH or its Agent. The P4HB participant's ID Card will meet the requirements set forth for Member ID Cards in Sections 4.3.6.2 (excluding Section 4.3.6.2.4), 4.3.6.3 and 4.3.6.4, and will identify the Demonstration component in which the P4HB participant is enrolled.	Yes
4.3.6.5.1 A Pink color will signify the P4HB participants as eligible for Family Planning Services Only.	Yes
4.3.6.5.2 A Purple color will signify the P4HB participants as eligible for Inter-pregnancy Care Services and Family Planning Services.	Yes
4.3.6.5.3 A Yellow color will signify the P4HB participant as eligible for Case Management – Resource Mothers Outreach Only.	Yes
4.3.6.6 Each time the P4HB participant's ID card is issued or re-issued to a P4HB participant, the Contractor shall provide written materials that explain the meaning of the color coding of the ID card and its relevance to Demonstration benefits.	Yes
4.3.3.1 The Contractor shall provide a Member Handbook, a P4HB participant Handbook, and other programmatic information to Members. The Contractor shall make the Member and P4HB participant Handbook available to Members through the Contractor's website. Upon request, the Contractor shall mail a hard copy of the Member Handbook to enrolled Member households and a P4HB participant information packet to P4HB participant households.	Yes

Overview of Member Services

PSHP is responsible for educating members about their rights and responsibilities. This is done via the member handbook. The member handbook is available on PSHP's website. Upon request, PSHP will also send a hard copy of the member handbook within three business days to members' households. If communications are mailed and returned to sender, two outreach contact attempts are made.

The member's rights and responsibilities are reviewed on an annual basis; however, the materials can be changed at any time. Changes must be sent and approved by DCH.

Eligibility and member ID cards are sent out within seven (7) calendar days of enrollment. If any information on the member ID changes, a new member ID card must be made and sent out within seven (7) days.

PSHP's marketing team is made up of four specialists. The marketing team distributes information by mail and through the website. The team makes an attempt to get social media write ups approved sixty (60) days in advance of publishing. If a member makes a comment on a social media post from PSHP that warrants a response, the comment will be routed to the member services team. The member services team receives the comment in a mailbox. The email is triaged and assigned to a member advocate or supervisor, who then reaches out to the member for resolution. The member can also submit a message on the PSHP website using their member login credentials. Member services has one (1) business day to respond to the comment and 72 hours for resolution.

Observations: Member Services

- *The marketing team conducts initiatives based on current events; for example, flu shots during flu season, breast cancer awareness month, etc.*
- *Marketing materials about current programs urge members to utilize the call center for questions or to obtain further information on initiatives.*
- *The main call center is located in Georgia. For business continuity, the Arizona call center serves as backup.*

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

Provider Complaints

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

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

Contract Language	PSHP 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 which individual(s) have the authority to review a Provider complaint.	No. There was no specific reference to this section of the contract in the submitted policy documents.
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.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.9.7.4 As part of the Provider Complaint System, the contractor shall: 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	Yes

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
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;	
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 simultaneously whenever payment is made for the Claim giving rise to the interest payment;	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.9.7.4.6 Accurately identify all interest payments on the associated remittance advice submitted by the Contractor to the Provider;	No. There was no specific reference to this section of the contract in the submitted policy documents.
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;	No. There was no specific reference to this section of the contract in the submitted policy documents.
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	No. There was no specific reference to this section of the contract in the submitted policy documents.

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.9.7.4.11 Ensure that Contractor executives with the authority to require corrective action are involved in the Provider Complaint process.	No. There was no specific reference to this section of the contract in the submitted policy documents.

Overview of Provider Complaints

The provider complaints department is responsible for receiving and resolving complaints submitted to the health plan by the provider. The provider must clearly describe the complaint in writing within thirty (30) days of the decision letter. Any complaints received after thirty (30) days will not be processed unless a health plan error occurred for claims complaints. If an error occurred, the compliance specialist has the ability to recommend the timeliness denial be waived and will continue to process the case following the health plans normal procedure. Otherwise, a letter is sent to the provider stating that the complaint will not be processed as it was received outside of the required timeframe. However, the provider has the right to request an administrative law hearing for complaints submitted after thirty (30) days.

The team may also receive the complaint as a DCH inquiry via email. Once received, the team enters the information on the complaints tracker to include the provider, member, the complaint subject, date received, and response deadline. The team will investigate the complaint to determine if the previous decision is upheld or overturned. An acknowledgement letter must be sent to the provider within ten (10) days and a resolution must be determined within thirty (30) days.

An example of a complaint may involve a denied claim. These complaints are investigated in the claims system to determine the reason for denial, member name, and date of service. The complaints team will conduct outreach to other departments, including claims configuration. The typical process to overturn a denied claim should be for the provider to submit an appeal; however, they do come in as complaints and are resolved accordingly.

Observations: Provider Complaints

- *The case load of complaints received varies; however, the average is about three (3) complaints per month.*

Myers and Stauffer determined some of PSHP's procedures for provider complaints were in accordance with the DCH contract. PSHP should incorporate these contract sections into policies and procedures.

Provider Network Management

We interviewed PSHP staff members and reviewed their existing policies and procedures in relation to provider NM. In the table below, we identify the key contract requirements and whether PSHP has policies and procedures consistent with the contract requirement(s).

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

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

Provider NM is delegated to Envolve Dental, Envolve Vision, and Envolve Pharmacy. We noted the following key items related to the provider network and provider contracting during the on-site interviews with PSHP representatives.

PSHP 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 PSHP's members residing in rural areas.

The primary way that PSHP ensures an adequate provider network is by recruiting. The provider relations representatives play an essential role in ensuring the adequacy of the network. They identify potential recruitment targets by comparing the provider network to Quest Analytics geo-analysis reporting. This is a weekly comparison.

PSHP uses the 7400 file to identify providers who are enrolled as Medicaid providers with DCH, and it is used in conjunction with the Quest Analytics geo-analysis 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 with the providers. PSHP offers incentive programs and opportunities in order to enhance the network of providers.

As a result of recruiting, PSHP's unique providers have increased by 4% from 2019 Quarter 2 to Quarter 3. PSHP has some areas and specialties for which access does not meet the minimum 90% threshold set by the State. Deficiencies have been noted in the following specialty categories: 24-hour pharmacy, endocrinology, infectious disease, and rheumatology. In general, PSHP has difficulties related to a shortage of providers in the rural areas of the state. PSHP and the subcontractors are working to address the deficiencies and expand the network.

Observations: Provider Network Management

- *Before a provider is submitted to DCH for approval of the termination, the plan reviews the network to make sure there is coverage in the area to replace the provider.*
- *PSHP 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.*
- *Providers are able to enroll in the network through the portal on PSHP's website.*

Myers and Stauffer determined PSHP's policies and procedures for provider NM are in accordance with the DCH contract.

Quality Improvement

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

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

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.12.1.1 The Contractor shall provide for the delivery of Quality care with the primary goal of improving the health status of Members and, where the Member's Condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in Condition or deterioration of health status. This shall include the identification of Members at risk of developing Conditions, the implementation of appropriate interventions and designation of adequate resources to support the intervention(s).	Yes
4.12.1.2 The Contractor shall seek input from, and work with, Members, Providers, community resources and agencies to actively improve the Quality of care provided to Members.	Yes
4.12.1.3.1 The Contractor shall obtain National Committee for Quality Assurance (NCQA) Interim Status by the Operational Start Date. Contractors shall apply for NCQA accreditation, or at other times as required by DCH as follows: 4.12.1.3.1.1 July 1, 2016: Apply for NCQA Interim Status 4.12.1.3.1.2 July 1, 2017: Apply for provisional status (first survey) 4.12.1.3.1.3 December 31, 2017: Notify NCQA of intent to submit data 4.12.1.3.1.4 June 15, 2018: Submit CY 2017 data	Yes
4.12.1.3.2 The Contractor shall achieve NCQA Commendable or Excellent accreditation status within three (3) years after the Operational Start Date. Contractors that lose NCQA Commendable or Excellent status must regain the status within one (1) year.	Yes
4.12.1.4.1 The Contractor shall establish a multi-disciplinary Quality Oversight Committee to oversee all Quality functions and activities.	Yes

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
This committee shall meet at least quarterly, but more often if warranted. The formal organizational structure must include at a minimum, the following: 4.12.1.4.1.1 A designated health care practitioner, qualified by training and experience, to serve as the QM Director; 4.12.1.4.1.2 A committee which includes representatives from the provider groups as well as clinical and non-clinical areas of the organization; 4.12.1.4.1.3 A senior executive who is responsible for program implementation; 4.12.1.4.1.4 Substantial involvement in QM activities by the Contractor's Medical Director; and 4.12.1.4.1.5 Accountability to the governing body of the organization to which it reports on activities, findings, recommendations, actions, and results on a scheduled basis.	
4.12.1.4.2 The Quality Management Committee must: 4.12.1.4.2.1 Maintain Records that document the committee's activities, findings, recommendations, actions, and results; and 4.12.1.4.2.2 Obtain DCH's approval of membership of the Quality Oversight Committee.	Yes
4.12.2.1 The Contractor shall support and comply with the Georgia Families DCH Quality Strategic Plan. The Quality Strategic Plan is designed to improve the Quality of Care and Service rendered to Georgia Families and Georgia Families 360 Members (as defined in Title 42 of the Code of Federal Regulations (42 CFR) 431.300 et seq. (Safeguarding Information on Applicants and Recipients); 42 CFR 438.200 et seq. (Quality Assessment and Performance Improvement Including Health Information Systems), and 45 CFR Part 164 (HIPAA Privacy Requirements).	Yes
4.12.2.2 The DCH Quality Strategic Plan promotes improvement in the Quality of care provided to enrolled Members through established processes. DCH staff within the Performance, Quality and Outcomes Unit is responsible for oversight of the Contractor's Quality program including:	Yes
4.12.2.2.1 Monitoring and evaluating the Contractor's service delivery	

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
system and Provider network, as well as its own processes for Quality management and performance improvement; 4.12.2.2.2 Implementing action plans and activities to correct deficiencies and/or increase the Quality of care provided to enrolled Members; 4.12.2.2.3 Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, Provider profiling, Utilization Management reviews, etc.; 4.12.2.2.4 Monitoring compliance with Federal, State and DCH requirements; 4.12.2.2.5 Ensuring the Contractor's coordination with State registries; 4.12.2.2.6 Ensuring Contractor executive and management staff participation in the quality management and performance improvement processes; 4.12.2.2.7 Ensuring that the development and implementation of Quality management and performance improvement activities include Provider participation and information provided by Members, their families and guardians; and 4.12.2.2.8 Identifying the Contractor's best practices, lessons learned and other findings for performance and Quality improvement.	
4.12.3.1 The Contractor shall comply with the GF DCH Quality Strategic Plan requirements to improve the health outcomes for all GF Members. Improved health outcomes will be documented using established performance measures. DCH uses the CMS issued CHIPRA Core Set and the Adult Core Set of Quality Measures technical specifications along with the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Agency for Healthcare Research and Quality (AHRQ) technical specifications for the quality and health improvement performance measures. DCH will monitor Performance Measure and incent Contractor improvement through the Value-based Purchasing program.	Yes
4.12.3.2 Several of the Adult and Child Core Set measures along with certain other HEDIS® measures utilize hybrid methodology, that is, they require a medical record review in addition to the administrative data requirement for measurement reporting. The number of required	Yes

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
record reviews is determined by the specifications for each hybrid measure.	
4.12.3.3 DCH establishes Performance Measure Targets for each measure. It is important that the Contractor continually improve health outcomes from year to year. The performance measure targets, as amended from time to time, for each performance measure can be accessed at http://dch.georgia.gov/medicaid-quality-reporting. Performance targets are based on national Medicaid Managed Care HEDIS® percentiles as reported by NCQA or other benchmarks as established by DCH.	Yes
4.12.3.4 DCH may also require a Corrective Action (CA) or Preventive Action (PA) form that addresses the lack of performance measure target achievements and identifies steps that will lead toward improvements. This evidence-based CA or PA form must be received by DCH within thirty (30) Calendar Days of receipt of notification of lack of achievement of performance targets. The CA or PA response must be approved by DCH prior to implementation. DCH may conduct follow up on-site reviews to verify compliance with a CA or PA response. DCH may assess Liquidated Damages on Contractors who do not meet the performance measure targets for any one performance measure.	Yes
4.12.3.5 The performance measures apply to the Member populations as specified by the measures' technical specifications. Contractor performance is evaluated annually on the reported rate for each measure. Performance Measures, benchmarks, and/or specifications may change annually to comply with industry standards and updates.	Yes
4.12.3.6 The Contractor must provide for an independent Validation of each performance measure rate and submit the validated results to DCH no later than June 30 of each year.	Yes
4.12.4 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys 4.12.4.1 The Contractor shall deliver to DCH the results of CAHPS Surveys conducted by an NCQA certified CAHPS survey vendor. The survey report must include but not limited be to the following items: 4.12.4.1.1 An Executive Summary with the description of the survey process conducted according to the CAHPS Health Plan Survey	Yes

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
guidelines of the HEDIS protocol; 4.12.4.1.2 Protocols for the administration of the survey via mail, telephone or mixed mode; 4.12.4.1.3 Definition of the sample size, number of completed surveys and response rates achieved. Response rates should, at a minimum, be no less than the NCQA average Medicaid response rates for the period; and 4.12.4.1.4 Detailed survey results and trend analysis.	
4.12.4.2 The Contractor shall submit, on an annual basis to DCH, Adult and Child CAHPS Survey reports as stated in Section 4.12.16.	Yes
4.12.5 Member and Provider Incentives 4.12.5.1 The Contractor shall implement Member and Provider incentives to increase Member and Provider participation in reaching program goals. The Contractor may provide: 4.12.5.1.1 Incentives to Members and/or Providers to encourage compliance with periodicity schedules. Such incentives shall be established in accordance with all applicable State and federal laws, rules and regulations. Member incentives must be of nominal value ($10.00 or less per item and $50.00 in the aggregate on an annual basis per Member) and may include gift cards so long as such gift cards are not redeemable for cash or Copayments. The Contractor shall submit the proposed incentive methods to DCH for review and receive DCH approval prior to implementation. Upon request by DCH, the Contractor shall provide DCH with reports detailing incentives provided to Members and/or Providers and illustrating efficacy of incentive programs. In accordance with 42 CFR 1003.101, the Nominal Value requirement stated herein is not applicable where the incentive is offered to promote the delivery of preventive care services, provided: 4.12.5.1.1.1 The delivery of the preventive services is not tied (directly or indirectly) to the provision of other services reimbursed in whole or in part by Medicare or Medicaid; 4.12.5.1.1.2 The incentive is not cash or an instrument convertible to cash; and 4.12.5.1.1.3 The value of the incentive is not disproportionally large in relationship to the value of the preventive care service (i.e., either the value of the service itself or the future health care costs reasonably expected to be avoided as a result of the preventive care).	No. There was no specific reference to this section of the contract in the submitted policy documents.

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.12.5.1.2 Provider incentives for the specific purpose of supporting necessary costs to transform and sustain NCQA PCMH recognition or TJC PCH accreditation through enhanced payment or performance based incentives for achieving the necessary parameters.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.12.5.1.3 Provider incentive strategies to improve Provider compliance with clinical practice guidelines and ensure consistent application of the guidelines.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.12.6 Quality Assessment Performance Improvement (QAPI) Program 4.12.6.1 The Contractor shall have in place an ongoing QAPI program consistent with 42 CFR 438.240. The program must be established utilizing strategic planning principles with defined goals, objectives, strategies and measures of effectiveness for the strategies implemented to achieve the defined goals. The Contractor's QAPI program shall be based on the latest available research in the area of Quality assurance and at a minimum must include: 4.12.6.1.1 A method of monitoring, analysis, evaluation and improvement of the delivery, Quality and appropriateness of Health Care furnished to all Members (including under and over Utilization of services), including those with special Health Care needs; 4.12.6.1.2 Written policies and procedures for Quality assessment, Utilization Management and continuous Quality improvement that are periodically assessed for efficacy; 4.12.6.1.3 A health information system sufficient to support the collection, integration, tracking, analysis and reporting of data; 4.12.6.1.4 Designated staff with expertise in Quality assessment, Utilization Management and Care Coordination;	Yes
4.12.6.2 The Contractor shall conduct PCP and other Provider profiling activities as part of its QAPI Program. Provider profiling must include multi-dimensional assessments of PCPs or Provider's performance using clinical, administrative and Member satisfaction indicators of care that are accurate, measurable and relevant to Members.	Yes
4.12.6.3 The Contractor's QAPI Program Plan must be submitted to DCH for initial review and approval and as updated thereafter.	Yes

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

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.12.7.2 Each performance improvement project must be completed in a period determined by DCH, to allow information on the success of the project in the aggregate to produce new information on Quality of care each year.	Yes
4.12.7.3 The Contractor shall perform the required performance improvement projects (PIPs), as specified by DCH and agreed upon by the Parties, on an annual basis. Plan Do Study Act cycles must be incorporated into each PIP process.	Yes
4.12.7.4 Each PIP will use a study period approved by DCH.	Yes
4.12.7.5 Each PIP must include AIM statements and Driver Diagrams and align with the EQRO prepared PIP template. PIP components will be included as agreed upon by DCH and the CMOs.	Yes
4.12.7.6 The Contractor shall submit the designated PIPs to the EQRO Contractor using the DCH specified template and format as defined in the PIP protocol approved by DCH.	Yes
4.12.7.7 The EQRO will evaluate the CMOs' PIPs performance, using CMS approved Rapid Cycle PIP and/or other EQRO protocols. DCH reserves the right to request modification of the PIPs based on this evaluation. Modifications will be discussed with each CMO prior to implementation.	Yes
4.12.7.8 The Contractor shall submit PIP documentation to DCH and/or the EQRO using the DCH specified template and format as specified in the CMS approved Rapid Cycle PIP and/or other EQRO protocols.	Yes
4.12.7.9 The Contractor shall submit a PIP Annual Improvement Strategy Plan to DCH and/or the EQRO using the DCH specified template and format by October 31st of each contract year. This Plan will describe the improvement strategies to be implemented in the upcoming plan year (January 1st – December 31st).	Yes
4.12.8 Clinical Practice Guidelines (CPGs) 4.12.8.1 The Contractor shall adopt a minimum of three (3) evidence-based clinical practice guidelines. Such guidelines shall: 4.12.8.1.1 Be based on the health needs and opportunities for	Yes

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
improvement identified as part of the QAPI program; 4.12.8.1.2 Be based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field; 4.12.8.1.3 Consider the needs of the Members; 4.12.8.1.4 Be adopted in consultation with network Providers; and 4.12.8.1.5 Be reviewed and updated periodically as appropriate.	
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
4.12.9 Focused Studies 4.12.9.1 Focused Studies examine a specific aspect of health care (such as prenatal care) for a defined point in time. These studies are usually based on information extracted from medical records or Contractor administrative data such as Enrollment files and Encounter/claims data. Steps that may be taken by the Contractor when conducting focused studies are: 4.12.9.1.1 Selecting the Study Topic(s) 4.12.9.1.2 Defining the Study Questions or Aim Statement	Yes

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.12.9.1.3 Selecting the Study Indicator(s) 4.12.9.1.4 Identifying a representative and generalizable study population 4.12.9.1.5 Documenting sound sampling techniques utilized (if applicable) 4.12.9.1.6 Collecting reliable data 4.12.9.1.7 Analyzing data and interpreting study results	
4.12.9.2 The Contractor may perform, at DCH discretion, a Focused Study to examine a specific aspect of health care (such as prenatal care) for a defined point in time. The Focused Study will have a calendar year study period and the results will be reported to DCH by June 30th following the year of the study. DCH shall retain the right to approve or disapprove all proposed Focus Studies.	Yes
4.12.10 Patient Safety Plan 4.12.10.1 The Contractor shall have a structured Patient Safety Plan, Report, and Analysis to address incidents and concerns regarding clinical care. This plan must include written policies and procedures for processing Member complaints regarding the care received and addressing incidents and concerns with clinical care. Such policies and procedures shall include: 4.12.10.1.1 A system of classifying incidents, concerns, and complaints according to severity; 4.12.10.1.2 A review by the Medical Director and a mechanism for determining which incidents will be forwarded to Peer Review; and 4.12.10.1.3 A summary of incident(s), including the final disposition, included in the Provider profile.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.12.10.2 At a minimum, the Patient Safety Program process shall: 4.12.10.1.4.1 Report and analyze the patient safety programs and outcomes in place within the CMO's network of hospitals; 4.12.10.1.4.2 Report and analyze Medication recalls; 4.12.10.1.4.3 Report and analyze Medication errors; 4.12.10.1.4.4 Describe the results of site Inspections; and 4.12.10.1.4.5 Report and analyze Patient Quality of Care Concerns, including those arising from patient grievances.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.12.10.3 The Contractor shall submit the Patient Safety Plan to DCH for initial review and approval and as updated and submit to DCH on	No. There was no specific reference to this section

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
an annual basis no later than June 30 of the Contract year a Patient Safety Program Report inclusive of the program components described in 4.12.10.1 and 4.12.10.2.	of the contract in the submitted policy documents.
4.12.11 External Quality Review 4.12.11.1 DCH will contract with an External Quality Review Organization (EQRO) to conduct independent reviews of the Quality outcomes, timeliness of, and access to, the services covered in this Contract. The Contractor shall collaborate with DCH and its EQRO to develop studies, surveys and other analytic activities to assess the Quality of care and services provided to Members and to identify opportunities for CMO improvement. To facilitate this process the Contractor shall supply data, as requested by DCH or its EQRO, to the EQRO.	Yes
4.12.12 Value-Based Purchasing (VBP) Program 4.12.12.1 The Contractor shall collaborate with DCH to implement a Value-Based Purchasing (VBP) model. A VBP model is an enhanced approach to purchasing and program management that focuses on value over volume. It is part of a cohesive strategy that aligns incentives for Members, Providers, Contractors and the State to achieve the program's overarching goals. The impact of initiatives is measured in terms of access, outcomes, quality of care and savings. 4.12.12.2 Prior to the Operational Start Date, DCH will establish a VBP performance management team ("VBP Performance Management Team"). The VBP Performance Management Team will have responsibility for planning, implementing, and executing the VBP initiative. The Team will work collaboratively with the Contractor to review the Contractor's progress on a monthly, quarterly and/or annual basis, determine incentive payments, and determine the need to modify priority areas, measures and targets.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.12.12.3 In addition to DCH staff, key leadership from the Contractor such as the Medical Director, Chief Operating Officer, or other designee approved by DCH will provide input and feedback on planned priorities and initiatives. As appropriate, DCH will engage operational-level Contractor staff.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.12.12.4 Through the VBP Performance Management Team, the Contractor and DCH shall meet at least quarterly to discuss progress on	No. There was no specific reference to this section

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
initiatives. Rapid cycle feedback is key to the success of a VBP model. The Contractor shall regularly review and provide real-time information focused on the initiatives it is undertaking to achieve required targets on a monthly and quarterly basis to DCH. The Contractor shall provide ongoing and ad hoc reports to DCH to highlight status and progress of initiatives, as well as successes and challenges. Regularly reviewing data is necessary for DCH and the Contractor to identify where initiatives are not resulting in improvements necessitating adjustments to the implemented approach. When adjustments are necessary, the Contractor shall report to DCH changes the Contractor will make to continually work towards improvements.	of the contract in the submitted policy documents.
4.12.12.5 Attachment U outlines the performance measures and related targets that the Contractor must achieve under the VBP model. The Contractor must establish in collaboration with DCH initiatives that it will undertake to achieve the specified targets. Such initiatives may differ from or include other required initiatives, such as Performance Improvement Projects (PIPs) and Focused Studies. Beginning in Calendar Year (CY) 2017, DCH will withhold five percent (5%) of the Contractor's Capitation Rates ("VBP withhold)" from which incentive payments will be made to the Contractor for achieving identified VBP targets. DCH will make incentive payments for achieving performance targets based on the HEDIS reporting and validation cycle. Therefore, the first incentive payments, if any, will be made in CY 2018.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.12.12.6 The Contractor will only receive incentive payments when meeting or exceeding specified targets (e.g., if one target is achieved, but others are not, the Contractor will only receive agreed upon incentive payment for the target achieved). The withhold amount will be allotted equally to each of the performance targets. The total amount of the incentive payments will be based on the Contractor's performance relative to the targets for the fourteen (14) performance measures. The maximum incentive payment to the Contractor will be the full five percent (5%) withhold. Contractor Payout Amount = (Number of Performance Targets Achieved/Total Number of Performance Targets) x Total VBP Withhold	No. There was no specific reference to this section of the contract in the submitted policy documents.

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.12.12.7 While the current performance measures are HEDIS measures, DCH reserves the right to change the measures over the term of this Contract. Should DCH identify performance measures that are not HEDIS measures, DCH shall develop and the Contractor shall agree to a methodology for quantifying the Contractor's success in achieving targets and payments for each measure.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.12.12.8 The Contractor shall incentivize Providers to participate in VBP and may also incentivize Members. The Contractor shall develop a plan for distributing to Providers fifty (50) percent of the Value-Based Purchasing incentive payments it receives from DCH for achieving targets. The frequency of incentive payments to the Providers is at the discretion of the Contractor (e.g., the Contractor may elect to incentivize Providers on a more frequent schedule than DCH's schedule for payment to the Contractor). Contractors are encouraged to collaborate to develop and implement interventions and solutions. The Contractor shall submit the plan to DCH for prior approval. The Contractor shall submit such plan for Provider incentives to DCH for review and approval within ninety (90) Calendar Days of the Contract Effective Date. The plan shall include details of how the Contractor will collaborate with Providers to determine the frequency of incentive payments to Providers and how the Contractor will encourage participation in the program.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.12.12.9 The Contractor shall comply with the requirements set forth in the VBP Operations Manual.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.12.13 Monitoring and Oversight Committee 4.12.13.1 The Contractor shall participate in the Georgia Families Monitoring and Oversight Committee ("GFMOC") and associated subcommittees as requested by DCH. The GFMOC and associated subcommittees will assist DCH in assessing the performance of the Contractor and developing improvements and new initiatives specific to the Georgia Families program. The GFMOC will serve as a forum for the exchange of best practices and will foster communication and provide opportunity for feedback and collaboration between State agencies, the Contractor and external stakeholders. Members of the GFMOC will be appointed by the DCH Commissioner or his designee.	No. There was no specific reference to this section of the contract in the submitted policy documents.

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
The GFMOC meetings must be attended by Contractor decision makers defined as one or more of the following: Chief Executive Officer, Chief Operations Officer, or equivalent named position; and Chief Medical Officer.	
4.12.14 Member Advisory Committee 4.12.14.1 The Contractor shall establish and maintain a Member Advisory Committee consisting of persons served by the Contractor including current and past Members and/or Authorized Representatives, and representatives from community agencies that do not provide Contractor-covered services but are important to the health and well-being of Members. The Committee shall meet at least quarterly, and its input and recommendations shall be employed to inform and direct Contractor Quality management activities and policy and operational changes. The Contractor must provide meeting schedules and minutes to DCH upon request. DCH may conduct onsite reviews of the membership of the Committee to ensure: 4.12.14.1.1 The Committee is discussing issues pertinent to the Member population; 4.12.14.1.2 The Committee is meeting as scheduled; and 4.12.14.1.3 The Committee members are in attendance.	Yes
4.12.15 Provider Advisory Committee 4.12.15.1 The Contractor shall establish and maintain a Provider Advisory Committee consisting of Providers contracted with the Contractor to serve Members. At least two (2) Providers on the Committee shall maintain health care practices that predominantly serve Medicaid beneficiaries. The Committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Contractor Quality management activities and policy and operational changes. The Contractor must provide meeting schedules and minutes to DCH upon request. DCH may conduct onsite reviews of the Committee meetings to ensure: 4.12.15.1.1 The Committee is discussing issues pertinent to the Member population; 4.12.15.1.2 The Committee is meeting as scheduled; and 4.12.15.1.3 The Committee members are in attendance.	Yes
4.12.16 Reporting Requirements 4.12.16.1 Contractors must submit the following data reports as	Yes

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
indicated. 1.Performance Improvement Project Proposal(s), Annually October 31, DCH PQO Unit 2.Quality Assurance Performance Improvement Plan, Annually June 30, DCH PQO Unit 3.Quality Assessment Performance Improvement Program Evaluation, Annually June 30, DCH PQO Unit 4.Performance Improvement, Project Report, Annually June 30, EQRO vendor 5.Performance Measures Report, Annually June 30, DCH PQO Unit 6.Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys, Annually July 31, DCH PQO Unit	
4.12.16.2 If an extension of time is needed to complete a report, the Contractor may submit a request in writing to the DCH PQO Unit.	Yes
4.12.16.3 The Contractor's Quality Oversight Committee shall submit to DCH Quality Oversight Committee Reports - Ad Hoc as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.	Yes
4.12.16.4 The Contractor shall submit to DCH Performance Improvement Project Reports no later than June 30 of the Contract year or per protocol described in Section 4.12.7.	Yes
4.12.16.5 The Contractor shall submit to DCH Focused Studies Reports no later than June 30 of the Contract year as described in Section 4.12.9.	Yes
4.12.16.6 The Contractor shall submit to DCH annual Patient Safety Plan Reports no later than June 30 of the Contract year as described in Section 4.12.10.	Yes

Overview of Quality Improvement

PSHP is required by contract to provide for the delivery of quality care, with improving the health of its members as their primary goal. There will be situations where the member's health status cannot be improved. In these cases, measures must be implemented to prevent further decline and/or

deterioration of the member's condition or health. PSHP must create strategies for identifying members at risk of developing health conditions and intervene to prevent decline or deterioration of those health conditions. Improving and/or maintaining the member's health condition is a joint effort involving the member, providers, community resources, and other health agencies who all strive for the singular goal of improving member's overall quality of care.

PSHP utilizes a yearly work plan as a tool to track and monitor activities designed to ensure maintenance of accreditation and achievement of annual quality-related goals. The work plan is broken down into categories that include, but are not limited to: data analytics, medical management, member interventions, provider interventions, and provider network. The work plan is developed in July and it runs until June of the following year. Throughout the year, the work plan is updated to reflect progress on the quality improvement activities.

The Performance Oversight Steering Committee meetings are used as a forum to discuss the components of the quality improvement plan. These meetings occur at least monthly and can be as frequently as weekly. Areas where the target is not being met are identified and discussed in the meeting, as well as interventions or strategies to meet them. Updates are made to the work plan, which contains an update column used to track changes/updates. At the end of the year, an evaluation is performed to determine if they met the performance and quality objectives that were set. The year-end evaluation is submitted to DCH upon completion.

PSHP also has a Quality Oversight Committee (QOC), which is an internal committee overseen by a senior medical director. The committee consists of representatives from all internal departments and external providers. They meet a minimum of once per quarter and more often if necessary. Discussions occur in this meeting about various subjects such as rates, improving activities, and provider peer group reviews. All of PSHP's committees, such as the UM Committee and the Credentialing Committee, report up to the QOC, which reports to the Board of Directors.

Per PSHP staff, DCH mandates that PSHP adhere to the clinical practice guidelines for asthma, diabetes and attention deficit hyperactivity disorder (ADHD). There is a team that reviews medical records from providers to ensure that they adhere to clinical practice guidelines. Every quarter 150 medical records, which equates to 50 per guideline, are requested from providers. The medical records are reviewed to ensure that the guidelines were followed using a tool provided by DCH. The QI abstractor, who has a clinical background, and two program coordinators, who are non-clinical, perform the medical record reviews. Inter-rater reliability (IRR) is performed twice a year to ensure review consistency. Peach State will follow up with providers who score between 80% and 85% in six (6) months. Providers whose medical record review scores are below 80% will receive PSHP follow up in three (3) months. If the provider scores above 85% on the medical record reviews, no follow-up is required.

PSHP reviews HEDIS measures in order to evaluate provider performance. Performance measurement involves the data analytics team and the clinical team, among others. The data analytics team pulls data for HEDIS measures, the HEDIS report card, and other state measures that are being tracked. Data analytics is also responsible for the development of the report card that is used to benchmark rates and track monthly performance. There is a clinical team of nurses that perform year-round medical record reviews and hybrid medical record reviews. The year-round review is on measures that PSHP collects on a regular basis, while the hybrid reviews are of records that are fewer in quantity and harder to acquire. There is a team of QI specialists who work with provider relations on HEDIS measures and quality services with gaps. Their goal is to identify providers with service gaps, communicate their specific services that are missing, and provide additional provider training as necessary.

Providers who participate with PSHP as primary care providers (PCPs) as of 2018 are automatically eligible for the HEDIS-based incentive program. Currently there are no specialty providers (e.g., dermatology or gastroenterology) approved to participate in the incentive program. The incentive program is an umbrella program based on HEDIS measures. There are seven (7) measures aligned with the incentives that include well child measures. PCPs can receive additional reimbursement based on performance percentiles.

Observations: Quality Improvement

- *As of 2018, all PCPs are set up to participate in PSHC's physician incentive program.*
- *DCH-approved gift cards valued between $25.00 and $50.00 are provided as member incentives.*
- *In order to improved HEDIS and well child measures, PSHP has been given approval by DCH to provide gift cards with higher dollar amounts as an incentive for members who are repeatedly non-compliant.*
- *Reviews of medical records for clinical practice guidelines for asthma result in 89% compliance.*
- *Reviews of medical records for clinical practice guidelines for diabetes result in 78% - 80% compliance.*
- *Reviews of medical records for clinical practice guidelines for ADHD result in >90% compliance.*

Myers and Stauffer determined that some of PSHP's procedures for provider quality improvement were in accordance with the DCH contract. PSHP should incorporate these contract sections into policies and procedures.

Utilization Management

We interviewed PSHP staff members and reviewed their existing policies and procedures in relation to UM. In the table below, we identify the key contract requirements and whether PSHP has policies and procedures consistent with the contract requirement(s).

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

Contract Language	PSHP 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 The Contractor shall provide assistance to Members and Providers to ensure the appropriate Utilization of resources, using the following program components: Prior Authorization and Pre-Certification, prospective review, concurrent review, retrospective review, ambulatory review, second opinion. Specifically, the Contractor shall have written Utilization Management Policies and Procedures that:	Yes
4.11.1.3.1 Include protocols and criteria for evaluating Medical Necessity, authorizing services, and detecting and addressing over-Utilization and under-Utilization. Such protocols and criteria shall comply with federal and State laws and regulations.	Yes
4.11.1.3.2 Address which services require PCP Referral; which services require Prior-Authorization and how requests for initial and continuing services are processed, and which services will be subject to concurrent, retrospective or prospective review.	Yes

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

Overview of Utilization Management

UM is the means by which PSHP 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. Envolve Dental and One Source Therapy Review have their own medical directors.

The UM department consists of six teams: the intake team, the prior authorization team, the inpatient team, the hospital-based discharge planners, the medical review unit, and the denial coordinators. The intake team processes telephone, web, and fax authorizations, as well as enters authorization templates into *Truecare* for the clinical team. The prior authorization team is made up of nurses who review the standard and expedited prior authorizations. The standard prior authorizations are reviewed within three (3) business days, and the expedited prior authorizations are reviewed within 24 hours. The inpatient team is made up of fifteen onsite hospital reviewers completing concurrent reviews. The hospital-based discharge planners complete the discharge planning for the hospitals. The medical review unit consists of two retrospective review nurses. The retrospective reviews are done within 30 days. Lastly, the denial coordinators process and send out the denial adverse determination letters. Staff from the teams are evaluated monthly through quality audits. The goal for the monthly audit is a score of 90% or greater. If the goal is not achieved, they receive education or a corrective action plan.

In the case of a denial of a prior authorization, a letter is generated to both the member and provider upon completion of the review. Both approvals and denials are accompanied by a letter. In the event of a denial, the letter advises of the right to appeal.

The top ten most common prior authorization denial reasons are as follows:

- *Duplicate claim service.*
- *Code coverage reimbursement not currently outlined by Medicaid.*
- *The time limit for filing a claim has expired.*
- *The service is not covered.*
- *The CPT code is invalid when billed with this diagnosis.*
- *No authorization on file that matches service(s) billed.*
- *Resubmit with modifier specified by state for proper payment.*
- *Bill primary insurer first and resubmit with EOB.*
- *When primary insurance receives information, resubmit to secondary insurance.*

- *Modifier billed is not valid.*

Observations: Utilization Management

- *For the inpatient team, 50% of prior authorization reviews are completed by on-site nurses that collaborate with the hospital team. The rest are completed via fax and phone with the care team at the hospital.*
- *If the UM team identifies a need for a CM referral, the referral is made through Truecare and received by a UM coordinator.*

After review of PSHP's policies and procedures for UM, we determined the policies and procedures are in compliance with the contract.

Program Integrity Oversight

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

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

Contract Language	PSHP 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.	There was no specific reference to this section of the contract in the submitted policy documents.
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

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
4.13.2.1.3 Policies to ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's Fraud, Waste and Abuse compliance plan;	Yes
4.13.2.1.4 Policies to establish a compliance committee that meets quarterly and reviews Fraud, Waste and Abuse compliance issues;	Yes
4.13.2.1.5 Policies to ensure that any individual who reports CMO violations or suspected Fraud, Waste and Abuse will not be retaliated against;	Yes
4.13.2.1.6 Policies of enforcement of standards through well-publicized disciplinary standards;	Yes
4.13.2.1.7 Provision of a data system, resources and staff to perform the Fraud, Waste and Abuse and other compliance responsibilities;	Yes
4.13.2.1.8 Procedures for the detection of Fraud, Waste and Abuse that includes, at a minimum, the following: 4.13.2.1.8.1 Prepayment review of claims; 4.13.2.1.8.2 Claims edits; 4.13.2.1.8.3 Post-processing review of Claims; 4.13.2.1.8.4 Provider profiling; 4.13.2.1.8.5 Quality Control; and 4.13.2.1.8.6 Utilization Management.	Yes
4.13.2.1.9 Written standards for organizational conduct;	Yes
4.13.2.1.10 Effective training and education for the Compliance Officer and the organization's employees, management, board Members, and Subcontractors;	Yes
4.13.2.1.11 Inclusion of information about Fraud, Waste and Abuse identification and reporting in Provider and Member materials;	Yes
4.13.2.1.12 Provisions for the investigation, corrective action and follow-up of any suspected Fraud, Waste and Abuse reports;	Yes

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
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
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
4.13.3.1 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.	There was no specific reference to this section of the contract in the submitted policy documents.

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
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

Overview of Program Integrity and On-site Observations

Peach State is contractually mandated to have a PI program to address prevention, detection, reporting, and corrective action as it relates to suspected cases of fraud, waste and abuse in the administration and delivery of Medicaid services. PI policies, procedures, and standards of conduct must be documented. The program must also include corrective action of suspected cases of fraud and abuse as a means to ensure the integrity of the Georgia Families program. Additionally, a mandatory compliance program and a pharmacy lock-in program are required under the contract.

Peach State's compliance program is coordinated by their compliance officer. The compliance program is monitored continuously and is adjusted as regulatory or legal developments take place. In addition to the compliance program, PSHP develops an annual work plan designed to be a guideline to follow to ensure that all areas of the compliance plan are addressed appropriately. Adjustments to the compliance plan and work plan may also result from audit findings and/or investigation results.

The compliance plan contains eight (8) core elements. Some of them are: reviewing and distributing a mandatory compliance plan; written standards of conduct and written policies and procedures; developing and implementing regular, effective education and training programs for all staff levels; using internal audits and other techniques to monitor compliance and reduce violations; and designating a compliance officer and a compliance committee.

The compliance committee meets on a quarterly basis to discuss the compliance program. Discussion topics include new initiatives and metrics, etc. The compliance committee has representation from all of the business units. At the conclusion of each meeting, all findings and/or takeaways are discussed with their business owners. The business owners and the committee work together to identify ways to mitigate negative findings.

All new employees, during the on-boarding process, must take mandatory compliance training. All other employees, board members, agents, providers, and subcontractors are subject to annual and ad hoc training on topics such as the mandatory annual FWA training, the mandatory annual HIPAA privacy program training, and the false claims act training. In lieu of tests, each training module has test questions throughout the testing materials.

After review of PSHP policies and procedures for PI, we did not identify policies or standard operating procedures for two contract sections. We recommend that PSHP, in accordance with their contract with DCH, create policies to address the contract requirements outlined in these areas.

Fraud, Waste, and Abuse Reporting

Peach State is also contractually required to submit a quarterly Fraud and Abuse Report to DCH. The contract specified that the reports must contain suspected cases of FWA identified in the administration and delivery of Medicaid services. FWA case reporting is required to include at least the:

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

Myers and Stauffer reviewed seven (7) quarterly Fraud and Abuse Reports submitted by Peach State for the first quarter of calendar year 2018 through the third quarter of calendar year 2019. These reports comprised 273 FWA cases. We reviewed the history of these cases in terms of the CMO's Special Investigative Unit (SIU) productivity, case mix, case outcomes, completeness, and consistency of reporting.

SIU Productivity

During the study period (January 2018 through September 2019), Peach State started with a backlog of 170 FWA cases, opened 104 additional cases, closed 189 cases, and ended with a backlog of 84 FWA

cases. The following diagrams trend case activity during the study period. It appears the SIU made a concerted effort from February through August 2018 to significantly reduce the existing backlog.

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

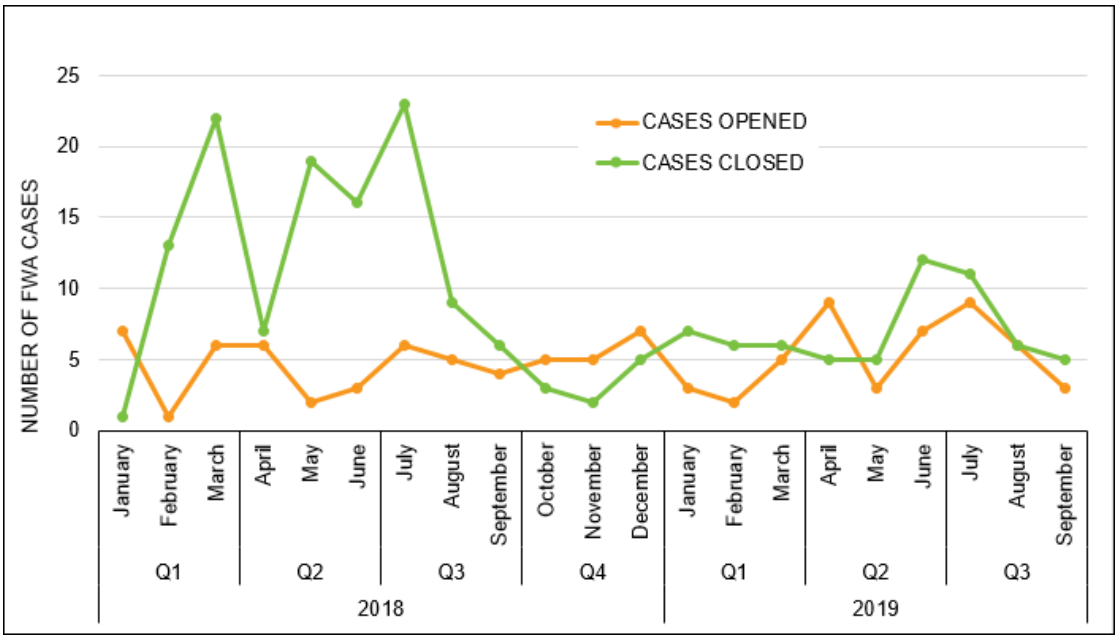
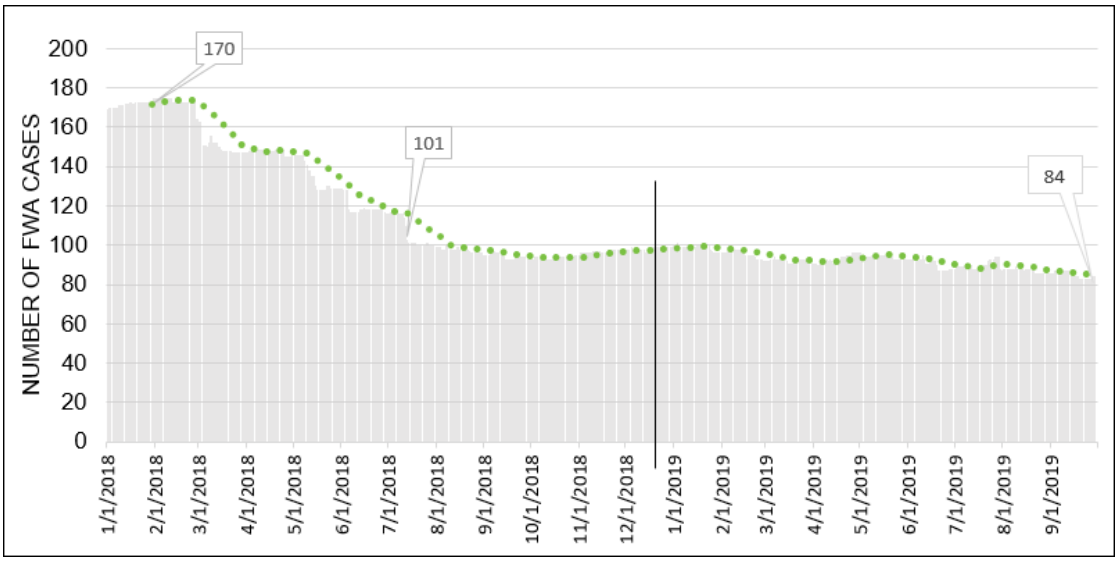


Figure 2: Number of Backlogged FWA Cases by Date



Additionally, it appears the backlog reduction focused on older cases. Of the 189 cases closed during the study period, 27 had been open for four or more years. Of the 84 cases still open at the end of the study

period, only two had been open as long as four years. The typical turnaround time (from open to close) for all cases was between 11 and 15 months.

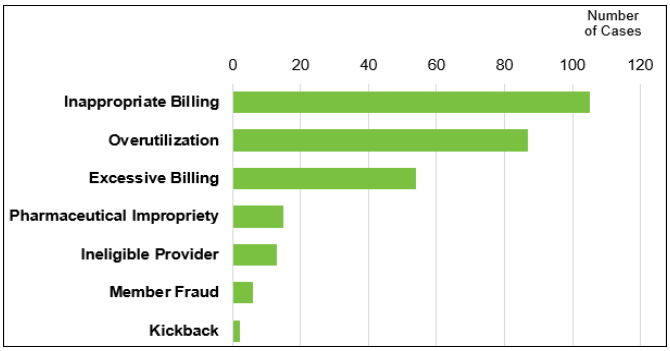
Peach State uses a risk assessment strategy to help them objectively determine the actions and efforts that should be taken with each FWA case. A case is assessed in terms of financial impact, member vulnerability, risk of reoccurrence, and regulatory violations. The case assessment is documented on a form that appears to be simple to complete. The assessment form requires the investigator to use check boxes confirming the range of financial impact, the number of members impacted, the potential impact on member safety, the existence of similar cases or allegations, and the appearance of regulatory/contractual violations. The form automatically generates a numeric score and the related standard recommended actions, such as "*Referral doesn't warrant SIU investigation; refer to other Health Plan department if applicable,*" "*Open a case and educate provider,*" or "*Open a case and proceed with investigation.*"

FWA Case Mix

Myers and Stauffer reviewed the FWA case mix within the 273 active cases during the study period in terms of the alleged FWA schemes and the types of providers, individuals, and entities involved. We settled on seven categories of FWA schemes, based on the nature of the complaint stated in the FWA quarterly reports. From most to least frequent, they were:

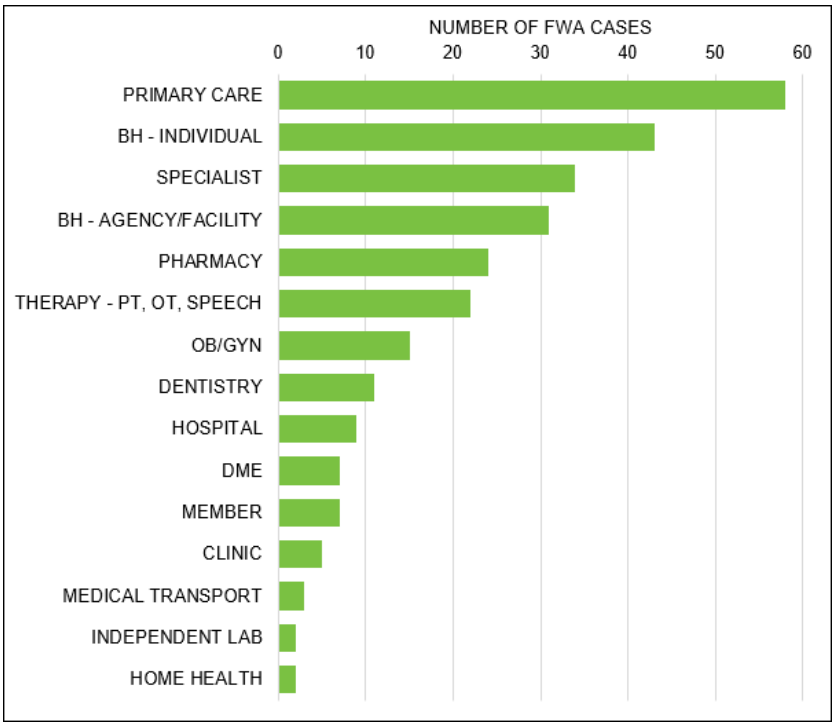
1. Inappropriate billing – including up-coding, unbundling, and false billing/diagnosis.
2. Overutilization.
3. Excessive billing.
4. Pharmaceutical impropriety – including drug diversion, excessive prescribing patterns, phantom pharmacy, and prescriptions with no oversight.
5. Ineligible provider – includes unlicensed providers and rendering services outside the scope of practice.
6. Member fraud.
7. Kickback.

Figure 3: FWA Scheme Categories



Of the alleged parties within the 273 FWA cases we reviewed, it appeared to mostly involve primary care, behavioral health, and specialists. No FWA cases for vision claims were reported by Peach State during the study period.

Figure 4: FWA Cases by Claim Type



The case mix evolved during the study period. The percentage of pharmacy, dentistry, and durable medical equipment (DME) cases grew, while the percentage of cases involving therapy and independent labs diminished. There were no home health or member FWA cases active during the first three quarters of 2019.

FWA Case Outcomes

Myers and Stauffer reviewed the actions and outcomes reported for the 273 FWA cases active during the study period. Actions and outcomes noted included provider education, recoupment, and provider termination. Note that some cases had multiple outcomes, so figures in the following table total to greater than 273 cases (greater than 100%).

Action / Outcome	Number of FWA Cases	Percentage of FWA Cases
Provider Education	90	33%
Recoupment	29 (Totaling $177,558.24)	11%
Cases Too Aged to Recoup	18	7%
Provider Terminated	8	3%
Cases Closed with Outcome Not Specified in the FWA Reports	87	32%
Open Cases with No Outcome by the End of the Study Period	80	29%

Completeness and Consistency of FWA Reporting

During our review of the seven (7) quarterly FWA reports, we noted the following potential issues in reporting on the 273 FWA cases:

- *No FWA cases for vision claims were reported during the study period.*
- *There were 24 FWA cases (8.8%) that failed to appear in subsequent reports although they had not been reported as closed in prior reports.*
- *Dates reported for FWA cases (date of complaint and close date) were not always consistent from one quarterly report to the next.*
    - *For 32 out of 273 FWA cases (11.7%), DATE_OF_COMPLAINT was not consistent across all reporting periods.*
    - *For 3 out of the 189 FWA cases (1.6%) that were closed during the study period, CLOSE_DATE was not consistent across all reporting periods.*
- *The column, "Disciplinary Action Imposed," was empty in all spreadsheets. Actions such as provider education and termination typically appeared in the columns, "Investigative Activities" and/or "Results."*
- *Four FWA cases appeared more than once in the same quarterly report.*

Myers and Stauffer recommends that Peach State work with Envolve Vision to encourage analysis of vision claims for patterns of FWA, and to promote the reporting of suspect activities to the SIU.

Additionally, we recommend that Peach State improve their FWA record keeping and reporting to ensure:

- *FWA cases are reported upon in every report up to and including the quarter in which they are closed.*
- *FWA cases are not duplicated within the report.*
- *Date of complaint and close date are accurate and are consistent from one quarterly report to the next.*
- *Closed cases clearly specify the case's outcome. In particular, the column, "Disciplinary Action Imposed," should be populated when FWA cases result in provider education, recoupment, or termination.*

Subcontractor Oversight

Myers and Stauffer reviewed the policies and procedures for subcontractor oversight provided by DCH, PSHP, and any related subcontractors. In the table below, we identify the key contract requirements and whether PSHP has policies and procedures consistent with the contract requirement(s). In the second section, we provide an overview and observations from the site visits.

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

Contract Language	PSHP 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	Yes

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
inspect all subcontract agreements at any time during the Contract period.	
18.1.4 All contracts entered into between Contractor and any Subcontractor related to this Contract must contain provisions which require Contractor to monitor the Subcontractor's performance on an ongoing basis and subject the Subcontractor to formal review according to a schedule established by DCH and consistent with industry standards or State laws and regulations. Contractor shall identify any deficiencies or areas for improvement related to any Subcontractor's performance related to this Contract, and upon request from DCH, provide evidence that corrective action has been taken to address the deficiency.	Yes
18.1.5 For any subcontract, there must be a designated project manager who is a member of the Subcontractor's staff that is directly accessible by the State. This individual's name and contact information must be provided to the State when the subcontract is executed. The subcontract agreement must contain a provision which requires the Contractor and its Subcontractors to seek binding arbitration to resolve any dispute between those parties and to provide DCH with written notice of the dispute.	Yes
18.1.6 Contractor shall give DCH immediate notice in writing by registered mail or certified mail of any action or suit filed by any Subcontractor and prompt notice of any Claim made against the Contractor by any Subcontractor or vendor that, in the opinion of Contractor, may result in litigation related in any way to this Contract.	Yes
18.1.7 All Subcontractors must fulfill the requirements of 42 CFR 438.6 as appropriate.	Yes
18.1.8 All Provider contracts shall comply with the requirements and provisions as set forth in Section 4.10 (Provider Contracts and Payments) of the 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

Contract Language	PSHP Policy Is Consistent with Contract Requirement(s) (Yes or No)
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

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

Overview of Subcontractor Oversight and On-site Observations

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

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

PSHP's Subcontractors						
Delegated Function	**Envolve (Dental)**	**Envolve (Vision)**	**Envolve Pharmacy/ Rx Advance**	**Envolve PeopleCare**	**Envolve PeopleCare (Nursewise)**	**One Source Therapy**
Case Management						X
Claims Adjudication	X	X	X			
Credentialing – Pharmacy			X			
Call Center Operations	X	X	X	X[1]	X	

[1] Operates a 24 hour crisis line.

PSHP's Subcontractors						
Delegated Function	**Envolve (Dental)**	**Envolve (Vision)**	**Envolve Pharmacy/ Rx Advance**	**Envolve PeopleCare**	**Envolve PeopleCare (Nursewise)**	**One Source Therapy**
Disease Management/Care Management				X		
Nurse Advice Line					X	
Prior Authorizations	X		X			X
Provider Complaints and Appeals	X	X	X			
Provider Network Management	X	X	X			
Utilization Management	X		X		X	X

The Myers and Stauffer engagement team reviewed the delegation oversight policies and procedures. PSHP is required to obtain prior written consent from DCH prior to hiring or entering into an agreement with any subcontractor. Delegation oversight audits are required annually via desktop or on-site, depending on the assessed risk to PSHP. Subcontractors are required to notify PSHP in the event they do not meet service requirements outlined in the DCH contract to functional area. PSHP's delegation team members have monthly operations meetings and quarterly Joint Operating Committee (JOC) meetings with the subcontractors.

Subcontractor Observations

Envolve Benefit Solutions (subsidiaries known as Envolve Dental and Envolve Vision)

Envolve Dental

Myers and Stauffer conducted an on-site visit to the Tampa, Florida, office of Envolve Dental on December 3, 2019. During the on-site, Myers and Stauffer interviewed representatives about call center operations, provider network, provider maintenance/provider directory, PI, quality, and UM to gain an understanding of Envolve Dental's policies and processes and to determine if policies and processes are in accordance with the contract between PSHP and DCH. Envolve Dental provides dental services to PSHP members.

Call Center Operations

There are 20 agents and two (2) call centers dedicated to supporting dental providers. One center is located in Tampa, Florida, and the second is located in Tempe, Arizona. These centers take provider calls only. Enterprise is the credentialing and claims processing system where demographic information on providers may be updated by call center staff.

Provider Network and Directory

PSHP forwards monthly provider roster updates, which are processed by Envolve Dental provider network staff. According to Envolve Dental personnel, there is no formal auditing of work completed by the provider network staff. We recommend Envolve Dental implement a process for monitoring the performance of provider network staff.

During the on-site, Envolve Dental personnel indicated there is a shortage of oral surgeons in Georgia. We recommend that Envolve Dental ensure there are targeted efforts in place to recruit the oral surgeons in surrounding areas (including across state borders) to help serve members of shortage areas. Telemedicine should also be used when possible to increase the availability of consultations with oral surgeons.

Quality

Envolve Dental previously sent a quality data file to the Centene corporate office for members to be marked as HEDIS compliant. Centene changed the process so that the only way a client can be marked compliant is through a claim. It was determined this new process was not always resulting in a member being marked HEDIS compliant in the QSI system. Envolve Dental and Centene have been working to resolve the issue. Envolve Dental should continue working with Centene to ensure an appropriate fix has been deployed to mitigate the issue in order to accurately capture dental quality indicators.

Envolve Dental has annual quality improvement initiatives. Currently they are implementing a quarterly opioid program, which includes receiving and reviewing pharmacy prescribing trends. For example, a dentist that is prescribing more than a 3-day supply would be flagged. Envolve Dental would then send reminders on standards for prescribing opioids to the identified dental providers. A peer review is also done if a provider continues to prescribe outside of the standards.

Program Integrity

Centene corporate began transferring the dental FWA investigations to Envolve Dental in January 2019. Kathryn Bass is setting up an internal special investigations unit and works closely with a FWA Committee to ensure investigations are complete and timely. The goal is to resolve cases within six months.

Utilization Management

Turnaround time for processing regular prior authorizations is three (3) days; the processing time is 24 hours or less for emergent authorizations. Audits are performed on 100% of prior authorizations. The audits check to see if the authorization has the proper codes, applicable/required notes based on the codes, x-rays, and provider information. A check is also conducted to confirm a prior authorization was required and the authorization is not a duplicate. Training is conducted as needed if errors are found.

Envolve Vision

Myers and Stauffer conducted an on-site visit to the Rocky Mount, North Carolina office of Envolve Vision on December 16-17, 2019. During the on-site, Myers and Stauffer interviewed representatives about call center operations, provider network, provider maintenance/provider directory, PI, and quality to gain an understanding of Envolve Vision's policies and processes and to determine if policies and processes are in accordance with the contract between PSHP and DCH. Envolve Vision provides vision care services to PHSP members.

Call Center Operations

There are two call centers that support vision providers. One is located in Rocky Mount, North Carolina and is for vision only. The Tempe, Arizona location provides support to both vision and dental providers.

Provider Network

According to Envolve Vision staff (Elizabeth Cobb – Director Quality Improvement), Georgia currently has an adequate vision provider network.

Program Integrity

Centene corporate began transferring the vision FWA investigations to Envolve Vision in January 2019. Kathryn Bass is setting up an internal special investigations unit and works closely with a FWA committee to ensure investigations are complete and timely. The goal is to resolve cases within six (6) months.

Quality

Envolve Vision previously sent a quality data file to Centene corporate for members to be marked as HEDIS compliant. Centene changed the process so that the only way a client can be marked compliant is through a claim. It was determined this new process was not always resulting in a member being marked HEDIS compliant in the QSI system. Envolve Vision and Centene have been working to resolve the issue. Envolve Vision should continue working with Centene to ensure an appropriate fix has been deployed to mitigate the issue in order to accurately capture vision quality indicators.

Envolve Vision has quality improvement initiatives. For example, an enhanced work flow tool was implemented for the vision appeals and grievances. Envolve Vision recognized the need for a more

robust module with the ability to add more information than the tool being utilized for dental appeals and grievances.

Envolve Pharmacy Solutions/RxAdvance

Myers and Stauffer conducted an on-site visit to the Orlando, Florida office of Envolve Pharmacy on December 4, 2019. During the on-site, Myers and Stauffer interviewed representatives from Envolve Pharmacy, as well as representatives from RxAdvance, about call center operations, eligibility management, pharmacy network, PI/claims audit, and UM/prior authorization to gain an understanding of Envolve Pharmacy's policies and processes and to determine if policies and processes are in accordance with the contract between PSHP and DCH.

RxAdvance

In April 2018, Envolve Pharmacy Solutions formed a strategic partnership with RxAdvance. RxAdvance is the delegated vendor for three services: claims adjudication; NM; and pharmacy network response. A readiness review was conducted prior to the switch.

Call Center Operations

Call centers are staffed in Orlando, Florida and Fresno, California. Call center representatives in the Fresno office primarily work directly with members. Pharmacy technicians in Orlando work with pharmacies. The majority of the technicians are nationally-certified pharmacy technicians. Hours of operation are 8:00 a.m. to 9:00 p.m. EST. An after-hours call center is staffed by nurses.

The types of calls received include: calls from members about medications; calls from pharmacies about new prescriptions and refills; calls from the health plan; doctors' offices trying to get a prior authorization; etc. The member calls are documented in the PBM systems.

For 2019, the call volume averaged 7,000 calls a month (for member and provider combined). The first and second quarters of FY 2020 averaged 8,500 calls per month. According to Envolve Pharmacy representatives, all performance standards and service levels are being met.

Eligibility Management

Envolve Pharmacy manages eligibility through daily files received from Centene. Envolve Pharmacy runs scripts that generate the specific files that go to RxAdvance. The files sent to RxAdvance have all the data needed to enroll members. The timeline from receipt of the 834 from Centene until it is uploaded into RxAdvance is usually the next business day (24-36 hours).

Pharmacy Network

Envolve Pharmacy Solutions utilizes RxAdvance to oversee credentialing, contracting, and network set-up (including reimbursement rates). During the on-site, Envolve Pharmacy representatives indicated there are no current deficiencies in the PSHP pharmacy network. However, during the review of PSHP's

overall provider network, Myers and Stauffer was informed there is shortage of 24-hour pharmacies. Envolve Pharmacy should develop a plan to reduce the shortage of 24-hour pharmacies in the network.

Program Integrity/Claims Audit

A claim review process is considered to be one component of a PI program. For Envolve Pharmacy, there is an evaluation of the accuracy of claims payments. This is done at the Envolve Pharmacy level by the Medicaid Program Management Unit. This same unit handles front-end edits to detect FWA. Envolve Pharmacy uses the formulary and benefit setup information to identify potential issues. There is a standard daily process in place. IPS is the company that performs claims reviews for Envolve Pharmacy/RxAdvance (data analytics, mining, etc.).

Utilization Management

The volume of authorizations for PSHP is approximately 58-60 per day on average. The turnaround time for prior authorizations is 24 hours for urgent and non-urgent cases. There is an allowance of 72 hours if additional information needs to be requested. Approximately 20% of prior authorization requests are categorized as urgent.

For November 2019, there were a total of 1,249 prior authorizations of which 778 (62%) were approved and 471 (38%) were denied. Sixty-five percent (65%) of the denials were due to the drug not being medically necessary. Eighteen percent (18%) were denied because the non-formulary exception rules were not met. Envolve Pharmacy should evaluate the reasons for such a high denial rate on prior authorizations and identify proactive solutions to be taken to reduce this percentage (i.e., provider education).

Quarterly audits of prior authorizations are done to gauge adherence to quality standards. An annual IRR (inter-rater reliability) test is also performed for all staff, including both clinical and non-clinical.

Envolve (Nurtur)

Myers and Stauffer conducted an on-site visit to the Dallas, Texas office of Envolve PeopleCare's Nurtur business line on November 20-21, 2019. During the on-site, Myers and Stauffer interviewed those responsible for administering the Nurtur functions, including health coaches, to gain an understanding of Nurtur's policies and processes and to determine if policies and processes are in accordance with the contract between PSHP and DCH.

Nurtur provides PSHP members with disease CM programs for asthma, diabetes, and a puff-free pregnancy. Schmitt-Thompson Clinical Guidelines are utilized to group callers into categories based on acuity or severity of illness. Levels 1 and 2 are considered emergent calls. Levels 3, 4, and 5 are non-emergent and are routed through the queue. Clinical guidelines are updated annually or as needed when new content becomes available.

During the on-site, the team reviewed six (6) medical records and listened to four (4) calls. Notable results and recommendations from the site visit are discussed in the following paragraphs.

- *Myers and Stauffer listened to recorded audio calls from the TeleCare Management Program. Per Amendment Number 10, members are placed in an "unable to locate" status after three failed attempts to be contacted. The interviewee explained that when Nurtur/Envolve PeopleCare makes three unsuccessful attempts to reach the member or caregiver for DM, a form of notification is mailed to the member informing him/her of Nurtur/Envolve PeopleCare's request to connect. If the member remains in an unable to locate status for 90 days, he/she is then unenrolled from the DM program. We determined the unable to locate process was not followed for three (3) members.*
- *Myers and Stauffer recommends that Nurtur:*
    - *Update the contract language to include provisions of the notification process following three failed contact attempts (i.e., while the member is in the unable to locate queue).*
    - *Implement a quality assurance process for confirming that the unable to locate policy is followed.*
- *Managed Healthcare Network (MHN) is contracted to provide 24/7 crisis call support. MHN follows the performance standards set by URAC. Nurtur does not provide oversight of performance standards. Nurtur should implement a process to monitor MHN's compliance with performance standards.*
- *Based on the interview with Judy Topolsky, Senior Director for Account Management, the performance standard for member satisfaction was not fully met. The member satisfaction target for adults is 85%. The result reported on the annual survey was 84.06%. No corrective plan was in place. Nurtur should implement a corrective action plan to ensure the 85% satisfaction rate for adult members receiving DM services is met in the future.*

Envolve (Nursewise)

Myers and Stauffer conducted an on-site visit at the Tempe, Arizona office of Envolve PeopleCare's Nursewise business line on December 9-10, 2019. Nursewise provides a 24/7 Nurse Advice Line and after hours member support services (7:00 p.m. – 7:00 a.m.). During the on-site, Myers and Stauffer interviewed those responsible for overseeing the Nurse Advice Line to gain an understanding of Nursewise's policies and processes and to determine if policies and processes are in accordance with the contract between PSHP and DCH.

During the on-site, Myers and Stauffer listened to the following types and numbers of calls: (a) five (5) calls answered by customer care professionals (CCPs) and, (b) four (4) calls answered by a registered nurse. We identified the following from the site visit and the calls:

- *The performance standard for the call/talk/handle time for the nurse advice line is not documented in the contractual agreement between PSHP and Nursewise. During the interview process, it was discovered from multiple sources that the goal for the length of talk time for a nurse advice line call is less than 12 minutes. When asked to describe the process if a call exceeds 12 minutes, the interviewee stated a supervisor would talk to the nurse about the extended call/talk/handle time. Her response indicated that exceeding 12 minutes on a nurse call would be considered negative. Myers and Stauffer recommends that Nursewise update their contract with PSHP to address the performance standards for the nurse advice line call/talk/handle time.*
- *Contact information for the online health information and audio health information tools can be provided as a method for member education. According to the nurse advice line representative, the process is to provide the information and allow the member to navigate the system on their own. If the member requires assistance after disconnecting the call, the member is required to call the nurse advice line again for the nurse to stay on the line with the member and provide guidance to obtain the information within the educational platforms. Nursewise should provide the member with instructions for the education sites and inquire about the member's level of comfort with navigating the sites. Nurse line representatives should offer to remain on the line with the member to ensure they do not have trouble accessing the educational sites. Such action increases first call resolution, as well as ensures the member obtained the educational information.*
- *During one of the call observations, a 16-year old caller required assistance to determine if she was an eligible member. She had lost her mother and found the insurance card in her mother's purse. After authenticating the member, the CCP continued the conversation despite the fact that the member was under 18 years old. During the discussion after the call was heard, Nursewise representatives indicated that CCPs can continue calls with members under 18 years old depending upon the nature of the call. Nursewise should document examples of extenuating circumstances, in their policy, to allow for coverage details and other information to be given to callers under the age of 18 years old. These circumstances should include instances where there is no guardian over 18 years of age to call on behalf of the member.*
- *During a call demonstration, a member mentioned the need to find a new PCP. The nurse advice line representative referred the member to an urgent care. There was no information provided on options for available urgent care locations, acceptance of Medicaid, distance from the member's home, etc. Nursewise should provide more resourceful information when members call about obtaining or changing a PCP. The education process should also include determining whether the member requires assistance in locating the nearest facility in order to receive care.*

One Source Therapy Review

Myers and Stauffer conducted an on-site visit to the Duluth, Georgia headquarters of One Source Therapy Review, LLC on November 14, 2019. During the on-site, Myers and Stauffer interviewed the

CEO, medical director, compliance officer, and therapy specialists to gain an understanding of One Source Therapy Review's policies and processes and to determine if policies and processes are in accordance with the contract between PSHP and DCH. One Source Therapy Review provides prior authorization for speech, occupational, and physical therapy services.

One Source Therapy Review provided requested documentation in advance, which was reviewed prior to the on-site visit. We identified the following:

- *A pre-audit report of prior authorizations and denials indicated a 22% denial rate for the cumulative period January 1, 2019 – June 30, 2019. According to the contract between PSHP and One Source Therapy Review effective July 1, 2017, "the denial rate due to lack or inadequate clinical information shall remain at or below 15% each month." The cumulative rate of 22% for the 1st and 2nd quarters of 2019 indicates there were months in which the denial rate exceeded the contract requirement. PSHP should ensure the denial rate contract requirement is being met and enforced.*
- *A pre-audit report of appeals for the months of March and June of 2019 showed the contract standard of "less than 10%" for overturned appeals was not met. For March 2019, the overturned appeals rate was 66.7%. The June 2019 rate was 33.3%. PSHP should ensure the overturned appeals rate in the contract is being met and enforced.*

During the on-site, Myers and Stauffer received a system demonstration. We also requested and subsequently reviewed: (a) supporting records for a random sample of 10 prior authorizations, including five denials and five appeals; and, (b) supporting prior authorization processing records for a random sample of 10 members. We identified the following:

- *No issues were identified with records for the five denials and five appeals. One Source Therapy Review had documentation to support the prior authorization review and decision process for these cases.*
- *On the random sample of 10 records, we found the following:*
  - *The PSHP to One Source Therapy Review contract requires "at least 98% of all non-urgent requests shall be reviewed within two business days of receipt of the authorization request from HMO's referral specialist." When examining records on-site, we found two cases out of ten (20%) did not meet the two-day turnaround time for review. One Source Therapy Review should monitor and ensure the two-day timeliness standard for prior authorizations is consistently met.*
  - *Based on the interviews and review of sample records, standards for determining medical necessity are not maintained in a central repository and are not consistently used by the therapists. PSHP should require One Source Therapy Review to develop a*

process for more consistent reviews across therapists. One option would be to create a central repository with the national and state-specific guidelines.

Interviews with One Source Therapy Review staff confirmed FWA training occurs annually. One Source Therapy Review provided a copy of the most recent annual FWA and HIPAA training documents. One Source Therapy Review was able to supply signed attestation training records for all staff interviewed by Myers and Stauffer.

Based on interviews and documentation provided by One Source Therapy Review, it does not appear that the subcontractor submits monthly reports detailing any findings of FWA as outlined in the PSHP to One Source Therapy Review contract (Section 2, Item h). The meeting agendas and the report submitted to the state are compiled directly by PSHP. One Source Therapy Review should be required to submit a monthly FWA report to aid PSHP in compiling the main report for the state, or the provision should be removed from the contract.

Encounter Submissions and Payment Systems

Approach and Methodology

Overview

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

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

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

The analysis was limited to claims and encounters for member populations covered by the PSHP having a service date during November 2019 or a paid date in December 2019. The CMO and its subcontractors were requested to provide all claims satisfying this criteria regardless of outcome (paid, denied, rejected) or version (original, adjusted, voided, replaced, final.)

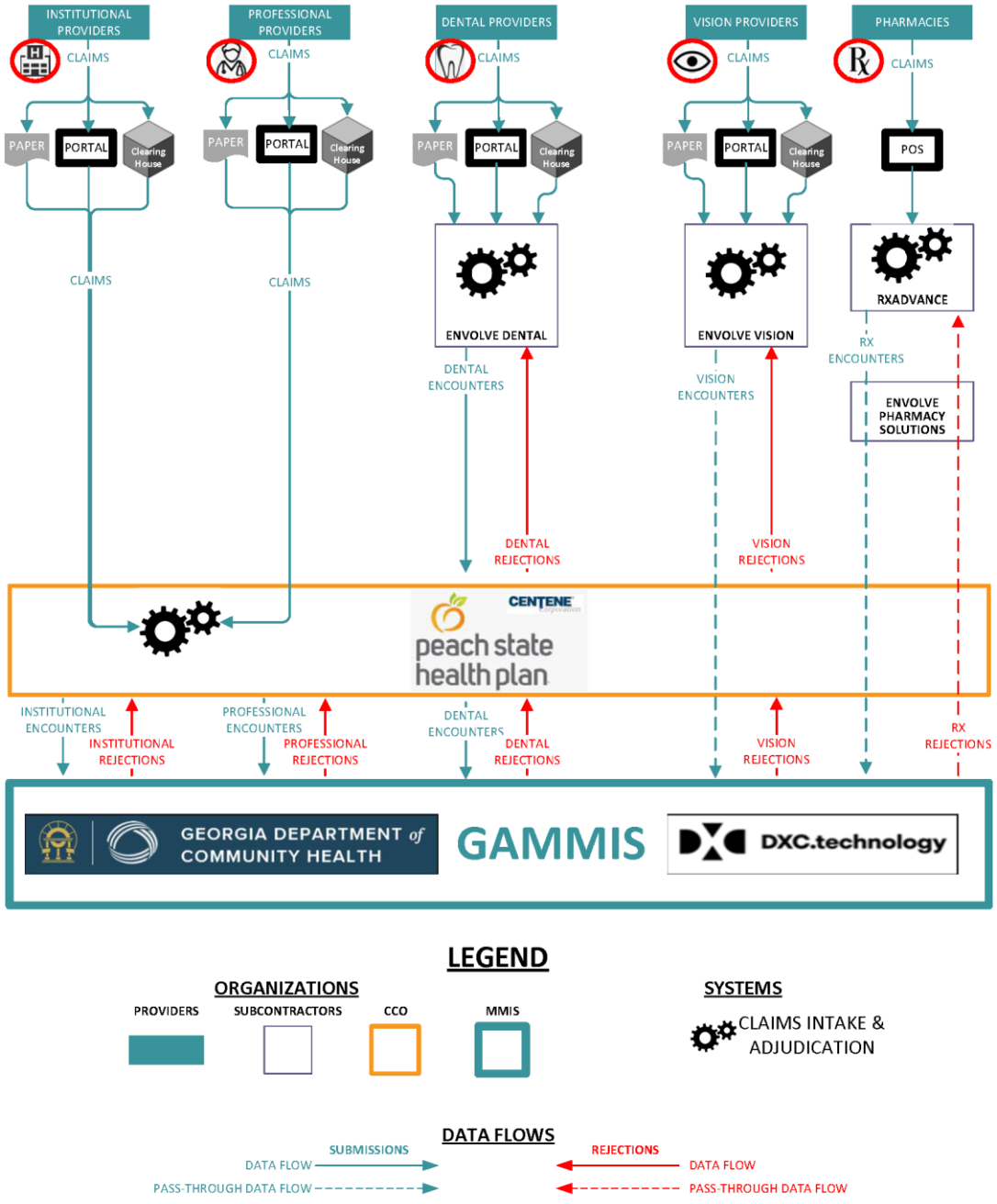
Myers and Stauffer receives encounter data on a weekly basis from DCH's fiscal agent contractor (FAC), DXC. This data extract contains paid and denied CMO institutional, medical, dental, and pharmacy encounters that are submitted by the CMO to the FAC and are subsequently loaded into the MMIS. Unless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

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

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

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

Figure 5: Claims and Encounters Data Flow Diagram



Claims/Encounters Completeness

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

- *CMO Capitation Rate Setting.*
- *Managed Care Oversight.*
- *Medicaid PI Initiatives.*

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

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

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

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

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

- ***Missing Claim Voids*** *- Replaced or voided claims which appear to be reported in the MMIS encounters but do not appear to be voided in the MMIS encounters. These instances may overstate payments and services reported in the MMIS.*

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

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

Encounter Submission Accuracy

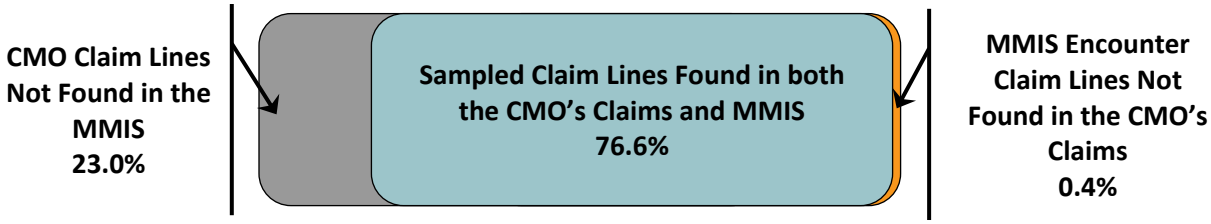
Myers and Stauffer compared data elements in the CMO and subcontractor claims to related encounter data within the claim/encounter life cycle to determine if the information in the originating system ultimately matched the information reported in the MMIS. We evaluated and documented differences in claim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

Fee for Service (FFS) Claims, Institutional and Professional – PSHP

Encounter Submission Completeness

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

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



Encounter Submission Completeness	
76.6%†	**Percentage of sampled lines appearing in both the CMO's claims and the State's MMIS encounters.**
23.0%	**Percentage of sampled lines appearing only in the CMO's claims.**
	• ***Denied (13.3%)*** *– A claim line denied for payment by the CMO during their claim adjudication process due to authorization, eligibility, limits issues, or other reasons.* • ***Other (8.8%)*** *– A claim line with insufficient information available to explain their absence as an encounter.* • ***Alternative Found (0.9%)*** *– Claim lines that did not appear to exist as encounters for which a different version or adjustment was found.*
0.4%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**
	• ***Alternative Found (0.2%)*** *– Encounter lines that did not appear to exist as claim lines for which a different version or adjustment was found.* • ***Other (0.1%)*** *– An encounter line with insufficient information available to explain its absence from the CMO's claims.*

† Note, percentages are rounded and may not always add to 100%.

CMO's claims not found in the MMIS encounters:

- ***Denied.*** *Approximately 239,700 (13.3 percent) Peach State FFS claim lines appear to be denied in the CMO's claims but do not appear to exist in the MMIS. Although we observed a subset of denied FFS claims in the MMIS encounters, more than half of the claims lines missing from the MMIS encounters were denied, whereas in the typical claim population, less than ten (10) percent are denied. It appears that Peach State may not be submitting all denied encounter claim lines to the MMIS.*

- ***Other.*** *Approximately 158,200 (8.8 percent) Peach State FFS claim lines in the CMO's claims did not appear to exist as encounter claim lines in the MMIS and there is no information present to explain the absence from the MMIS.*
- ***Alternative Found.*** *Approximately 16,800 (0.9 percent) Peach State FFS claim lines in the CMO's claims did not appear to exist in the MMIS; however, an alternate version or adjustment of the claim line was found in the MMIS. Many of these claims lines (approximately 7,200; 0.4 percent) appear to have alternate versions with matching line payment amounts when compared to the associated version identified in the MMIS. Approximately 3,900 (0.2 percent) additional claim lines appear to have been adjudicated within seven (7) days of the associated version identified in the MMIS. These claim lines may have been adjusted within the CMO's weekly cycle for encounter submissions and Peach State may have only submitted the most recent claim adjustment to the MMIS.*

MMIS encounters not found in the CMO's claims:

- ***Alternative found.*** *Approximately 3,800 (0.2 percent) Peach State FFS encounter claim lines in the MMIS did not appear to exist in the CMO's claims; however, an alternate version or adjustment of the claim line was found in the CMO's claims. Most of these encounter claim lines (approximately 3,200; 0.2 percent) appear to have alternate versions with matching line payment amounts and matching paid dates compared to the associated version identified in the CMO's claims.*

Encounter Submission Accuracy

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

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

- ***Date Claim Submitted to Peach State by the Provider*** *(Institutional and Professional Encounters) – The claim receipt date in the MMIS encounters appeared to have been consistently misreported to be the same as the claim's paid date.*
- ***Discharge Date*** *(Institutional Encounters only) – For approximately 1.2% of the institutional claim lines in the MMIS encounters, the discharge date did not match the value in Peach State's claims extracts. Rather, the discharge date in the encounters appeared to equal the claim header's last date of service, which may not always be the case.*
- ***Last Date of Service, Claim Header*** *(Institutional Encounters only) – For approximately 1.2% of the institutional claim lines in the MMIS encounters, the claim header's last date of service did*

not match the value in Peach State's claims extracts. Rather, the claim header's last date of service appeared to be derived from detail line service dates.

- ***Amount Paid, Claim Header*** *(Professional Encounters only) – For approximately 2.1% of the professional claim lines in the MMIS encounters, the claim header's paid amount did not match the value in Peach State's claims extracts. It appeared Peach State's claims extracts included interest payments in the claim header paid amount, whereas encounters did not include interest payments in the claim header paid amount.*
- ***Amount Paid, Claim Detail Lines*** *(Institutional and Professional Encounters) – Approximately 2.4% of detail lines in the Peach State encounters had paid amounts that did not match the value in Peach State's claim extracts. These discrepancies took a number of forms, among them the occurrence of line bundling, the amount paid at the header level not equaling the sum of the detail lines, and the inclusion/exclusion of interest payments and/or TPL amounts in claims but not encounters.*
- ***Payee Provider Tax ID*** *(Institutional and Professional Encounters) – Approximately 9.0% of the detail lines in the Peach State encounters appeared to have payee provider tax IDs that were derived from the claim's rendering provider. They may not accurately reflect the claim payee/billing provider submitted on the claim itself.*
- ***Rendering Provider National Provider Identifier (NPI)*** *(Institutional and Professional Encounters) – For approximately 2.1% of the detail lines in the MMIS encounters for Peach State, the rendering provider's NPI did not match the value found in the claims extracts submitted by Peach State.*
- ***Referring Provider NPI*** *(Institutional and Professional Encounters) – The MMIS institutional encounters for Peach State appeared to have no entries for referring provider NPI, even for those claims in the Peach State extracts which did have an entry. For Peach State's MMIS professional encounters, we observed 0.6% of the lines were missing the referring provider NPI which appeared in the claims extracts submitted by Peach State.*
- ***Operating Provider NPI*** *(Institutional Encounters only) – The MMIS institutional encounters for Peach State appeared to have no entries for operating provider NPI, even for those claims in the Peach State extracts which did have an entry.*
- ***Units Billed*** *(Institutional and Professional Encounters) – We observed approximately 9.1% of the detail lines in the MMIS encounters for Peach State for which the units billed was either blank or zero, even when those detail lines in Peach State's claims extracts had non-zero entries for units billed.*
- ***NDC*** *(Institutional and Professional Encounters) – The MMIS encounters for Peach State appeared to have no entries for NDC, even for those claims in the Peach State extracts which did have an entry.*

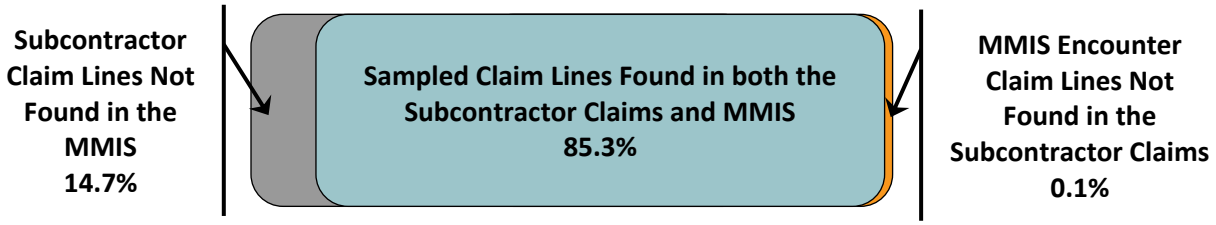
- ***Procedure Code Modifier 1*** *(Institutional Encounters only) – Approximately 2.6% of the institutional claim lines in the MMIS encounters for Peach State had potentially invalid procedure code modifier values ("XX" or "XY"). The corresponding procedure code modifier values in the Peach State claim extracts were blank.*
- ***Place of Service*** *(Professional Encounters only) – Approximately 2.7% of professional claim lines in the MMIS encounters for Peach State had place of service codes which did not match those in the corresponding Peach State claims extracts. More than half of these codes in the MMIS encounters were assigned the non-specific code of "99" (meaning "other").*

Exhibit II comprises additional detail concerning the accuracy of all data elements reviewed for institutional encounters (*Table 1*) and professional encounters (*Table 2*).

Dental Claims—Envolve Dental

Encounter Submission Completeness

Myers and Stauffer reviewed approximately 265,000 claim lines adjudicated by Envolve Dental for dental claims. Encounter submission completeness is expressed as a percentage of the sampled claim lines appearing at multiple points in the claim/encounter life cycle. Sampled subcontractor claim lines were compared to MMIS encounters, and the percentage of lines appearing in both data sources or appearing in only one data source is outlined in the table below. The percentage of sampled lines appearing only in the subcontractor claims and the percentage of sampled lines appearing only in the MMIS encounters are further broken out in the bullets below each percentage. Additional observations are provided in the following section for percentages greater than 0.2%.



Encounter Submission Completeness	
85.3%†	**Percentage of sampled lines appearing in both the subcontractor's claims and the State's MMIS encounters.**
14.7%	**Percentage of sampled lines appearing only in the subcontractor's claims.**
	• ***Denied (13.0%)*** *– A claim line denied for payment by the subcontractor during their claim adjudication process due to authorization, eligibility, limits issues, or other reasons.*

	• ***Alternative Version Found (1.1%)*** *– Claim lines that did not appear to exist as encounters for which a different version or adjustment was found.* • ***Other (0.6%)*** *– A claim line with insufficient information available to explain its absence as an encounter.*
0.1%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**
	• ***Other (0.1%)*** *– An encounter line with insufficient information available to explain its absence from the subcontractor's claims.*

† Note, percentages are rounded and may not always add to 100%.

Envolve Dental claims not found in the MMIS encounters:

- ***Denied.*** *Approximately 34,500 (13.0 percent) Envolve Dental claim lines appear to be denied in the subcontractor's claims but do not appear to exist in the MMIS. We observed a small number of denied dental claims (approximately 20 total) included in the MMIS encounters, but it appears the majority of denied Envolve Dental claims are not included in the MMIS encounters.*
- ***Alternative Found.*** *Approximately 2,790 (1.1 percent) Envolve Dental claim lines in the subcontractor's claims did not appear to exist in the MMIS; however, an alternate version or adjustment of the claim line was found in the MMIS. Many of these claims lines (approximately 1,900; 0.7 percent) appear to have appear to have been adjudicated within seven (7) days of the associated version identified in the MMIS. These claim lines may have been adjusted within the CMO's weekly cycle for encounter submissions and Peach State may have only submitted the most recent claim adjustment to the MMIS.*
- ***Other.*** *Approximately 1,400 (0.6 percent) Envolve Dental claim lines in the subcontractor's claims did not appear to exist as encounter claim lines in the MMIS and there is no information present to explain the absence from the MMIS.*

Encounter Submission Accuracy

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

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

- ***Date Claim Submitted to Envolve Dental by the Provider*** *– The claim receipt date in the MMIS encounters appeared to have been consistently misreported as the same as the claim's paid date.*

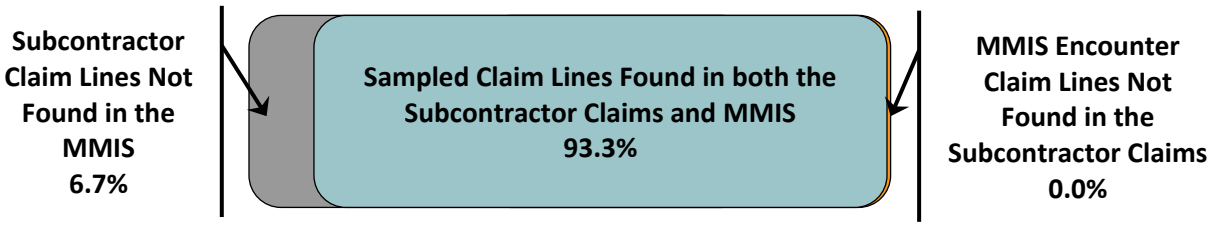
- ***Interest Paid*** *– We normally expect interest paid amounts to be identified with an adjustment reason code. No identifiable interest amounts were observed to exist in the MMIS dental encounters for Envolve Dental.*
- ***Payee Provider Tax ID*** *– Approximately 25.5% of the detail lines in the Envolve Dental encounters appeared to have payee provider tax IDs that were derived from the claim's rendering provider. They may not accurately reflect the payee/billing provider as submitted on the provider's claim.*
- ***Diagnosis Codes*** *– Envolve Dental encounters in the MMIS appeared to have no diagnosis codes reported at either the header or the detail line level.*
- ***Units Billed*** *– In the MMIS it appears that for all Envolve Dental encounters the units billed is entered as 0 (zero).*
- ***Tooth Number and Tooth Surface*** *– It appeared that claim lines reporting the same procedure for multiple teeth and/or tooth surfaces may have been bundled into a single line in the MMIS encounters. This bundling action eliminated reporting on all but one of the multiple codes representing the teeth/surfaces in the original claim.*

Exhibit II, Table 3 comprises additional detail concerning the accuracy all dental data elements reviewed.

Vision Claims—Envolve Vision

Encounter Submission Completeness

Myers and Stauffer reviewed approximately 33,300 claim lines adjudicated by Envolve Vision for vision claims. Encounter submission completeness is expressed as a percentage of the sampled claim lines appearing at multiple points in the claim/encounter life cycle. Sampled subcontractor claim lines were compared to MMIS encounters and the percentage of lines appearing in both data sources or in only one data source is outlined in the table below. The percentage of sampled lines appearing only in the subcontractor claims and the percentage of sampled lines appearing only in the MMIS encounters are further broken out in the bullets below each percentage. Additional observations are provided in the following section for percentages greater than 0.2%.



Encounter Submission Completeness	
93.3%†	**Percentage of sampled lines appearing in both the subcontractor's claims and the State's MMIS encounters.**
6.7%	**Percentage of sampled lines appearing only in the subcontractor's claims.**
	• ***Denied (4.1%)*** *– A claim line denied for payment by the subcontractor during their claim adjudication process due to authorization, eligibility, limits issues, or other reasons.* • ***Alternative Version Found (1.8%)*** *– Claim lines that did not appear to exist as encounters for which a different version or adjustment was found.* • ***Other (0.7%)*** *– A claim line with insufficient information available to explain its absence as an encounter.*
0.0%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**
	• ***Not Applicable***

† Note, percentages are rounded and may not always add to 100%.

Envolve Vision claims not found in the MMIS encounters:

- ***Denied.*** *Approximately 1,380 (4.1 percent) Envolve Vision claim lines appear to be denied in the subcontractor's claims but do not appear to exist in the MMIS. Although we observed a subset of denied vision claims in the MMIS encounters, more than half of the claims lines from the MMIS encounters were denied, whereas in the typical claim line population, less than ten (10) percent are denied. It appears that Envolve Vision may not be submitting all denied encounter claim lines to the MMIS.*
- ***Alternative Found.*** *Approximately 590 (1.8 percent) Envolve Vision claim lines in the subcontractor's claims did not appear to exist in the MMIS; however, an alternate version or adjustment of the claim line was found in the MMIS. Approximately 230 (0.7 percent) appear to have alternate versions with matching line payment amounts when compared to the associated version identified in the MMIS. Approximately 85 (0.3 percent) additional claim lines appear to have been adjudicated within seven (7) days of the associated version identified in the MMIS. These claim lines may have been adjusted within the subcontractor's weekly cycle for encounter submissions and Envolve Vision may have only submitted the most recent claim adjustment to the MMIS.*
- ***Other.*** *Approximately 240 (0.7 percent) Envolve Vision claim lines in the subcontractor's claims did not appear to exist as encounter claim lines in the MMIS and there is no information present to explain the absence from the MMIS.*

Encounter Submission Accuracy

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

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

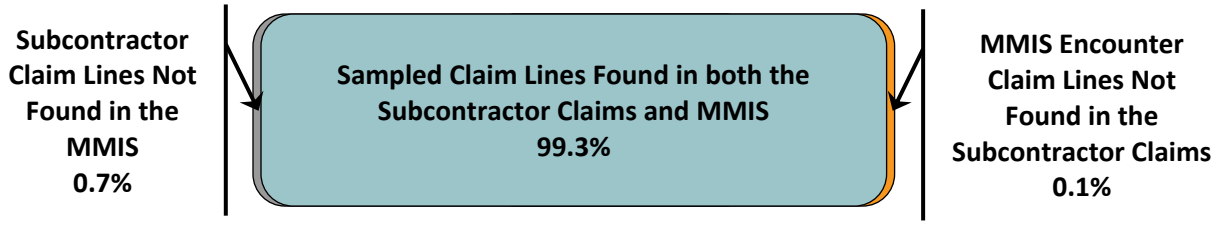
- ***Date Claim Submitted to Envolve Vision by the Provider*** *– The claim receipt date in the MMIS encounters appeared to have been consistently misreported to be the same as the claim's paid date.*
- ***Date Claim Paid*** *– In the MMIS encounters for Envolve Vision, approximately 73.0% of paid dates appeared to be the claim adjudication date.*
- ***Payee Provider Tax ID*** *– Approximately 4.7% of the detail lines in the Envolve Vision encounters appeared to have payee provider tax IDs that were derived from the claim's rendering provider. They may not accurately reflect the payee/billing provider as submitted on the provider's claim.*
- ***Rendering Provider NPI*** *– For approximately 1.5% of the detail lines in the MMIS encounters for Envolve Vision, the rendering provider's NPI did not match the value found in the claims extracts submitted by Envolve Vision.*

Exhibit II, Table 4 comprises additional detail concerning the accuracy of all vision data elements reviewed.

Pharmaceutical Claims – RxAdvance

Encounter Submission Completeness

Myers and Stauffer reviewed approximately 467,400 claim lines adjudicated by RxAdvance for pharmaceutical claims. Encounter submission completeness is expressed as a percentage of the sampled claim lines appearing at multiple points in the claim/encounter life cycle. Sampled subcontractor claim lines were compared to MMIS encounters and the percentage of lines appearing in both data sources or appearing in only one data source is outlined in the table below. The percentage of sampled lines appearing only in the subcontractor claims and the percentage of sampled lines appearing only in the MMIS encounters are further broken out in the bullets below each percentage. Additional observations are provided in the following section for percentages greater than 0.2%.



Encounter Submission Completeness	
99.3%†	**Percentage of sampled lines appearing in both the subcontractor's claims and the State's MMIS encounters.**
0.7%	**Percentage of sampled lines appearing only in the subcontractor's claims.**
	• ***Other (0.6%)*** *– A claim line with insufficient information available to explain its absence as an encounter.* • ***Alternative Version Found (0.1%)*** *– Claim lines that did not appear to exist as encounters for which a different version or adjustment was found.*
0.1%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**
	• ***Alternative Found (0.1%)*** *– Encounter lines that did not appear to exist as claim lines for which a different version or adjustment was found.*

† Note, percentages are rounded and may not always add to 100%.

RxAdvance claims not found in the MMIS encounters:

- ***Other.*** *Approximately 2,800 (0.6 percent) RxAdvance claim lines in the subcontractor's claims did not appear to exist as encounter claim lines in the MMIS and there is no information present to explain the absence from the MMIS.*

Encounter Submission Accuracy

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

Myers and Stauffer observed no significant discrepancies which could have a concerning impact on the use of encounters for program management, PI, and regulatory reporting. *Exhibit II, Table 5* comprises the details concerning the accuracy of all RxAdvance pharmaceutical data elements reviewed.

Pharmaceutical Claims – CVS Health

Encounter Submission Completeness

Myers and Stauffer reviewed approximately 32,000 claim lines adjudicated by CVS Health for pharmaceutical claims. All of these claim lines were marked as rejected or denied. These claim lines did not appear to exist in the State's MMIS; however, approximately 4,700 (14.7%) claim lines did appear to have a different version or adjustment adjudicated by RxAdvance in the MMIS encounters based on matching member, provider, service date, prescription number, and refill number. These alternative versions were assumed to be claim resubmissions by the provider to RxAdvance. CVS Health results are indicative of vendor runout following their contract expiration on July 31, 2019.

Encounter Submission Accuracy

No CVS Health claim lines were identified in the MMIS encounters for the sample periods. Myers and Stauffer was unable to validate encounter submission accuracy for CVS Health.

Findings and Recommendations

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

Findings and Recommendations			
Entity	**Functional Area**	**Finding**	**Recommendation**
PSHP	Encounter Submissions	Myers and Stauffer observed potentially missing data in the MMIS, in particular denied claim lines missing from the encounters submitted to the MMIS by Peach State, Envolve Dental, and Envolve Vision.	Peach State and its subcontractors should review processes and policies for the reporting of encounters to the MMIS and adjust their processes to ensure reliable reporting of claim lines.
PSHP	Encounter Submissions	Myers and Stauffer observed mismatching claim data elements between the Peach State FFS claims, subcontractor encounters extracts, and the MMIS encounters.	Peach State and its subcontractors should review their processes and policies for the reporting of encounters to the MMIS and adjust their processes to ensure reliable reporting of claim data elements.
PSHP	Program Integrity	There were no reported cases of FWA for Vision during the testing period.	Peach State should work with Envolve Vision to encourage the analysis of vision claims for patterns of FWA and to promote the reporting of suspect claim activities to the SIU.

Findings and Recommendations			
Entity	**Functional Area**	**Finding**	**Recommendation**
PSHP	Program Integrity	FWA Reports submitted to DCH were neither entirely complete nor consistent.	We recommend the following: • FWA cases are reported upon in every report up to and including the quarter in which they are closed. • FWA cases are not duplicated within the report. • Date of Complaint and Close Date are accurate and are consistent from one quarterly report to the next. • Closed cases clearly specify the case's outcome. In particular, the column, "Disciplinary Action Imposed," should be populated when FWA cases result in provider education, recoupment, or termination.
PSHP	Provider Complaints	Denied claims is the most common type of provider complaint.	PSHP should educate their providers on proper claim resolution and resubmission instructions.
PSHP	Provider Network Management	PSHP has geographic areas and physician specialties for which access does not meet the State's minimum 90% threshold. Deficiencies have been noted in the following categories: 24-hour pharmacy, endocrinology, infectious disease, and rheumatology.	PSHP should develop a plan to address deficiencies in the provider network. One option would be to increase the use of telemedicine to enable access to needed specialists in deficient areas.
PSHP	Quality Improvement	Per PSHP staff, providers who participate in the provider incentive program tend to have higher HEDIS scores than providers who do not participate in the incentive program.	PSHP should revise its provider incentive program and develop physician-level financial and non-financial incentives in order to engage providers effectively and increase alignment across incentive programs.
PSHP	Quality Improvement	PSHP staff reported a 50/50 success rate with member incentives. They also stated that August and November have the highest member participation, possibly due to "back to school" preparation and the holidays.	PSHP should review the marketing initiatives for the current member incentives and maximize use of those that are the most effective.
PSHP	Utilization Management	Genetic testing represents the procedure with the highest number of denied authorizations. The reason is	Myers and Stauffer recommends provider education be performed to ensure genetic counseling is being provided

Findings and Recommendations			
Entity	**Functional Area**	**Finding**	**Recommendation**
		due to the provider not performing genetic counseling first.	to members prior to submitting the authorization for genetic testing.
PSHP	One Source Therapy Review, LLC	One Source Therapy does not provide monthly FWA reports to PSHP as required by contract.	PSHP should require One Source Therapy to submit monthly FWA reports as specified in their contract.
Envolve Benefit Solutions **Envolve Dental**	Dental Provider Network	There is no formal review process for monitoring the performance of Envolve Dental's provider network staff.	Envolve Dental should implement performance standards and a process to audit the provider network staff to ensure the updated provider information is being entered accurately into the system.
Envolve Benefit Solutions **Envolve Dental**	Dental Provider Network	According to Envolve Dental personnel, there is a shortage of oral surgeons in Georgia.	Envolve Dental should conduct targeted efforts to recruit oral surgeons in surrounding areas (including across state borders) to help serve members of deficient areas.
Envolve Benefit Solutions **Envolve Dental and Vision**	Member Data Maintenance	The HEDIS measure to determine if members are receiving the proper service was changed so that compliance was determined through a claim. Envolve Benefit Solutions discovered this new process was not always resulting in a member being marked compliant in the quality (QSI) system.	Envolve Benefits Solutions should ensure an accurate and complete fix has been deployed to consistently update the dental and vision quality indicators for members.
Evolve Pharmacy Solutions	Utilization Management	For November 2019, there were a total of 1,249 prior authorizations of which 471 (38%) were denied. Sixty-five percent (65%) of the denials were due to the drug	Envolve Pharmacy should evaluate the reasons for the high denial rate on prior authorizations and identify

Findings and Recommendations			
Entity	**Functional Area**	**Finding**	**Recommendation**
	Prior Authorizations	not being medically necessary. Eighteen percent (18%) were denied because the non-formulary exception rules were not met.	proactive solutions to reduce this percentage (e.g., provider education).
Envolve Pharmacy Solutions	Pharmacy Network	Envolve Pharmacy representatives indicated there are no current deficiencies in the PSHP pharmacy network. However, during review of PSHP's overall provider network, we were informed there is a shortage of 24-hour pharmacies.	Envolve Pharmacy should continue its efforts to maintain an adequate pharmacy network to serve PSHP members statewide. This should include developing a plan to increase the number of 24-hour pharmacies in the network.
Nurtur	Crisis Call Support	Managed Healthcare Network (MHN) is contracted to provide 24/7 crisis call support. MHN follows the performance standards set by URAC. Nurtur does not provide oversight of performance standards.	Nurtur should implement a process to monitor MHN's compliance with performance standards.
Nurtur	Disease Management	Contract language does not include Nurtur's notification process once three (3) unsuccessful attempts have been made to contact a member. Currently, a form of notification is mailed to the member informing him/her of Nurtur/Envolve PeopleCare's request to connect. If the member remains in an unable to locate status for 90 days, he/she is then unenrolled from the DM program.	PSHP and Nurtur should update contract language to include the notification process following three failed contact attempts while in the unable to locate queue. Since the process results in member termination from the DM program, it should be documented in the contract.
Nurtur	Disease Management	The unable to locate process for program disenrollment was not followed for three members. *Refer to the above finding.*	Nurtur should implement a quality assurance process for confirming that the unable to locate procedures are followed.
Nurtur	Disease Management	The performance standard for member satisfaction was not fully met. The member satisfaction target for adults is 85%. The result reported on the annual survey was 84.06%. No corrective action plan was in place.	Nurtur should implement a corrective action plan to ensure the 85% satisfaction rate for adult members receiving DM services is met in the future.

Findings and Recommendations			
Entity	**Functional Area**	**Finding**	**Recommendation**
Nursewise	Nurse Advice Line	The performance standard for the call/talk/handle time for the nurse advice line is not documented in the contractual agreement between PSHP and Nursewise. During the interview process, it was discovered from multiple sources that the goal for the length of talk time for a nurse advice line call is less than 12 minutes. When asked to describe the process if a call exceeds 12 minutes, an interviewee stated a supervisor would talk to the nurse about the extended call/talk/handle time.	Myers and Stauffer recommends Nursewise update their contract with PSHP to address the performance standards for the nurse advice line call/talk/handle time.
Nursewise	Nurse Advice Line Call Observation	During a call observation, a 16-year old caller inquired about her eligibility. She had lost her mother and found the insurance card in her mother's purse. After authenticating the member, the customer care professional continued the conversation despite the member was under 18 years old.	Nursewise should document examples of extenuating circumstances, in their policy, to allow for coverage details and other information to be given to callers under the age of 18 years old.
Nursewise	Nurse Advice Line Call Observation	During a call observation, a member called the nurse advice line and mentioned the need to find a new PCP. The member was referred to urgent care; however, there was no information provided on options for available urgent care locations, acceptance of Medicaid, distance from the member's home, etc.	When referring members to either a new PCP, urgent care, or other specialty service, Nursewise should assist members in locating the nearest facility in order to receive care and other information about PCP changes.
PSHP	One Source Therapy Review, LLC Denial Rates	From information obtained in the pre-audit report for January 1, 2019 through June 30, 2019, the prior authorization denial rate was 22%. According to the contract between PSHP and One Source Therapy effective July 1, 2017, "the denial rate due to lack or	PSHP should closely monitor One Source Therapy denial rates to ensure that contractual standards of "at or below 15%" are met.

Findings and Recommendations			
Entity	**Functional Area**	**Finding**	**Recommendation**
		inadequate clinical information shall remain at or below 15% each month."	
One Source Therapy Review, LLC	Overturn Rate of Appeals	From information obtained in the pre-audit report for the months of March and June of 2019, the overturned appeals rate was 66.7% for March and 33.3% for June.	One Source Therapy Review should adhere to the contractual standard of requiring an overturned appeal rate of less than 10%.
One Source Therapy Review, LLC	Prior Authorization Turnaround Time	Myers and Stauffer examined prior authorization records on-site, we found two cases out of ten (20%) that did not meet the two-day turnaround time for review.	One Source Therapy should monitor and ensure the two-day timeliness standard for prior authorizations is met.
One Source Therapy Review, LLC	Prior Authorization Reviews	Based on the interviews and review of sample records, standards for determining medical necessity are not maintained in a central repository and are not consistently used by the therapists.	One Source Therapy should develop a process for more consistent reviews across therapists. One option would be to develop a central repository for the National Practice Guidelines and state specific guidelines and policies utilized for the determination of medical necessity.

Exhibit I: On-site Interview Schedules

Interviews with PSHP

In order to gain a better understanding of PSHP's policies and procedures for contract compliance, PI, encounter submissions, and subcontractor oversight, Myers and Stauffer interviewed the individuals listed in the table below on the dates and at the locations indicated. In addition to the on-site interviews, a teleconference was held on December 16, 2019. Peach State personnel who participated in the teleconference are also listed in the table below.

Date	Interviewees	Title	Location
10/28/2019	Patricia Elder	Director, Compliance	Atlanta, GA
10/28/2019	Claudette Bazile	VP, Compliance	Atlanta, GA
10/28/2019	Brian Editone	Bus Analyst III, Regulatory Reporting	Atlanta, GA
10/28/2019	Kenyetta Smith	Fraud Investigator	Atlanta, GA
10/28/2019	Chris Wilde	Sr. Mgr., Subcontractor/Delegation Oversight	Atlanta, GA
10/28/2019	Tammy Sanchez	Project Manager III	Atlanta, GA
10/28/2019	Remedios Rodriguez Dominguez	VP, Behavioral Health Operations	Atlanta, GA
10/28/2019	Roni Zalatal	Sr. Dir, Medical Management	Atlanta, GA
10/28/2019	Lisa Ross Jones	Dir, Case Management	Atlanta, GA
10/28/2019	Laquanda Brooks	VP, Medical Management	Atlanta, GA
10/28/2019	Tomeika Horne	Sr. Dir, Utilization Management	Atlanta, GA
10/28/2019	Idalia Gonzalez	Sr. Medical Director	Atlanta, GA
10/28/2019	Christin Agnew	Compliance Specialist	Atlanta, GA
10/29/2019	Lamar Watson	Sr. Mgr., Grievance and Appeals	Atlanta, GA
10/29/2019	Lakeisha Moore	Sr. Mgr., Customer Service	Atlanta, GA
10/29/2019	Tawonna Ingram	Sr. Dir, Quality Improvement	Atlanta, GA
10/29/2019	Shay Hawkins	Sr. Dir, Quality Improvement	Atlanta, GA
10/29/2019	Andrew Bossie	Dir, Provider Network & Contracting	Atlanta, GA
10/29/2019	Leonora Coopwood	Sr. Mgr., Provider Network Management (Behavioral Health)	Atlanta, GA
10/29/2019	Carla Simmons	Manager	Atlanta, GA
10/29/2019	Jennifer Morris	Trainer II	Atlanta, GA
10/29/2019	Brittney Mathis	Sr. Dir, Provider Relations	Atlanta, GA
10/29/2019	Thailla Crawford	Director	Atlanta, GA
10/29/2019	Travis Brice	Director	Atlanta, GA
10/30/2019	Shanteri Mills	Mgr., Pharmacy Specialist	Atlanta, GA
10/30/2019	Charles Kim	VP, Pharmacy Operations	Atlanta, GA

Date	Interviewees	Title	Location
10/30/2019	Larry Santiago	Sr. Dir, Network & Quality	Atlanta, GA
10/30/2019	Lakeisha Davis	Sr. Mgr., Claims & Contract Support	Atlanta, GA
11/12/2019	Julie Sniegowski	VP, Internal Audit	Clayton, MO
11/12/2019	Dan Powderly	Mgr., Encounter Business Ops	Clayton, MO
11/12/2019	Kyle Chestnut	Business Analyst II	Clayton, MO
11/12/2019	Jim Larocca	IT Lead	Clayton, MO
11/12/2019	Brett Gibson	IT Manager	Clayton, MO
11/12/2019	Jamie Berghaus	Mgr., Claims	Clayton, MO
11/12/2019	Paige Savage	Supervisor, Claims	Clayton, MO
11/13/2019	Margaret Richardson	Director, IT	Clayton, MO
11/13/2019	Tameka Williams	Product Manager, EDI	Clayton, MO
11/13/2019	Phillip Blenis	Sr. Mgr., Data Analytics	Clayton, MO
11/13/2019	Michael Lively	Data Analyst	Clayton, MO
11/13/2019	Phil Manquist	SVP, Health Economics	Clayton, MO
11/13/2019	Maria Ray	Sr. Dir, Business Ops Solutions	Clayton, MO
11/13/2019	Brian Dull	Sr. Dir, IT	Clayton, MO
11/13/2019	Corey Gerstenschlager	Mgr., Special Investigations Unit	Clayton, MO
11/13/2019	Ryan Wilhelm	Sr., Special Investigator	Clayton, MO
11/13/2019	Robert Nolan	VP, Product & Compliance Governance	Clayton, MO
11/13/2019	Josh Kramer	Corporate Subcontractor Oversight	Clayton, MO
11/13/2019	Wilma Costa	Corporate Subcontractor Oversight	Clayton, MO
11/13/2019	Jason Moseley	Process Owner, COB	Clayton, MO
11/13/2019	Deanna Walker	Mgr., Payment Integrity (TPL)	Clayton, MO
11/14/2019	Trisha Rothgangel	Dir, Finance	Clayton, MO
11/14/2019	Ron Boggs	Mgr., Enterprise Data Quality	Clayton, MO
11/14/2019	Christopher Cioffi	VP, Internal Audit Claims & Quality Systems	Clayton, MO
11/14/2019	Tricia Stanton	Supervisor, CBH (Behavioral Health Claims Processing)	Clayton, MO
11/14/2019	Lisa Delacruz	Senior Support Analyst	Clayton, MO
12/16/2019	Sandra Middlebrooks	Sr. Contract Compliance Manager (DCH)	Teleconference
12/16/2019	Lesa Perez	Director, Claims Operations (Centene)	Teleconference
12/16/2019	Trisha Stanton	Supervisor, Claims Operations (Centene)	Teleconference
12/16/2019	Ashley Rogers	Supervisor, Claims Operations (Centene)	Teleconference
12/16/2019	Yolanda Singleton	Manager, EDI (Centene)	Teleconference

Date	Interviewees	Title	Location
12/16/2019	Daniel Powderly	Mgr., Encounter Business Operations (Centene)	Teleconference
12/16/2019	Carol Cooper	Claims Manager	Teleconference

Interviews with Subcontractors

One Source Therapy Review

One Source Therapy Review provides speech, occupational, and physical therapy prior authorization services for PSHP members. The Myers and Stauffer engagement team met with One Source Therapy Review personnel on November 14, 2019 at the office located in Duluth, GA. We interviewed the individuals listed in the table below.

Date	Interviewees	Title
11/14/2019	Jacqueline Tedesco	CEO
11/14/2019	Lorriane Sanchez	VP, Clinical Case Mgt; Privacy Officer; Fraud, Waste, and Abuse Coordinator; and Compliance Officer
11/14/2019	David Hammer	Medical Director
11/14/2019	Christine Ellenberg	Physical Therapy Lead
11/14/2019	Rosie Horta	Occupational Therapy Clinical Lead
11/14/2019	Carol Siu	Physical Therapy Staff Reviewer
11/14/2019	Kelly Day	Speech Therapy Staff Reviewer
11/14/2019	Jelline Camacho	Office Coordinator/Claims Analyst

Nurtur

Nurtur provides DM/care management and call center services to PSHP members. The Myers and Stauffer engagement team interviewed Nurtur personnel in Dallas, Texas on November 20-21, 2019. We interviewed the individuals listed in the table below on the date indicated.

Date	Interviewees	Title
11/20/2019	Cynthia Gonzalez	Sr. Director
11/20/2019	Blair Sector	Director
11/20/2019	Judy Topolsky	Sr. Director
11/20/2019	Courtney Willenzik	Compliance Officer
11/20/2019	Krystal Johnson	Manager
11/20/2019	Maria Torres	Care Support Representative
11/20/2019	Pam Reider	Health Coach

Date	Interviewees	Title
11/20/2019	Christina Fogarty	Health Coach
11/20/2019	Elise Griffin	Health Coach, Team Lead
11/20/2019	Lee Tulumello	Director
11/20/2019	Fonny Wright	Sr. Manager
11/20/2019	Sheree Oliver	Manager
11/20/2019	Jennifer Crouch-Clark	Senior Behavioral Health Care Manager
11/20/2019	Tracy Austin	Field Health Coach

Envolve Dental

Envolve Dental provides dental services to PSHP members. The functions delegated to Envolve Dental include: claims adjudication, call center operations, provider complaints and appeals, provider NM, and UM.

The Myers and Stauffer engagement team interviewed Envolve Dental personnel in Tampa, Florida on December 3, 2019. In addition to the on-site interviews, a teleconference was held on December 12, 2019. We interviewed the individuals listed in the following table.

Date	Interviewees	Title
12/3/2019	Renee Holmes	Mgr, Call Center
12/3/2019	Paul Marino	VP, Network
12/3/2019	Brian Webber	VP, Operations
12/3/2019	Steven Graff	Network Directory Analyst
12/3/2019	Steve Livengood	Sr. Mgr, Data Analytics
12/3/2019	Katherine Bass	Manager
12/10/2019	Markeya Baskerville	Claims Supervisor
12/10/2019	Glenda Broadnax-McCoy	Director, Claims Operations
12/10/2019	Amie Brooks	Supervisor, Benefit Configuration
12/10/2019	Steve Livengood	Sr. Mgr. Data Analytics and Reporting
12/10/2019	Paul Ottoson	Sr. Accountant

Envolve Pharmacy Solutions and Subcontractor RxAdvance

Envolve Pharmacy Solutions provides pharmacy services to PSHP members. RxAdvance is a subcontractor of Envolve Pharmacy Solutions. The functions delegated to Envolve Pharmacy Solutions include: claims adjudication, credentialing – pharmacy, call center operations, provider complaints and appeals, provider NM, and UM.

The Myers and Stauffer engagement team interviewed Envolve Dental personnel in Orlando, Florida, on December 4, 2019. In addition to the on-site interviews, a teleconference was held on December 17, 2019. We interviewed the individuals listed in the table below.

Date	Interviewees	Title
12/4/2019	Phil Doveikis	Account Executive
12/4/2019	Lindsay Hull	VP, Strategic Initiatives
12/4/2019	Leander Lee Monk	VP, Pharmacy Operations
12/4/2019	Rebecca Bainter	Sr. Dir, Clinical Pharmacy Services
12/4/2019	Antonio Popjordanov	Mgr, Operations
12/4/2019	Kym McFarland	Dir, Pharmacy Network Operations
12/4/2019	Didra Hellett	Mgr, Pharmacy Operations
12/4/2019	Aruna Wichremeratne	Rx Advance
12/4/2019	Heather Johnson	Rx Advance
12/4/2019	Justin Stubstad	VP, Compliance
12/4/2019	Ned Hanson	Sr. Dir, Formulary & Benefit Management
12/17/2019	Stephen Lee-Thomas	Director Benefit Operations
12/17/2019	Brian Fu	IT Developer III
12/17/2019	Marquita Frederick	Staff
12/17/2019	Shanteri Mills	Mgr. Pharmacy Services
12/17/2019	Steve McClure	IT Director
12/17/2019	Matt Feeser	IT Manager of Integrated Services
12/17/2019	Kymberly McFarland	Director Pharmacy networks
12/17/2019	Waylon Wolf Black	Sr. Business Analyst
12/17/2019	Clinton Palmer	VP, Finance
12/17/2019	Amy Davis	Mgr. Billing and Collections

Nursewise

Nursewise provides 24/7 Nurse Line services to PSHP members. The primary function delegated to Nursewise is the Nurse Advice Line (NAL).

The Myers and Stauffer engagement team interviewed Nursewise personnel in Tempe, Arizona on December 9-10, 2019. We interviewed the individuals listed in the following table.

Date	Interviewees	Title
12/9/2019	Susan Messer	Director, NAL Call Center
12/9/2019	Omar Garcia	Non-Clinical Manager, NAL Call Center
12/9/2019	Alan Rosenfeld	Lead Account Manager
12/9/2019	Oscar Perez	Clinical Manager, NAL Call Center

Date	Interviewees	Title
12/9/2019	Jennifer Belcher	Telehealth Nurse, NAL Call Center
12/9/2019	Elizabeth Caraveo	Lead, NAL Call Center
12/9/2019	Antonio Valenzuela	Customer Care Professional
12/9/2019	Michelle Brochu	Director, Outreach Call Center
12/9/2019	Sara Dominguez	Supervisor, Outreach Call Center

Envolve Vision

Envolve Vision provides vision services to PSHP members. The functions delegated to Envolve Vision include: claims adjudication, call center operations provider complaints and appeals, and provider NM.

The Myers and Stauffer engagement team interviewed Envolve Vision personnel in Rocky Mount, North Carolina on December 16-17, 2019. In addition to the on-site interviews, a teleconference was held on December 16, 2019. We interviewed the individuals listed in the table below.

Date	Interviewees	Title
12/16/2019	Melody Bardowell	Manager, Account Management
12/16/2019	Anne Buff	Director, Data Governance
12/16/2019	Elizabeth Cobb	Director, Quality
12/16/2019	Sandra Vaughan	Supervisor, Grievances and Appeals
12/16/2019	Marlo Williams	VP, General Counsel
12/16/2019	Paula Shearon	VP, Compliance
12/16/2019	Carol Cooper	Claims Manager
12/16/2019	Valerie Poland	Claims System Specialist
12/16/2019	Jonathan Pittman	Senior Auditing Analyst
12/16/2019	Andres Lopez	Project Coordinator
12/16/2019	April Carter	Accountant
12/17/2019	Tim Shea	Director, Customer Service
12/17/2019	Angel Richardson	Supervisor, Customer Service
12/17/2019	Chris Comerford	Director, Claims
12/17/2019	Kim Bass	Manager, System Configuration
12/17/2019	Memezie Kiadii	Director, Utilization Management

Exhibit II: Supporting Detail for Encounter Submissions and Payment Systems

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

- *PSHP*
  - *Table 1 – Institutional (837I / UB04)*
  - *Table 2 – Professional (837P / CMS-1500)*
- *Envolve Dental*
  - *Table 3 – Dental (837D / ADA)*
- *Envolve Vision*
  - *Table 4 – Vision (837P / CMS-1500)*
- *RxAdvance*
  - *Table 5 – Pharmaceutical (NCPDP)*

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

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

Table 1 – Peach State Institutional Claims

Table 1 – Peach State FFS - Institutional (837I / UB04) Claim Lines Reviewed = 482,100			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Plan by Provider	0.0	The claim receipt date reported in the Peach State FFS 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 encounters may represent the date Peach State paid the claim, since the claim receipt date appears to be the same date as the encounter paid date.
2	Date Paid	99.7	
3	Amount Paid - Claim Header	99.2	
4	Amount Paid - Claim Detail Lines	95.0	For approximately 14,400 institutional claim lines (3.0%) the detail line amount paid in the MMIS institutional encounters for Peach State appeared to include either interest paid or a TPL amount. Approximately 3,800 institutional claim lines (0.8%) appeared to have been bundled into fewer claim lines in the MMIS institutional encounters for Peach State. The sum of bundled line paid amounts in the Peach State extracts appeared to match the line paid amount reported in the MMIS encounters. Additionally, there appeared to be approximately 4,100 institutional claim lines (0.9%) where the detail line paid amount reported in the Peach State institutional claim extracts did not match the value reported in the MMIS encounters, and the sum of the line paid amounts in the MMIS did not equal the header paid amount.

Table 1 – Peach State FFS - Institutional (837I / UB04) Claim Lines Reviewed = 482,100			
	Claim Data Element	**% Match**	**Notes**
5	Interest Paid - Claim Header	99.6	
6	Denial Indicator - Claim Header	99.8	
7	Member Medicaid ID	99.8	
8	Payee Provider Tax ID	79.2	Myers and Stauffer requested that Peach State include the payee provider tax ID when preparing the claims extracts; however, it appeared the payee provider tax ID was not included for approximately 83,900 institutional claim lines (17.4%). For approximately 16,400 Peach State institutional claim lines (3.4%) it appeared that the payee provider in the MMIS institutional encounters for Peach State was derived from the rendering provider. The payee provider in the MMIS may not accurately reflect the claim payee/billing provider reported on the claim submission.
9	Rendering Provider NPI	95.5	We observed approximately 13,300 institutional claim lines (2.8%) where the rendering provider NPI in the MMIS institutional encounters for Peach State appeared to be an older NPI associated with the Medicaid provider ID on the claim. The NPI reported in the MMIS encounters may not be the most appropriate ID currently used by the rendering provider. We also observed approximately 8,100 institutional claim lines (1.7%) where the rendering provider NPI reported in the MMIS institutional encounters for Peach State did not appear to match the rendering provider NPI in the Peach State claims extracts but did

Table 1 – Peach State FFS - Institutional (837I / UB04) Claim Lines Reviewed = 482,100			
	Claim Data Element	**% Match**	**Notes**
			appear to match the payee provider NPI in the Peach State extracts.
10	Referring Provider NPI	0.0	The referring provider NPI did not appear to be reported in the DCH MMIS for Peach State institutional encounters. We observed the referring provider NPI reported on approximately 5,600 claim lines in the Peach State claims extracts (1.2%).
11	Attending Provider NPI	95.6	For approximately 21,000 institutional claim lines (4.4%) in the Peach State claims extracts, the attending provider NPI did not appear to represent the attending provider and may have represented the payee provider. We were unable to validate the attending provider NPI in the MMIS encounters for these claim lines.
12	Operating Provider NPI	0.0	The operating provider NPI did not appear to be reported in the MMIS for Peach State institutional encounters. We observed the operating provider NPI reported on approximately 133,300 claim lines (27.7%) in the Peach State institutional claims extracts.
13	DRG Code	99.5	
14	Claim ICD Diagnosis Codes	91.4	Myers and Stauffer requested that Peach State include all claim diagnosis codes when preparing the claims extracts; however, it appeared the admitting, patient reason, and external cause of injury diagnosis codes were not included in the Peach State claims extracts for a subset or claims. We observed admitting, patient reason, or external cause of injury diagnosis codes reported for approximately 202,000 institutional claim lines (8.1%) in the

Table 1 – Peach State FFS - Institutional (837I / UB04) Claim Lines Reviewed = 482,100			
	Claim Data Element	**% Match**	**Notes**
			MMIS institutional encounters for Peach State which did not appear to be included in the Peach State institutional claims extracts.
15	Claim ICD Surgical Procedure Codes	99.2	
16	Type of Bill	99.9	
17	Medical Record Number	82.1	Myers and Stauffer requested that Peach State include the medical record number when preparing the claims extracts; however, it appeared the medical record number was not included in the Peach State claims extracts for approximately 84,400 institutional claim lines (17.5%).
18	Amount Billed - Claim Header	98.8	Myers and Stauffer requested that Peach State include the header billed amount when preparing the claims extracts; however, it appeared the header billed amount was not included in the Peach State claims extracts for approximately 2,800 institutional claim lines (0.6%).
19	Amount Billed - Claim Detail Lines	97.9	Approximately 8,300 Peach State institutional claim lines (1.7%) appeared to have been bundled into fewer claim lines in the MMIS encounters. The sum of bundled line billed amounts in the Peach State institutional extracts appeared to match the line billed amount reported in the MMIS encounters.
20	Admission Date	99.8	
21	Discharge Date	98.8	The discharge date for approximately 5,800 institutional claim lines (1.2%) in the Peach State claims extracts did not match the discharge date reported in the MMIS institutional encounters for Peach State;

Table 1 – Peach State FFS - Institutional (837I / UB04) Claim Lines Reviewed = 482,100			
	Claim Data Element	**% Match**	**Notes**
			however, the discharge date reported in the MMIS encounters appeared to match the claim header last date of service. The discharge date reported in the MMIS encounters for these claim lines may not be accurate.
22	First Date of Service – Claim Header	99.9	
23	Last Date of Service – Claim Header	98.7	For approximately 5,900 institutional claim lines (1.2%), it appeared the claim header last date of service in the Peach State claims extracts did not match the claim header last date of service in their MMIS institutional encounters. The header last date of service reported in the MMIS institutional encounters for Peach State may be derived from the claim detail line service dates and may not accurately represent the claim last date of service.
24	First Date of Service – Claim Detail Lines	99.9	
25	Last Date of Service – Claim Detail Lines	99.9	
26	Claim Detail Line Number	84.8	Approximately 8,300 institutional claim lines (1.7%) appeared to have been bundled into fewer claim lines in the MMIS institutional encounters for Peach State. Additional claims were observed where one or more claim lines in the Peach State claims extracts did not appear to be reported in the MMIS encounters. As a result of potential claim line bundling and potential missing claim lines, the line number on approximately 69,200 Peach State institutional claim lines (14.4%)

Table 1 – Peach State FFS - Institutional (837I / UB04) Claim Lines Reviewed = 482,100			
	Claim Data Element	**% Match**	**Notes**
			appeared to have been either renumbered or reordered in the MMIS encounters.
27	Units Billed	83.8	Myers and Stauffer requested that Peach State include the units billed when preparing the claims extracts; however, it appeared the units billed was not included in the Peach State claims extracts for approximately 33,200 institutional claim lines (6.9%). Non-zero billed units on Peach State claim lines appeared to be missing or reported as zero on approximately 32,800 institutional encounter claim lines (6.8%) in the MMIS. Approximately 7,400 Peach State institutional claim lines (1.5%) appeared to have been bundled into fewer claim lines in the MMIS encounters. The sum of bundled line billed units in the Peach State institutional extracts appeared to match the line billed units reported in the MMIS encounters.
28	Revenue Code	99.9	
29	Procedure Code	99.9	
30	Procedure Code Modifier 1	96.7	Procedure code modifier 1 was blank for approximately 12,700 institutional claim lines (2.6%) in the Peach State claims extracts, but contained a value of "XX" or "XY" in the corresponding Peach State MMIS institutional encounters.
31	Procedure Code Modifier 2	99.9	
32	Procedure Code Modifier 3	99.9	
33	Procedure Code Modifier 4	100.0	Procedure Code Modifier 4 did not appear to be populated in either the Peach State institutional claims extracts or the MMIS

Table 1 – Peach State FFS - Institutional (837I / UB04) Claim Lines Reviewed = 482,100			
	Claim Data Element	**% Match**	**Notes**
			institutional encounters. The sample review period may not include any institutional claim lines with more than three procedure code modifiers, which may explain the absence of values.
34	NDC	0.0	The NDC did not appear to be reported in the DCH MMIS for Peach State institutional encounters. We observed the NDC reported on approximately 33,700 institutional claim lines (7.0%) in the Peach State claims extracts.

Table 2 – Peach State Professional Claims

Table 2 – Peach State FFS - Professional (837P / CMS-1500) Claim Lines Reviewed = 899,300			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Plan by Provider	0.0	The claim receipt date reported in the Peach State FFS extracts for professional claim lines did not match the claim receipt date reported in the MMIS professional encounters for Peach State. The claim receipt date reported in the MMIS professional encounters may represent the date Peach State paid the claim, since the claim receipt date appeared to be the same date as the encounter paid date.
2	Date Paid	99.8	
3	Amount Paid – Claim Header	96.1	The header amount paid on the claim did not appear to be populated for approximately 10,300 professional claim lines (1.2%) in the Peach State claims extracts. We were unable

Table 2 – Peach State FFS - Professional (837P / CMS-1500) Claim Lines Reviewed = 899,300			
	Claim Data Element	**% Match**	**Notes**
			to verify the header amount paid reported in the MMIS encounters for these claim lines. Additionally, we observed approximately 18,500 professional claim lines (2.1%) where the header paid amount reported in the Peach State claims extracts did not match the header paid amount reported in the MMIS encounters. The difference between the paid amounts appeared to be interest included in Peach State's professional claims extracts but not in the MMIS professional encounters for Peach State.
4	Amount Paid – Claim Detail Lines	98.6	We observed approximately 7,600 professional claim lines (0.9%) for which the detail line paid amount reported in Peach State's claims extracts did not match the value reported in the MMIS professional encounters for Peach State, and for which the sum of the MMIS line paid amounts did not equal the MMIS header paid amount. For approximately 2,900 professional claim lines (0.3%), the detail line amount paid in the Peach State MMIS professional encounters appeared to include a TPL paid amount.
5	Interest Paid - Claim Header	99.3	
6	Denial Indicator - Claim Header	99.8	
7	Member Medicaid ID	99.7	
8	Payee Provider Tax ID	83.6	For approximately 107,600 professional claim lines (12.0%), the payee provider in the MMIS professional encounters for Peach State appeared to be derived from the rendering provider. The payee provider in the MMIS may

Table 2 – Peach State FFS - Professional (837P / CMS-1500) Claim Lines Reviewed = 899,300			
	Claim Data Element	**% Match**	**Notes**
			not accurately reflect the claim payee/billing provider reported on the claim submission. Myers and Stauffer requested that Peach State include the payee provider tax ID when preparing the claims extracts; however, it appeared the payee provider tax ID was not included for approximately 38,200 professional claim lines (4.3%).
9	Rendering Provider NPI	98.5	We observed approximately 3,800 professional claim lines (0.4%) where the rendering provider NPI reported in the MMIS encounters did not appear to match the rendering provider NPI in the Peach State claims extracts, but the mismatched rendering provider NPIs did appear to be related through a common Georgia Medicaid payee provider ID referenced in the MMIS supporting provider tables. We observed approximately 2,800 professional claim lines (0.3%) where the rendering provider NPI in the MMIS encounters appeared to be an older NPI associated with the Medicaid provider ID on the claim. The NPI reported in the MMIS encounters may not be the most appropriate ID currently used by the rendering provider. We also observed approximately 1,400 professional claim lines (0.2%) where the rendering provider NPI reported in the MMIS encounters did not appear to match the rendering provider NPI in the Peach State claims extracts but did appear to match the payee provider NPI in the Peach State extracts.

Table 2 – Peach State FFS - Professional (837P / CMS-1500) Claim Lines Reviewed = 899,300			
	Claim Data Element	**% Match**	**Notes**
10	Referring Provider NPI	98.1	Myers and Stauffer requested that Peach State include the referring provider NPI when preparing the claims extracts; however, it appeared the referring provider NPI was not included in the Peach State claims extracts for approximately 11,100 professional claim lines (1.2%). We observed approximately 5,600 professional claim lines (0.6%) where the referring provider's NPI was reported in the Peach State claims extracts but appeared to be missing in the MMIS professional encounters.
11	Claim ICD Diagnosis Codes	97.5	For approximately 22,200 professional claim lines (2.5%), we observed values for one or more diagnosis codes in the Peach State claims extracts which we were unable to interpret. We relied on a crosswalk to interpret the diagnosis codes provided in the claims extracts; however, the crosswalk was incomplete for the identified claim lines. We were unable to verify the diagnosis codes reported in the MMIS encounters for these claims.
12	Amount Billed – Claim Header	98.6	We observed approximately 7,500 professional claim lines (0.8%) where the claim header billed amount in the Peach State claims extracts did not match the amount in the MMIS professional encounters. For most (5,700 claim lines), the difference in amount was $0.01. Additionally, Myers and Stauffer requested that Peach State include the claim header billed amount when preparing the claims

Table 2 – Peach State FFS - Professional (837P / CMS-1500) Claim Lines Reviewed = 899,300			
	Claim Data Element	**% Match**	**Notes**
			extracts; however, it appeared the header billed amount was not included in the Peach State claims extracts for approximately 4,800 professional claim lines (0.5%). We were unable to verify the header billed amount reported in the MMIS encounters for these claims.
13	Amount Billed - Claim Detail Lines	99.8	
14	First Date of Service – Claim Header	99.9	
15	Last Date of Service – Claim Header	99.9	
16	First Date of Service – Claim Detail Lines	99.9	
17	Last Date of Service – Claim Detail Lines	99.9	
18	Claim Detail Line Number	87.9	We observed claims where one or more claim lines in the Peach State claims extracts did not appear to be reported in the MMIS encounters. As a result of potential missing claim lines, the line number on approximately 105,500 Peach State professional claim lines (11.7%) appeared to have been either renumbered or reordered in the MMIS encounters.
19	Units Billed	85.5	Non-zero billed units on Peach State claim lines appeared to be missing or reported as zero on approximately 92,400 professional encounter claim lines in the MMIS (10.3%). Additionally, Myers and Stauffer requested that Peach State include the units billed when preparing the claims extracts; however, it appeared the units billed was not included in the Peach State claims extracts for

Table 2 – Peach State FFS - Professional (837P / CMS-1500) Claim Lines Reviewed = 899,300			
	Claim Data Element	**% Match**	**Notes**
			approximately 33,000 professional claim lines (3.7%). We were unable to verify the units billed reported in the MMIS encounters for these claims.
20	Place of Service	97.2	For approximately 23,800 professional claim lines (2.7%), the place of service in the Peach State claims extracts did not appear to match the value in the corresponding MMIS Peach State professional encounters. For many of these claim lines (15,100), the place of service code reported in the MMIS encounters was "99" (other place of service), while the place of service code reported in the claims extract was more specific (not "99").
21	Procedure Code	99.9	
22	Procedure Code Modifier 1	99.9	
23	Procedure Code Modifier 2	99.9	
24	Procedure Code Modifier 3	99.9	
25	Procedure Code Modifier 4	99.9	
26	NDC	0.0	NDC did not appear to be reported in the MMIS for Peach State professional encounters. We observed the NDC reported on approximately 15,900 professional claim lines (1.8%) in the Peach State claims extracts.
27	Claim Detail Line ICD Diagnosis 1	76.2	We observed approximately 167,300 professional claim lines (18.6%) in Peach State's professional claims extracts whose claim detail line diagnosis code 1 did not match the value for their corresponding claim line in the MMIS professional encounters; however, we found all line diagnosis codes for the claim line did exist in the encounters but

Table 2 – Peach State FFS - Professional (837P / CMS-1500) Claim Lines Reviewed = 899,300			
	Claim Data Element	**% Match**	**Notes**
			appeared in a different order. Additionally, Myers and Stauffer requested that Peach State include the detail line diagnosis codes when preparing the claims extracts; however, it appeared the detail line diagnosis codes were not included in the Peach State claims extracts for approximately 45,700 professional claim lines (5.1%). We were unable to verify the detail line diagnosis codes reported in the MMIS encounters for these claims.
28	Claim Detail Line ICD Diagnosis 2	78.9	We observed approximately 176,300 professional claim lines (19.6%) in Peach State's professional claims extracts whose claim detail line diagnosis code 2 did not match the value for their corresponding claim line in the MMIS professional encounters; however, we found all line diagnosis codes for the claim line did exist in the encounters but appeared in a different order. Additionally, Myers and Stauffer requested that Peach State include the detail line diagnosis codes when preparing the claims extracts; however, it appeared the detail line diagnosis codes were not included in the Peach State claims extracts for approximately 45,700 professional claim lines (5.1%). We were unable to verify the detail line diagnosis codes reported in the MMIS encounters for these claims.
29	Claim Detail Line ICD Diagnosis 3	87.9	We observed approximately 103,500 professional claim lines (11.5%) in Peach State's professional claims extracts whose claim detail line diagnosis code 3 did not match the value for their corresponding claim

Table 2 – Peach State FFS - Professional (837P / CMS-1500) Claim Lines Reviewed = 899,300			
	Claim Data Element	**% Match**	**Notes**
			line in the MMIS professional encounters; however, we found all line diagnosis codes for the claim line did exist in the encounters but appeared in a different order. Additionally, Myers and Stauffer requested that Peach State include the detail line diagnosis codes when preparing the claims extracts; however, it appeared the detail line diagnosis codes were not included in the Peach State claims extracts for approximately 45,700 professional claim lines (5.1%). We were unable to verify the detail line diagnosis codes reported in the MMIS encounters for these claims.
30	Claim Detail Line ICD Diagnosis 4	93.9	We observed approximately 52,400 professional claim lines (5.8%) in Peach State's professional claims extracts whose claim detail line diagnosis code 4 did not match the value for their corresponding claim line in the MMIS professional encounters; however, we found all line diagnosis codes for the claim line did exist in the encounters but appeared in a different order. Additionally, Myers and Stauffer requested that Peach State include the detail line diagnosis codes when preparing the claims extracts; however, it appeared the detail line diagnosis codes were not included in the Peach State claims extracts for approximately 45,700 professional claim lines (5.1%). We were unable to verify the detail line diagnosis codes reported in the MMIS encounters for these claims.

Table 3 – Envolve Dental

Table 3 – Envolve Dental (837D / ADA) Claim Lines Reviewed = 225,900			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Subcontractor by Provider	0.0	The claim receipt date reported in the Envolve Dental extracts for dental claim lines did not match the claim receipt date reported in the MMIS encounters. The claim receipt date reported in the MMIS encounters may represent the date Envolve Dental paid the claim, since the claim receipt date appears to be the same date as the encounter paid date.
2	Date Paid	99.9	
3	Subcontractor Amount Paid – Claim Header	99.9	
4	Subcontractor Amount Paid – Claim Detail Lines	83.5	Approximately 35,500 dental claim lines (15.7%) appeared to have been bundled into fewer claim lines in the MMIS encounters for Envolve Dental. The sum of bundled line paid amounts in the Envolve Dental extracts appeared to match the line paid amount reported in the MMIS encounters.
5	Interest Paid - Claim Header	N/A	Myers and Stauffer requested Envolve Dental include provider interest payments when preparing the claims extracts; however, it appeared none were included. Likewise, it appeared none were reported in the matching claim lines in the MMIS encounters for Envolve Dental. We would expect to see the interest paid amount identified with an encounter adjustment reason code in the MMIS encounters.
6	Denial Indicator - Claim Header	99.9	
7	Member Medicaid ID	99.9	

Table 3 – Envolve Dental (837D / ADA) Claim Lines Reviewed = 225,900			
	Claim Data Element	**% Match**	**Notes**
8	Payee Provider Tax ID	74.1	For approximately 57,700 dental claim lines (25.5%), it appeared that the payee provider in the MMIS encounters for Envolve Dental were derived from the rendering provider. The payee provider in the MMIS may not accurately reflect the claim payee/billing provider reported on the claim submission.
9	Rendering Provider NPI	99.1	
10	Referring Provider NPI	N/A	Myers and Stauffer requested that Envolve Dental include the referring provider's NPI when preparing the claims extracts; however, it appeared none were included. Likewise, it appeared none were reported in the matching claim lines in the MMIS encounters for Envolve Dental.
11	Claim ICD Diagnosis Codes	0.0	Claim ICD diagnosis codes did not appear to be reported in the MMIS encounters for Envolve Dental. We observed claim ICD diagnosis codes existed on approximately 5,100 claim lines (2.3%) in the Envolve Dental extracts.
12	Amount Billed - Claim Header	99.9	
13	Amount Billed - Claim Detail Lines	83.9	Approximately 35,100 Envolve Dental claim lines (15.5%) appeared to have been bundled into fewer claim lines in the MMIS encounters. The sum of bundled line billed amounts in the Envolve Dental extracts appeared to match the line billed amount reported in the MMIS encounters.
14	First Date of Service – Claim Header	100.0	
15	Last Date of Service – Claim Header	99.7	

Table 3 – Envolve Dental (837D / ADA) Claim Lines Reviewed = 225,900			
	Claim Data Element	**% Match**	**Notes**
16	First Date of Service – Claim Detail Lines	99.8	
17	Last Date of Service – Claim Detail Lines	99.8	
18	Claim Detail Line Number	77.7	Approximately 35,500 Envolve Dental claim lines (15.7%) appeared to have been bundled into fewer claim lines in the MMIS encounters. As a result of this bundling, the line number on approximately 50,300 Envolve Dental claim lines (22.2%) appeared to have been either renumbered or reordered in the MMIS encounters.
19	Units Billed	0.0	The billed units appeared to be reported as zero for all MMIS encounters and did not appear to match the billed units reported in the Envolve Dental extracts.
20	Place of Service	100.0	
21	Procedure Code	99.9	
22	Procedure Code Modifier 1	0.0	Procedure Code Modifier 1 appeared to be missing from all claim lines in the MMIS encounters for Envolve Dental. We observed Procedure Code Modifier 1 reported on approximately 60,800 claim lines (26.9%) in the Envolve Dental claim extracts; however, the modifier values reported in the Envolve Dental claim extracts did not appear to be typical modifier codes and may represent the tooth quadrant, not procedure code modifiers billed on the claim.
23	Procedure Code Modifier 2	0.0	Procedure Code Modifier 2 appeared to be missing from all claim lines in the MMIS encounters for Envolve Dental. We observed Procedure Code Modifier 2 reported on

Table 3 – Envolve Dental (837D / ADA) Claim Lines Reviewed = 225,900			
	Claim Data Element	**% Match**	**Notes**
			approximately 61,400 claim lines (27.2%) in the Envolve Dental claim extracts; however, the modifier values reported in the Envolve Dental claim extracts did not appear to be typical modifier codes and may represent the tooth quadrant, not procedure code modifiers billed on the claim.
24	Procedure Code Modifier 3	N/A	Procedure Code Modifier 3 did not appear to be populated in either the Envolve Dental claims extracts or the MMIS dental encounters. The sample review period may not include any dental claim lines with more than two procedure code modifiers, which may explain the absence of values.
25	Procedure Code Modifier 4	N/A	Procedure Code Modifier 4 did not appear to be populated in either the Envolve Dental claims extracts or the MMIS dental encounters. The sample review period may not include any dental claim lines with more than two procedure code modifiers, which may explain the absence of values.
26	Tooth Number	89.3	The tooth number on approximately 23,900 claim lines (10.6%) in the Envolve Dental claim extracts did not appear to match the tooth number reported in the MMIS encounters for Envolve Dental. This appeared to be the result of multiple claim lines in the Envolve Dental extracts being bundled into one claim line in the MMIS encounters. It appeared only one tooth number was reported when the claim lines were bundled.
27	Tooth Surface Code 1	98.6	The tooth surface on approximately 3,100 claim lines (1.4%) in the Envolve Dental claim extracts did not appear to match the tooth

Table 3 – Envolve Dental (837D / ADA) Claim Lines Reviewed = 225,900			
	Claim Data Element	**% Match**	**Notes**
			surface reported in the MMIS encounters for Envolve Dental. This appeared to be the result of multiple claim lines in the Envolve Dental extracts being bundled into one claim line in the MMIS encounters. It appeared only one tooth surface value was reported when the claim lines were bundled.
28	Tooth Surface Code 2	99.9	
29	Tooth Surface Code 3	99.9	
30	Tooth Surface Code 4	99.9	
31	Tooth Surface Code 5	99.9	
32	Claim Detail Line ICD Diagnosis 1	0.0	ICD diagnosis codes did not appear to be reported in the DCH MMIS for Envolve Dental encounters. We observed claim detail line ICD diagnosis code 1 reported on approximately 1,140 claim lines (0.5%) in the Envolve Dental claims extracts.
33	Claim Detail Line ICD Diagnosis 2	0.0	ICD diagnosis codes did not appear to be reported in the DCH MMIS for Envolve Dental encounters. We observed claim detail line ICD diagnosis code 2 reported on approximately 140 claim lines (0.1%) in the Envolve Dental claims extracts.
34	Claim Detail Line ICD Diagnosis 3	0.0	ICD diagnosis codes did not appear to be reported in the DCH MMIS for Envolve Dental encounters.
35	Claim Detail Line ICD Diagnosis 4	0.0	ICD diagnosis codes did not appear to be reported in the DCH MMIS for Envolve Dental encounters.

Table 4 – Envolve Vision

Table 4 – Envolve Vision (837P / CMS-1500) Claim Lines Reviewed = 30,800			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Subcontractor by Provider	0.0	The claim receipt date reported in the Envolve Vision extracts for vision claim lines did not match the claim receipt date reported in the MMIS encounters. The claim receipt date reported in the MMIS encounters may represent the date Envolve Vision paid the claim, since the claim receipt date appears to be the same date as the encounter paid date.
2	Date Paid	26.9	For approximately 22,500 vision claim lines (73.0%), the paid date in the MMIS encounters for Envolve Vision appeared to be the claim adjudication date and not the claim paid date.
3	Subcontractor Amount Paid – Claim Header	100.0	
4	Subcontractor Amount Paid – Claim Detail Lines	100.0	
5	Interest Paid - Claim Header	100.0	
6	Denial Indicator - Claim Header	100.0	
7	Member Medicaid ID	99.9	
8	Payee Provider Tax ID	94.9	For approximately 1,500 vision claim lines (4.7%), it appeared the payee provider in the MMIS encounters for Envolve Vision was derived from the rendering provider. The payee provider in the MMIS may not accurately reflect the claim payee/billing provider reported on the claim submission.
9	Rendering Provider NPI	98.5	For approximately 450 vision claim lines (1.5%), the rendering provider NPI reported in the Envolve Vision claim extracts did not

Table 4 – Envolve Vision (837P / CMS-1500) Claim Lines Reviewed = 30,800			
	Claim Data Element	**% Match**	**Notes**
			match the rendering provider NPI reported in the MMIS encounters for Envolve Vision. We observed approximately 160 vision claim lines (0.5%) for which the rendering provider NPI reported in the Envolve Vision claim extracts appeared to be an individual, whereas the rendering provider NPI in the MMIS encounters appeared to be an institution or organization. We also observed approximately 100 vision claim lines (0.3%) for which the rendering provider NPI reported in the Envolve Vision claim extracts did not match the one reported in the MMIS encounters for Envolve Vision, but did appear to share a common payee/billing Medicaid provider ID.
10	Referring Provider NPI	N/A	Myers and Stauffer requested that Envolve Vision include the referring provider's NPI when preparing the claims extracts; however, it appeared none were included. We observed the referring provider NPI reported for approximately 4,600 claim lines (15.0%) in the MMIS encounters for Envolve Vision.
11	Claim ICD Diagnosis Codes	68.7	Myers and Stauffer requested that Envolve Vision include all claim ICD diagnosis codes when preparing the claims extracts; however, it appeared only the first ICD diagnosis code was included in the Envolve Vision claim extracts. We observed the diagnosis codes reported for approximately 14,000 vision claim lines (32.3%) in the MMIS encounters for Envolve Vision which appeared to be missing from Envolve Vision's claim extracts.
12	Amount Billed - Claim Header	99.9	

Table 4 – Envolve Vision (837P / CMS-1500) Claim Lines Reviewed = 30,800			
	Claim Data Element	**% Match**	**Notes**
13	Amount Billed - Claim Detail Lines	99.9	
14	First Date of Service – Claim Header	100.0	
15	Last Date of Service – Claim Header	100.0	
16	First Date of Service – Claim Detail Lines	100.0	
17	Last Date of Service – Claim Detail Lines	100.0	
18	Claim Detail Line Number	18.2	
19	Units Billed	100.0	
20	Place of Service	100.0	
21	Procedure Code	100.0	
22	Procedure Code Modifier 1	100.0	
23	Procedure Code Modifier 2	100.0	
24	Procedure Code Modifier 3	99.9	Procedure Code Modifier 3 did not appear to be populated in either the Envolve Vision's claims extracts or the MMIS encounters for Envolve Vision. The sample review period may not include any vision claim lines with more than two procedure code modifiers, which may explain the absence of values.
25	Procedure Code Modifier 4	100.0	Procedure Code Modifier 4 did not appear to be populated in either the Envolve Vision's claims extracts or the MMIS encounters for Envolve Vision. The sample review period may not include any vision claim lines with more than two procedure code modifiers, which may explain the absence of values.
26	NDC	N/A	Myers and Stauffer requested that Envolve Vision include the NDC when preparing the

Table 4 – Envolve Vision (837P / CMS-1500) Claim Lines Reviewed = 30,800			
	Claim Data Element	**% Match**	**Notes**
			claims extracts; however, it appeared none were included. Likewise, it appeared none were reported in the matching claim lines in the MMIS encounters for Envolve Vision.
27	Claim Detail Line ICD Diagnosis 1	N/A	Myers and Stauffer requested that Envolve Vision include the claim detail line ICD diagnosis codes when preparing the claims extracts; however, it appeared none were included. We observed claim detail line ICD diagnosis code 1 reported for approximately 30,800 vision claim lines (100%) in the MMIS encounters for Envolve Vision.
28	Claim Detail Line ICD Diagnosis 2	N/A	Myers and Stauffer requested that Envolve Vision include the claim detail line ICD diagnosis codes when preparing the claims extracts; however, it appeared none were included. We observed claim detail line ICD diagnosis code 2 reported for approximately 6,400 vision claim lines (20.8%) in the MMIS encounters for Envolve Vision.
29	Claim Detail Line ICD Diagnosis 3	N/A	Myers and Stauffer requested that Envolve Vision include the claim detail line ICD diagnosis codes when preparing the claims extracts; however, it appeared none were included. We observed claim detail line ICD diagnosis code 3 reported for approximately 620 vision claim lines (2.0%) in the MMIS encounters for Envolve Vision.
30	Claim Detail Line ICD Diagnosis 4	N/A	Myers and Stauffer requested that Envolve Vision include the claim detail line ICD diagnosis codes when preparing the claims extracts; however, it appeared none were included. We observed claim detail line ICD diagnosis code 4 reported for approximately

Table 4 – Envolve Vision (837P / CMS-1500) Claim Lines Reviewed = 30,800			
	Claim Data Element	**% Match**	**Notes**
			110 vision claim lines (0.4%) in the MMIS encounters for Envolve Vision.

Appendix A: Glossary

- ***837 Healthcare Claim Transaction*** *– An electronic transaction designed to submit one or more encounters from the CMO to the FAC.*
- ***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).*
- ***Behavioral Health*** *– The discipline or treatment focused on the care and oversight of individuals with mental disorders and/or substance abuse disorders as classified in the Diagnostic and Statistical Manual of Mental Disorders-Five [DSM-5] published by the American Psychiatric Association. Those meeting the medical necessity requirements for services in Behavioral Health usually have symptoms, behaviors, and/or skill deficits which impede their functional abilities and affect their quality of life.*
- ***Behavioral Health Home (BHH)*** *– A behavioral health home is responsible for the integration and coordination of the individual's health care (physical as well as behavioral health care services). Behavioral health home providers do not need to provide all the services themselves, but must ensure that the full array of primary and behavioral health care services is available, integrated, and coordinated.*
- ***Behavioral Health Services (BH)*** *– Covered services for the treatment of mental, emotional, or chemical dependency disorders.*
- ***Care Management Organization (CMO)*** *– An organization that has entered into a risk-based contractual arrangement with the Department to obtain and finance care for enrolled Medicaid and PeachCare for Kids® members. CMOs receive a per capita or capitation claim payment from the Department for each enrolled member.*
- ***Cash Disbursement Journal (CDJ)*** *– A listing of individual cash payments made to providers by a CMO or subcontractor for a given period. Cash, in this case, refers to amounts paid via cash, check, or electronic funds transfer.*
- ***Centene*** *– Centene is a multi-line healthcare corporation that provides service to governmental healthcare programs.*
- ***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 CMO detailing the healthcare services provided to a patient for which the provider is requesting payment. A claim may contain multiple healthcare services.*

- ***Claim Adjudication*** *– The determination of the CMO's payment or financial responsibility, after the member's insurance benefits are applied to a claim.*
- ***Claims 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 an individual is covered under multiple plans.*
- ***Credentialing Verification Organization (CVO)*** *– The entity contracted by DCH to determine the qualifications and ascribed privileges of providers to render specific health care services and make all decisions for whether a provider meets requirements to enroll in Medicaid and in Georgia Families®.*
- ***Department of Community Health (DCH or Department)*** *– The Department within the state of Georgia that oversees and administers the Medicaid and PeachCare for Kids® programs.*
- ***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 FAC 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 FFS program and such application is approved by DCH or its Agent.*
- ***Envolve Business Solutions*** *– Includes the subsidiaries of Envolve Dental and Envolve Vision.*
- ***Envolve Dental*** *– The PSHP subcontractor responsible for managing dental services. Also referred to as Envolve Business Solutions.*

- ***Envolve Pharmacy*** *– The PSHP subcontractor responsible for managing pharmacy services.*
- ***Envolve PeopleCare*** *– The specialty organization that is part of the Centene family of companies. Includes Nursewise and Nurtur.*
- ***Envolve Vision*** *– The PSHP subcontractor responsible for managing vision services. Also referred to as Envolve Benefit Solutions.*
- ***Fee for Service (FFS) Medicaid*** *– For purposes of this engagement, FFS delivery is the portion of the Medicaid and PeachCare for Kids® program which provides benefits to eligible members who were not participants in the Georgia Families® program and where providers were paid for each service.*
- ***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 CMOs to manage and finance the care of eligible members.*
- ***Grievance*** *– An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided or aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the nember'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.*
- ***Nursewise – Nurse Advice Line (NAL)*** *– One of the business lines under the Envolve PeopleCare umbrella serving members of the PSHP. The Nurse Advice Line provides medical triage and health information to Peach State members who call in to speak with a registered nurse on a 24-hour basis. The NAL also provides after hours coverage for Peach State member services from 7:00 p.m. – 7:00 a.m. and on weekends.*
- ***Nurtur*** *– One of the business lines under the Envolve PeopleCare umbrella providing disease management services to members of the PSHP.*
- ***Ombudsman*** *– PSHP 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.*
- ***Peach State Health Plan (PSHP)*** *– A CMO contracted by DCH to deliver health care services to Georgia Families® enrollees.*
- ***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 FWA, 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 CMO 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.*
- ***RxAdvance*** *– RxAdvance is the vendor subcontracted by Envolve Pharmacy to adjudicate pharmacy claims and manage the pharmacy network.*
- ***Special Investigations Unit (SIU)*** *– PSHP/Centene department responsible for the detection, prevention, investigation, reporting, correction, and deterrence of FWA.*
- ***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)*** *– TPL refers to the legal obligation of any other health insurance plan or carrier (i.e. individual, group, employer-related, self-insured, commercial carrier, automobile*

insurance, and/or worker's compensation) or program to pay all or part of the member's health care expenses.

- ***U.S. 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: Agreed-Upon Procedures

The agreed-upon procedures described below will be applied to PSHP 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 PSHP and its subcontractors identify and provide policies and procedures related to Contract Compliance in the areas of Compliance Plan, Program Integrity, Subcontractor Oversight, Utilization Management, Quality Improvement, Behavioral Health, Member Services, Provider Network, Member and Provider Data Maintenance, Grievances and Appeals, Provider Complaints, Claims Management, 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 PSHP.
    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 PSHP.

2. We will request that PSHP 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 PSHP.
    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 PSHP.
    c. We will analyze the encounter workflows and processes within PSHP and between PSHP and its subcontractors.
    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 PSHP'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 PSHP 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 PSHP.
    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 PSHP.
    c. We will review PSHP and the subcontractor's program integrity programs and their 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 PSHP 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 PSHP.
    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 PSHP.
    c. We will review corrective action procedures administered, if any, by PSHP as a result of contract non-compliance.