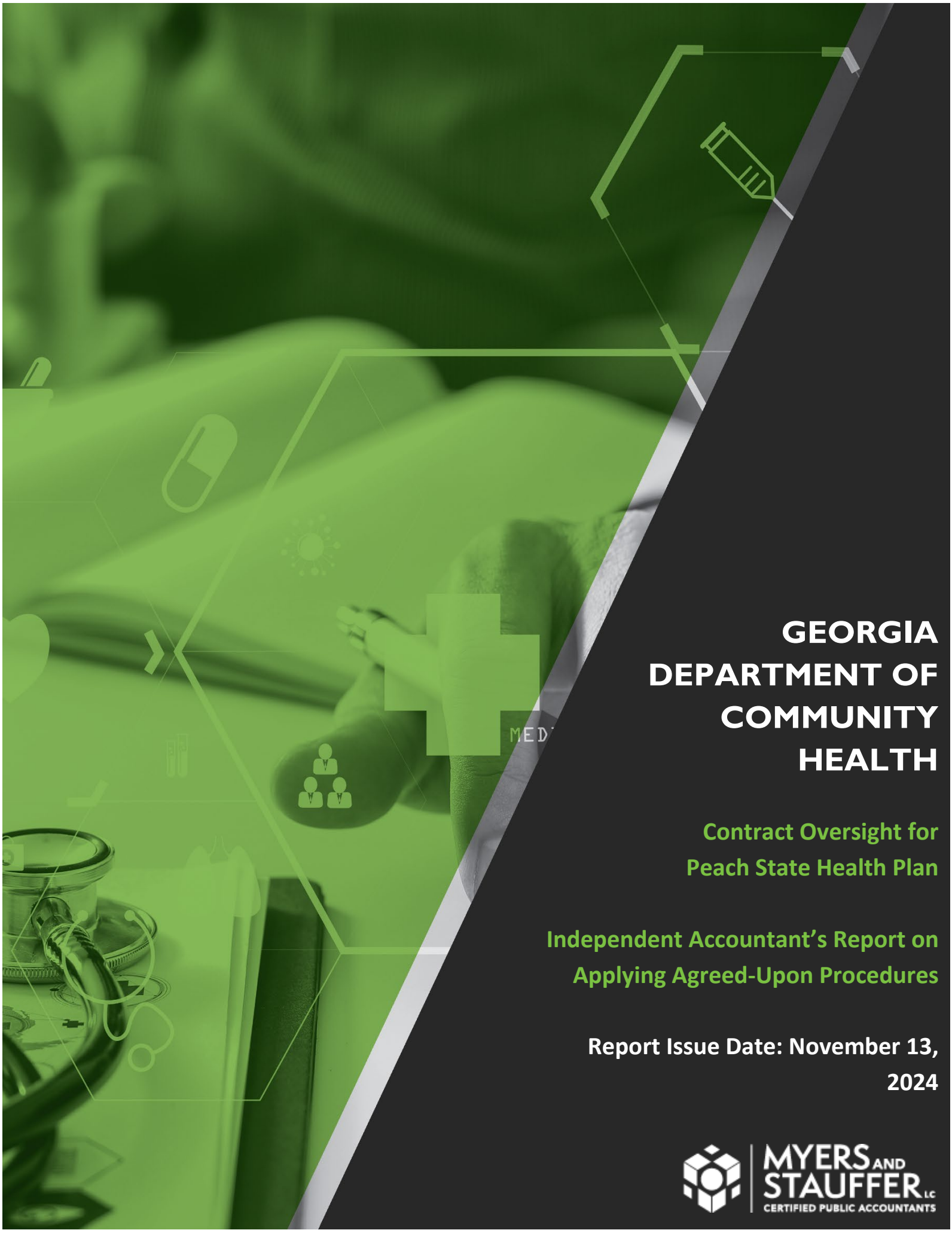

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Contract Oversight for Peach State Health Plan

Independent Accountant's Report on Applying Agreed-Upon Procedures

Report Issue Date: November 13, 2024

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Independent Accountant's Report

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We have performed the procedures enumerated in *Appendix B: Agreed-Upon Procedures* on the documentation and information provided by Peach State Health Plan (PSHP) from September 27, 2023 through December 14, 2023. We were asked to apply these procedures in order to evaluate PSHP's contract compliance, program integrity (PI) oversight, subcontractor oversight, and encounter submissions. PSHP's management is responsible for the documentation and information provided, which was submitted to the Georgia Department of Community Health (DCH or the Department) for purposes of compliance with the Department's policies and procedures for encounter submissions.

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

Our procedures are contained within *Appendix B: Agreed-Upon Procedures*, and our findings are contained in the *Findings and Recommendations* section beginning on page 75 of this report.

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

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

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

Myers and Stauffer LC

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November 13, 2024

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Project Background

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

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

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

Methodology

Pre-Interviews

On September 27, 2023, prior to initiating the interviews, we submitted a data and documentation request to PSHP. Interviews were performed both in-person and virtually. The materials requested for our inspection were designed to provide us with detailed background information specific to the objectives of this engagement. We scrutinized the contracts, policies, procedures, and other documentation related to the engagement's procedures to validate the compliance of PSHP and its subcontractors. These pre-interview activities began October 27, 2023 and continued through November 10, 2023.

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

- *The requirements included in the contract (and amendments) between DCH and PSHP.*
- *The requirements included in the contracts (and amendments) 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 interview activities and identified the specific focal areas, based on the results of the preliminary analysis. Utilizing the data and documentation provided, we also performed the following:

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

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

Interviews

Interviews, both in-person and virtual, of designated PSHP and Centene staff members were conducted by Myers and Stauffer staff. General and ad-hoc questions were asked of PSHP staff to ensure our thorough understanding of the subject matter being discussed. In the same manner, virtual interviews were conducted with the subcontractors CVS Health (CVS), Envolve Dental, and Envolve Vision. Myers and Stauffer identified additional PSHP or subcontractor staff and performed additional interviews where further clarification and/or additional information was necessary.

The in-person and virtual interviews began November 14, 2023 and concluded on December 14, 2023. *Table 1* outlines the health plan, interview dates, and the Myers and Stauffer engagement team members.

Table 1: Virtual Interview Schedule and Details

Virtual Interview Schedule and Details		
Health Plan	**Date**	**Myers and Stauffer Engagement Team**
CVS Health	11/14/2023	Savombi Fields Stephen Fader Nickie Turner Hailey Plemons Shawn Finnerty
Envolve Vision/Dental	11/29/2023- 11/30/2023	Savombi Fields Stephen Fader Nickie Turner Hailey Plemons Shawn Finnerty
Envolve Dental	12/04/2023	Savombi Fields Stephen Fader Nickie Turner Hailey Plemons Shawn Finnerty
PSHP (local)	12/06/2023- 12/08/2023	Savombi Fields Stephen Fader Nickie Turner Hailey Plemons Shawn Finnerty

Virtual Interview Schedule and Details		
Health Plan	**Date**	**Myers and Stauffer Engagement Team**
Centene (Corporate)/ Centene Pharmacy Services (CPS)	12/12/2023-12/14/2023	Savombi Fields Stephen Fader Nickie Turner Hailey Plemons Shawn Finnerty

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

Post-Interviews

Post-interviews, Myers and Stauffer identified key findings, if any, from each interview session. Documentation submitted by PSHP and the subcontractors meant to address any follow-up questions or concerns identified during the interview sessions was inspected for relevance.

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 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, CVS, Envolve Dental, and Envolve Vision.
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

In this section of the report, we provide an overview of PSHP's contract compliance. Myers and Stauffer assessed the operational areas of internal grievance/appeal system, member and provider call center operations, member services including ombudsman, provider network, provider services, quality management and performance improvement, and utilization management (UM). Key contractual requirements were identified and a determination was made as to whether PSHP's policies and procedures were in compliance with the DCH contract outlined in *Appendix C: Contract Compliance*.

Internal Grievance/Appeal System

Overview of Internal Grievance/Appeal System

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

PSHP policy acknowledges the right of the member, parent, legal guardian or their authorized representative to voice dissatisfaction with any matter with the exception of and adverse benefit determination, by filing a grievance. Grievances can be filed by fax, mail, or telephone.

The process for filing a grievance or appeal is outlined in PSHP member materials provided upon enrollment and annually. If a member requires assistance submitting a grievance, reasonable assistance is provided to them by a Grievance and Appeals Coordinator at no cost.

Per PSHP policy, a member or their authorized representative can initiate a grievance orally or in writing. A provider cannot file a grievance on behalf of the member.

Upon initiating a member grievance, a written acknowledgement letter is sent to the member within 10 days of PSHP's receipt of the grievance. The grievance is investigated by an approved health care professional under the supervision of the PSHP Medical Director, upon completion, a resolution letter is mailed to the member within 90 calendar days of the receipt of the grievance. The resolution letter clearly states the resolution and includes the basis for the resolution. The resolution letter also notifies the member of their right to appeal the decision. Standard grievances must be processed within 90 calendar days of the filing date. Expedited grievances must be resolved within 72 hours of receipt.

An appeal may be requested if the member receives and adverse benefit and/or medical necessity determinations. An appeal must be submitted within 60 days of receipt of the adverse benefit determination. If a member requires assistance with requesting an appeal or an appeal to the resolution letter, PSHP Appeals Coordinators are available to assist the member with those requests.

Upon initiating a member appeal, a written acknowledgement letter is sent to the member within 10 days of PSHP's receipt of the appeal. The appeal is investigated by a health care professional under the supervision of the PSHP Medical Director, and upon completion, a resolution letter is mailed to the member within 30 calendar days of the receipt of the appeal. The resolution letter clearly states the resolution and includes the basis for the resolution. Standard appeals must be processed within 60 calendar days of the filing date. Expedited appeals must be resolved to within 72 hours of receipt.

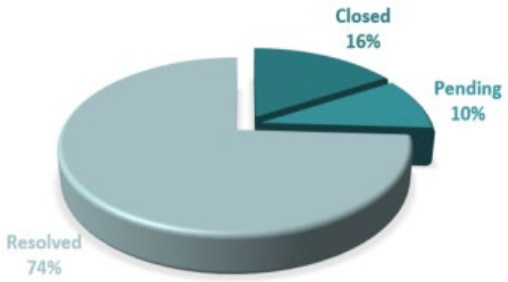
Analyses: Internal Grievance/Appeal System (including Complaints)

Myers and Stauffer has completed an analysis on PSHP's complaints, grievances, and appeals systems for 2023 quarter (Q) 2 and Q3, and have consolidated our findings to illustrate grievances status, grievances status by appeal type, and grievances processing time compliance, number of appeals by service category, number of appeals by appeal type, expedited appeals by service category, and appeal processing time compliance.

Complaints, Grievances, and Appeals Status

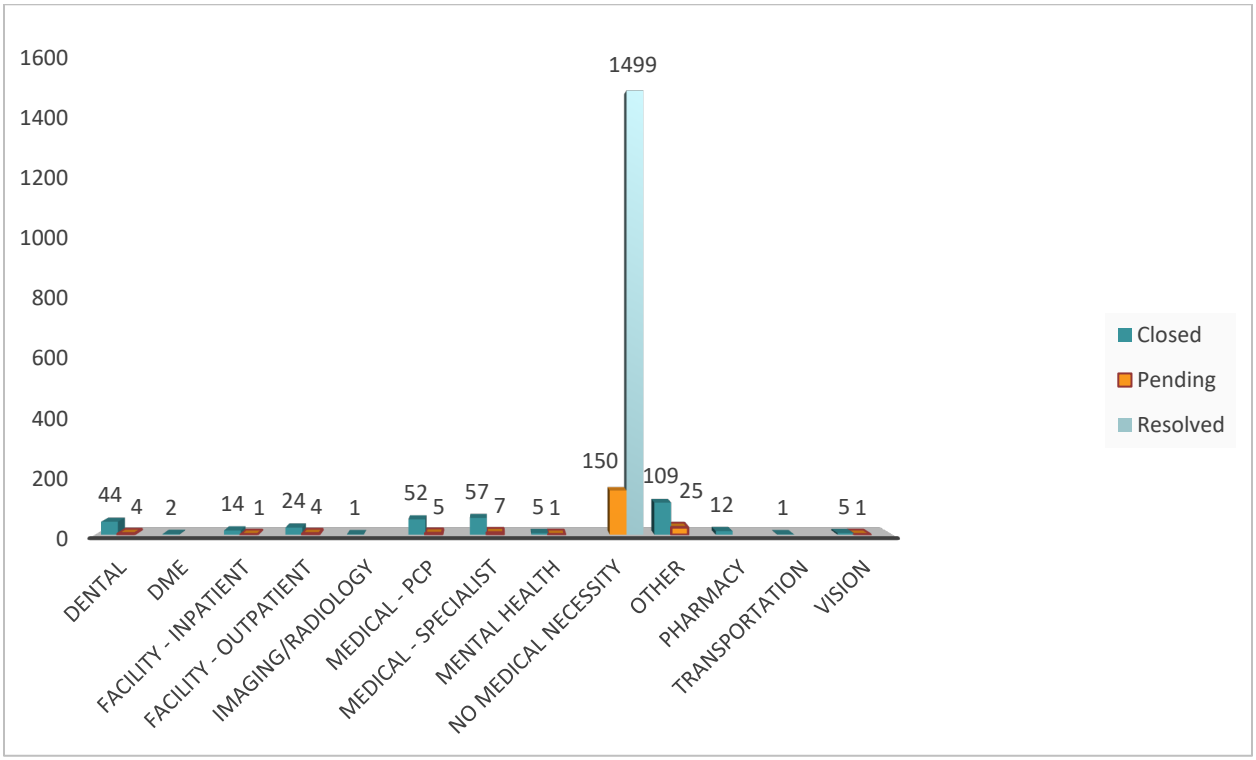
During the examination of 2,023 complaints, grievances and appeals recorded in 2023, we first identified and compared pending, resolved and closed grievances, as shown in *Figure 1*. We identified 198 cases still pending, 1,499 cases resolved, and 326 cases closed.

Figure 1: Complaints, Grievances, and Appeals Status



Upon further analysis, we streamlined the complaint, grievance and appeal nature to include dental, DME, inpatient and outpatient facility, radiology, medical primary care provider (PCP), medical specialist, mental health, pharmacy, transportation, vision, no medical facility, and other (billing and financial). We identified pending, resolved and closed cases within each nature category and found that no medical necessity, other (billing and financial), and medical specialist are the most common complaint, grievance and appeal types. Less than 10% of their cases were still pending at date of report as shown in *Figure 2*.

Figure 2: Complaints, Grievances, and Appeals Status by Type



Complaints, Grievances, and Appeals Processing

Section 4.14.3.4 states that issuance of disposition on complaints, grievances, and appeals must be completed within 90 calendar days of the grievance filing date. In accordance with the contract stipulations between DCH and PSHP concerning processing time for complaints, grievances and appeals, we determined that PSHP is operating in compliance with the contract as shown in *Table 2*.

Table 2: Complaints, Grievances, and Appeals Processing Time Compliance

90 days or Greater	0
60 days or Less	216
30 Days or Less	1,807
Total	2,023
% in Compliance	100%

Observations: Internal Grievance/Appeal System (including Complaints)

- *PSHP has four grievance and appeal coordinators dedicated to processing the grievances and appeals; and a single team lead who is dedicated to performing quality audits of the coordinators work.*
- *PSHP members may file a grievance for any dissatisfaction excluding a proposed action.*

- *Most grievances begin as call center inquiries worked by call center staff. If the call center staff cannot resolve the grievance, it is transferred to the grievance and appeals team for resolution.*
- *PSHP, via the semi-annual Grievance System Analysis, reported receiving 373 total grievances last year, with the majority of them resulting from specialty care.*
- *PSHP, via the semi-annual Grievance System Analysis, reported receiving 223 grievances in Q1 and Q2 of 2023. The top five grievance types reported were as follows:*
    - *Specialists Care – 32.7%.*
    - *Health Plan – 22.6%.*
    - *Dental – 12.0%.*
    - *Inpatient Services – 8.0%.*
    - *Pharmacy – 7.3%.*
- *PSHP, via the semi-annual Grievance System Analysis, reported receiving 150 grievances in Q3/Q4 of 2023. The top five grievance types reported were as follows:*
    - *Specialists Care – 25.1%.*
    - *Primary Care – 22.9%.*
    - *Health Plan – 14.4%.*
    - *Dental – 14.4%.*
    - *Outpatient Services – 12.1%.*
- *PSHP disclosed that they receive approximately 167 appeals per month.*
- *Members may appeal and adverse grievance or complaint decision. PSHP will notify the member of the adverse decision and, their right to appeal.*
- *Members seeking an appeal after receiving a notice of an adverse grievance disposition must submit to PSHP a written request to be received by PSHP no later than 15 calendar days from the date of the written Notice of Disposition of the original grievance resolution.*
- *PSHP, via the semi-annual Grievance System Analysis, reported receiving 846 appeals in Q1 and Q2 of 2023. The top five appeal outcomes reported were as follows:*
    - *Upheld – 38.3%.*
    - *Overturned – 36.1%.*
    - *Unable to Process due to Lack of Consent – 13.1%.*
    - *Unable to Process due to Untimely Appeal Submission – 11.8%*

- *Partially Overturned – 0.7%.*

- *PSHP, via the semi-annual Grievance System Analysis, reported receiving 774 appeals in Q3 and Q4 of 2023. The top five appeal outcomes reported were as follows:*
  - *Upheld – 39.7%.*
  - *Overturned – 34.5%.*
  - *Unable to Process due to Untimely Appeal Submission – 12.4%.*
  - *Appeals Pending Resolution Still within Timeframe – 5.8%.*
  - *Unable to Process due to Lack of Written Request – 4.9%.*

Assessment: Internal Grievance/Appeal System

Upon assessment of PSHP's submitted policies and procedures, documentation, and interviews, Myers and Stauffer did not identify complete policies or SOPs for contract Section 4.14.1.2. We recommend that PSHP, in accordance with their contract with DCH, create updates to policies, SOPs and/or policy references to address the contract requirement outlined in this area.

Our data analyses determined that PSHP's processing time for complaints, grievances, and appeals was in compliance with the DCH contract for the data sample analyzed.

Member and Provider Call Center Operations

Overview of Member and Provider Call Center Operations

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

PSHP policy indicates that the plan operates a toll-free call center from 7:00 a.m. to 7:00 p.m. EST, with the exception of certain state of Georgia holidays. During the hours of 7:00 a.m. to 7:00 p.m., Customer Service Representatives (CSRs) are available to assist callers. PSHP maintains a 24 hour nurse information and triage line that is staffed by Envolve People Health clinicians.

PSHP employs bilingual CSR's to handle calls where the member's primary language is not English. For languages not spoken by a PSHP CSR, access to interpreter services is available. PSHP provides accommodation for hearing impaired members through Georgia Relay Services for the Deaf.

Myers and Stauffer, during the Call Center Operations interview session, noted an area of concern. PSHP disclosed that the behavioral health (BH) call center metrics were out of compliance in the recent past.

PSHP stated that they identified the cause of the noncompliance and mitigated it by increasing the number of call center agents and providing improved training specific to handling BH calls.

Analyses: Member and Provider Call Center

Myers and Stauffer has completed analyses on PSHP call center figures for Q2 and Q3 of 2023, and have consolidated our findings to illustrate number of offered calls received, number of calls handled, average speed of answer, average hold time, abandonment rate (percentage), block call rate (percentage) and the top reasons for telephone inquiries at both member and provider call centers.

Member Call Center

Member Call Center: Number of Offered Calls Received and Calls Handled

During the examination of the monthly data, we identified the number of offered calls received (to include handled, abandoned, and blocked) and number of calls handled over the months of April through September of 2023. We found that PSHP received an average of 29,429 member offered calls and handled an average of 29,118 member calls.

Average Speed of Answer and Average Hold Time

In accordance with the contract stipulations between DCH and PSHP concerning the member call center's average speed of answer and average hold time standards, we determined that PSHP is operating in compliance with the contract. The service level agreement (SLA) for average speed of answer requires 80% of calls to be answered by a person within 30 seconds with the remaining 10% answered within an additional 30 seconds. Our evaluation of monthly data for each standard showed that PSHP met these standards across months maintaining an average speed of answer percentage of 98% and above. The SLA for average hold time requires the plan to meet an average hold time standard of less than one minute 99% of the time. Across months, PSHP maintained average hold times below 20 seconds.

Abandoned Call Rate

During the assessment of the monthly data, we determined that PSHP is operating in compliance with the abandonment rate standards expressed in the contract. Section 4.3.7.6.2 states member the abandoned call rate shall be 5% or less. Our assessment showed that September 2023, although still in compliance, had the highest rate of abandoned call at 2.79% accounting for 735 abandoned calls total. Additionally, May 2023 had the lowest abandonment rate of 0.50% accounting for 154 total abandoned calls for the month.

Blocked Call Rate

In our evaluation of the monthly data, we determined that PSHP is operating in compliance with the blocked call rate standards expressed in the contract. Section 4.3.7.6.3 states the blocked call rate shall

not exceed 1%. In our assessment of the monthly data, we determined that July 2023, although still in compliance, had the highest rate of blocked calls at 0.05% accounting for 14 blocked calls total. Additionally, September 2023 had the lowest blocked call rate of 0.00% accounting for zero total abandoned calls for the month.

Top Reasons for Telephone Inquiries

During the assessment of the monthly data, we identified the top five reasons for telephone inquiries. Across months, we found that the most common reasons for inquiries, were to update member demographics, update member preferences, inquire about eligibility, and fulfill materials.

Provider Call Center

Number of Offered Calls Received and Calls Handled

During the assessment of the monthly data, we identified the number of offered calls received (to include handled, abandoned, and blocked) and number of calls handled over the months of April through September of 2023. We found that PSHP received an average of 30,914 offered calls and handled an average of 30,614 calls.

Average Speed of Answer and Average Hold Time

In accordance with the contract stipulations between DCH and PSHP concerning the provider call center's average speed of answer and average hold time standards, we determined that PSHP is operating in compliance with the contract. Our assessment of monthly data for each standard showed that PSHP met these standards across months April-September. The service level agreement (SLA) for average speed of answer requires 80% of calls to be answered by a person within 30 seconds with the remaining 10% answered within an additional 30 seconds. Across months, PSHP maintained an average speed of answer percentage of 95% and above. The SLA for average hold time requires the plan to meet an average hold time standard of less than one minute 99% of the time. Across months, PSHP maintained average hold times below 20 seconds.

Abandoned Call Rate

During the assessment of the monthly data from April-September, we determined that PSHP is operating in compliance with the abandonment rate standards expressed in the contract. Section 4.9.5.6.2 states the provider abandoned call rate shall be 5% or less. Our assessment showed that September 2023, although still in compliance, had the highest rate of abandoned call at 1.55% accounting for 444 abandoned calls total. Additionally, May 2023 had the lowest abandonment rate of 0.60% accounting for 200 total abandoned calls for the month.

Blocked Call Rate

In our assessment of the monthly data from April-September, we determined that PSHP is operating in compliance with the blocked call rate standards expressed in the contract. Section 4.9.5.6.3 states the blocked call rate shall not exceed 1%. In our assessment of the monthly data, we found that June and July, although still in compliance, had the highest rates of blocked calls at 0.02% accounting for 12 blocked calls total. Additionally, May and August 2023 had the lowest blocked call rates of 0.00% accounting for zero total abandoned calls for these months.

Top Reasons for Telephone Inquiries

During the assessment of the monthly data, we identified the top five reasons for provider telephone inquiries. Across months, we found that the most common reasons for inquiries, were benefits and enrollment inquiry, claims inquiry, coordination of benefits, medical authorization inquiry, and pharmacy authorization inquiry.

Observations: Member and Provider Call Center Operations

- *An interactive voice response system is utilized to document calls, and a repository documentation system enables PSHP to access accounts on calls.*
- *Five monthly quality evaluations are completed by the vendor, the Northridge Group. These are housed in PSHP' Quality Central tool for Member Call Center. Two evaluations are completed for Provider Call Center.*
    - *The specialists can dispute results of assessment within six business days and their requests are processed within five to seven days once received.*
- *Customer issues are prioritized by grades of high, medium, and low, with high priority items being regulatory in nature. PSHP aims to resolve provider tickets within 72 hours.*
    - *There is no service-level agreement (SLA) around e-mailed requests; however, alerts are responded to within the hour, and lower prioritized events receive responses within seven days.*
- *PSHP maintains dashboards that monitor turnaround times (TATs) for the Issue Resolution (IR) team. The team lead for IR will do five ticket audits every month on their specialists.*
- *The IR teams meets monthly with the claims team to discuss issues and trends.*
- *The average number of calls for the Provider Call Center is between 300 and 400 calls daily.*
- *SLAs for average speed of answer, average hold time, abandoned call rate, and blocked call rate were met for both member and provider call centers for the time period analyzed.*
- *PSHP records monthly accuracy rates based on the member call center quality criteria and protocols. The accuracy rates for April through September of 2023, referenced below, met the contract requirement of 90% and above.*

- *April – 95.5%.*
- *May – 96.20%.*
- *June – 93.50%.*
- *July – 96.60%.*
- *August – 94.60%.*
- *September – 92.80%.*

- *PSHP monitors and tracks the number of email inquiries received by the member call center, the average response time, and the average TAT. The timely email response rates for April through September of 2023 are referenced in Table 3.*

Table 3: Emails Received by Member Call Center

Emails Received by Member Call Center (Excluding Behavioral Health)						
Criteria	**April**	**May**	**June**	**July**	**August**	**September**
Number of Emails Received	1075	1018	1116	1302	1421	901
Average Response Time (hh:mm:ss)	0:02	0:02	0:02	0:02	0:02	0:02
Average TAT (hh:mm:ss)	32:52:44	14:59:00	30:05:46	22:35:00	31:00:14	27:59:16

- *PSHP records monthly accuracy rates based on the provider call center quality criteria and protocols. The accuracy rates for April through September of 2023, referenced below, met the contract requirement of 90% and above.*

- *April – 97.00%.*
- *May – 97.80%.*
- *June – 97.60%.*
- *July – 99.00%.*
- *August – 97.60%.*
- *September – 96.00%.*

- *PSHP monitors and tracks the number of email inquiries received by the member call center, the average response time, and the average TAT. The timely email response rates for April through September of 2023 are referenced below:*

Table 4: Emails Received by Provider Call Center

Emails Received by Provider Call Center (Excluding Behavioral Health)

Criteria	April	May	June	July	August	September
Number of Emails Received	406	488	396	380	273	337
Average Response Time (hh:mm:ss)	0:02	0:02	0:02	0:02	0:02	0:02
Average TAT (hh:mm:ss)	36:02:05	39:33:12	26:49:10	42:18:33	36:51:47	27:52:46

Assessment: Member and Provider Call Center Operations

Upon assessment of PSHP's submitted policies and procedures, documentation, and interviews, Myers and Stauffer did not identify complete policies or SOPs for contract Sections 4.3.7.3, 4.3.7.5, 4.3.7.6, 4.3.7.6.1, 4.3.7.7, 4.9.5.6, 4.9.5.7. We recommend that PSHP, in accordance with their contract with DCH, create policies, SOPs, and/or policy references to address the contract requirements outlined in these areas. Additional areas of concern identified during this engagement are referenced below in *Potential Findings: Member and Provider Call Center Operations*.

Our data analyses determined that PSHP's member and provider call centers service levels were in compliance with the DCH contract for the data sample analyzed.

Potential Findings: Member and Provider Call Center Operations

- *PSHP discussed how BH call center metrics were out of compliance in the recent past. They identified the reason for non-compliance and mitigated the issue by adding agents and improving training to bring the metrics into compliance.*

Member Services including Ombudsman

Overview of Member Services including Ombudsman

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

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

The contract states PSHP must utilize all forms of popular communication to reach members and generate responses. Acceptable forms of communication include telephone, hard copy documents via mail, email, social media, and texting.

PSHP per their policy, must make all written materials available to members in a way that is considerate to their needs, while also having the information in alternate formats. PSHP member services agents are available to provide guidance on how to access those alternate formats. All written information must be provided in all other prevalent non-English languages as defined by DCH. All written materials that are distributed to members shall include a language block printed in Spanish and all other prevalent non-English languages. All written materials must be written so they can be understandable to a person who reads at a fifth grade level and be culturally competent based on a DCH approved Cultural Competency Plan. PSHP provides access and assistance to member materials for the member population who requires interpretation and/or translations services.

PSHP's member's services staff will include Ombudsman Liaisons. The Ombudsman Liaison will work with the office of Ombudsman, DCH, members, and providers. Ombudsman staff are responsible for collaborating with DCH's designated staff to identify and attempt to resolve member issues. The Ombudsman staff will work collaboratively with DCH staff on member issues, such as finding a doctor, accessing health care services, obtaining Medicaid identification (ID) cards, requesting transportation, and any other member-related concerns. Ombudsman staff also assist members and providers with resolving complaints and grievances, issues surrounding cultural competency, investigating and resolving access and disability competency issues, coordinating services with local community organizations, and working with advocacy organizations. PSHP monitors member enrollment levels to evaluate the number of Ombudsman Liaisons necessary to meet member needs.

During the interview discussion regarding marketing materials, Centene disclosed that the marketing specialists are responsible for reviewing marketing documents to confirm proper grammar usage, ensure fifth grade reading level, and verify that the appropriate graphic designs were used. They are also responsible for obtaining approval of the marketing materials from DCH, prior to releasing them to the public. We inquired about the department's procedures for quality reviews and/or oversight of activities performed by the marketing staff. The interviewee responded that she was unaware of any quality assurance being performed on their work products.

Myers and Stauffer noted that the Marketing and Communication interview responses from PSHP indicated that their processes did not appear to contain steps for quality reviews and/or oversight of activities performed by the marketing specialists.

As a result of this finding, a corrective action plan (CAP) was assessed on PSHP. PSHP responded and provided additional context to address the finding. PSHP stated, "The Marketing and Communication team does have an oversight and quality review processes in place to review the work activities of the plan's marketing specialists. Monthly, the Marketing and Communications Director performs detailed

audits on the staff which includes a full review of the materials that were requested, developed, and approved. This review evaluates whether the specialists followed the required steps to developing a marketing and communication piece (including 5th grade reading level requirements) as well as collecting all required approvals including that of DCH. The results of these audits are a part of the team member's regular meetings with their director as well as performance goals."

After further review of the information provided by PSHP, it should be noted that this information was not provided during the interview. As a result, Myer and Stauffer recommends that PSHP implement ongoing education and consistent awareness of the departmental policies and procedures for oversight and quality review of marketing and communications tasks.Observations: Member Services including Ombudsman

- *Member ID cards are updated annually and as needed throughout the year.*
- *Member handbooks are updated on a quarterly basis.*
- *Per PSHP, marketing activities are a dual function of the local plan and the corporate office.*
- *Ombudsman staff typically receive 10 to 15 cases per week in the Georgia market.*
- *TAT on Ombudsman member complaints is 72 hours.*
    - *Within that timeframe, the Ombudsman will report the complaint to DCH and update them on the status.*
- *TATs for Ombudsman member complaints in 2023 ranged between a minimum of zero days and a maximum of 26 days. During the same year the average TAT was three days.*
    - *55% of the Ombudsman member complaints in 2023 were resolved within three days/72 hours.*
- *In 2023, PSHP reported 351 Ombudsman member grievances.*
- *The top five grievance types in 2023 were as follows:*
    - *Access to care – 240.*
    - *Other – 46.*
    - *Administration – 34.*
    - *Care/Benefits – 13.*
    - *Provider Service Issues – 9.*

- *Ombudsman inquiries are escalated and can be further escalated to a supervisor, director or vice president for resolution as necessary.*
- *Ombudsman Liaisons advocate for the members, ensuring availability and access to care, promoting education, and identifying and mitigating barriers to care appropriate for the member's condition.*
- *Ombudsman Liaisons investigate and mitigate cultural sensitivity issues identified by the member, Member Services staff, DCH, providers, and advocacy organizations.*

Assessment: Member Services including Ombudsman

Myers and Stauffer evaluated PSHP's policies and procedures, documentation, and interviews for member services including ombudsman and determined that PSHP was in compliance with the DCH contract; however, an area concern identified during this engagement is referenced below in *Potential Findings: Member Services including Ombudsman*.

Potential Findings: Member Services including Ombudsman

- *It appears that no oversight or quality review of the marketing specialists work activities are in place for Centene or PSHP.*

Overview of Centene Pharmacy Services

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

CPS is a division of Centene that maintains pharmacy operations. CPS manages the subcontractor relationship with CVS; the preferred drug list updates; and claims adjudication. CPS also manages the pharmacy network, to include contracting, credentialing, re-credentialing and oversight, and ensuring that their subcontracted PBM (CVS) meets the network standards outlined in the contract.

Observations: Centene Pharmacy Services

- *PSHP is welcoming a new PBM effective January, 1 2024.*
    - *Express Scripts, Inc. (ESI) will assume the responsibility for PBM services at that time.*
- *CPS provides real time oversight to ensure that CVS is following guidelines and meeting required service levels.*
- *CPS observation teams have access to the claims data and metrics which allows them to see irregularities, outliers, strange trends, and other issues.*
    - *Calls are monitored to identify trends in daily operations.*
- *CPS manages the oversight of the pharmacy network utilizing pharmacy termination reports.*
    - *CPS works with CVS to make sure those reports are submitted with accurate data and in a timely manner prior to sending them to PSHP.*
- *CPS has regular standing meetings with CVS to ensure proper oversight.*
    - *There is a monthly joint oversight meeting to discuss metrics and whether or not they are being met.*

- *CPS performs periodic internal audits of CVS, in addition to an annual audit with the Centene corporate teams examining all delegated functions.*
- *CPS conducts a quarterly geoaccess analysis seeking to identify geographic areas with deficiencies.*
- *On a quarterly basis, CPS will perform a check on a sample of pharmacies to ensure proper credentialing.*
- *CPS has the ability to re-run all reports sent by CVS in order to ensure accuracy.*
    - *Encounter reporting is used to ensure data accuracy.*
    - *The finance team also reviews the numbers to ensure accuracy.*
    - *Audits of CVS data may be performed, to validate data and ensure accuracy, if needed.*

Assessment: Centene Pharmacy Services

Myers and Stauffer evaluated CPS' policies and procedures, documentation, and interview responses for pharmacy services and determined their compliance with the DCH contract.

Provider Network

Overview of Provider Network

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

Per policy, PSHP developed and maintains a network of providers and facilities adequate to deliver covered Medicaid services to its member population. PSHP's provider network is designed to reflect, where possible, the diversity of cultural and ethnic backgrounds of its member population to include individuals with limited English proficiency. PSHP's providers and facilities will be credentialed by DCH's Credentialing Verification Organization where appropriate. In rural areas, and when otherwise appropriate, the use of telemedicine may be an option for providing care to members in deficient areas.

The provider network contains physicians, specialists, BH providers, pharmacies, hospitals, physical therapists, occupational therapists, speech therapists, border providers, and other health care professionals. The network will not include any providers that have been excluded from participation by the U.S. Department of Health and Human Services, Office of the Inspector General, or are on the list of

excluded providers in Georgia. PSHP will perform monthly checks of the exclusions list to identify and immediately terminate any participating provider found on the list.

An area of concern was identified during the Provider Data Maintenance interviews with PSHP. Based on the discussion of provider data maintenance activities, the interviewee disclosed that the Provider Data Maintenance department does not perform any validation steps such as, Office of Inspector General (OIG) exclusion checks, for providers entering their network. The interviewee advised that they rely on what is provided on the State's 7,400 data provider file since those providers are credentialed through the Credentialing Verification Organizations (CVO). Myers and Stauffer noted this action as a potential weakness in the provider enrollment process for validating providers.

As a result of this finding, a corrective action plan (CAP) was assessed on PSHP. PSHP responded and provided additional context to address the finding. PSHP stated, "there is a process in place to validate for OIG provider exclusions. The process is owned by the Centene Credentialing department and not the Provider Data Maintenance department. The Credentialing department performs monthly OIG reviews and terminations for exclusions. This review includes all practitioners/providers listed in the Provider Data Management system, regardless of participation status."

After further review of the information provided by PSHP, it should be noted that this information was not provided during the interview. As a result, Myer and Stauffer recommends that PSHP implement ongoing education and consistent awareness of the departmental policies and procedures for credentialing providers which includes performing monthly OIG reviews and terminations for exclusions.

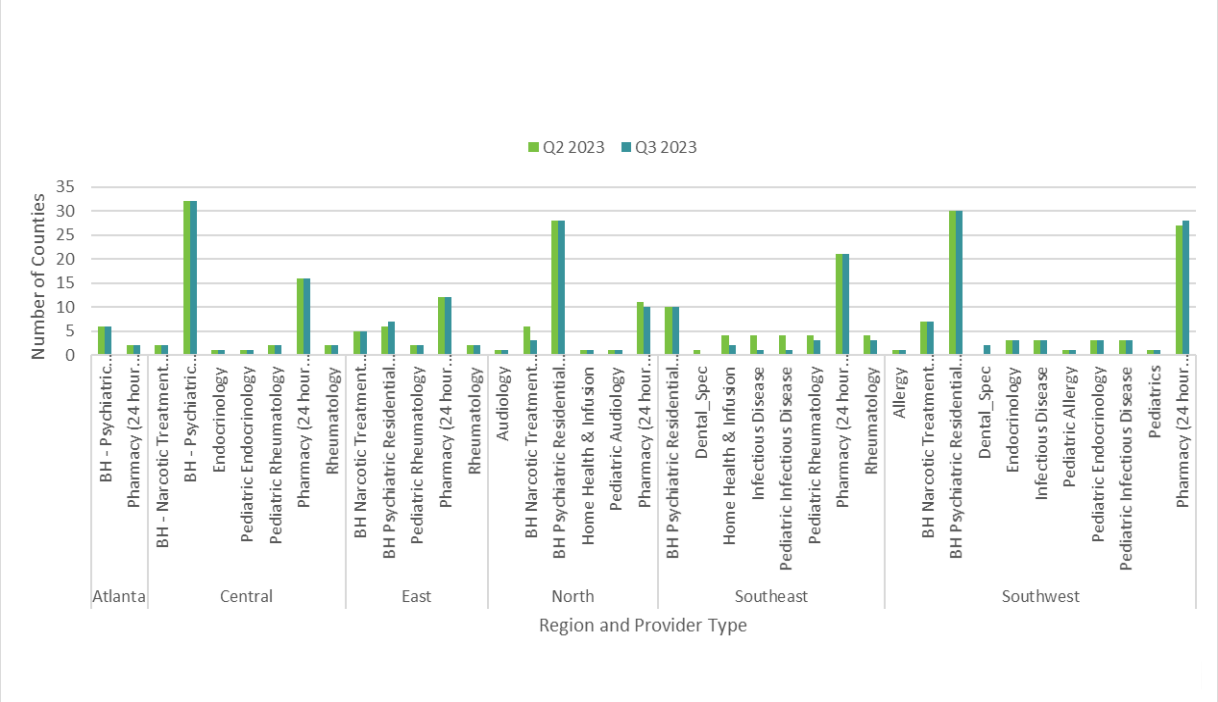
Provider Network Analyses

Myers and Stauffer has completed an analysis on PSHP's provider network for Q2 and Q3 of 2023. The analysis looked at member data where greater than 90% of the members do not have access to providers. We have consolidated our findings to illustrate members without access (>90%) by region, members without access (>90%) by region and provider type, counties with no providers by provider type, and appointment waiting time standards by provider type.

Members without Access by Region and Provider Type – (<90%)

During the analysis conducted by Myers and Stauffer of provider network data from Q2 and Q3 of 2023, we were able to determine the number of counties by region and provider specialty where members with access was less than 90%. See Figure 4 below for the overall breakdown of counties by region and provider specialty where members with access was less than 90%.

Figure 3: Members Without Access by Region and Provider Type



Myers and Stauffer identified that BH – PRTFs and 24-hour pharmacies were the two provider types across all regions which had the highest number of counties where members with access was less than 90%. We found that all regions had at least 5 counties where members with access was less than 90% for BH – PRTFs and 24-hour pharmacies. The Central, North, and Southwest region had the highest number of counties where members with access was less than 90% for BH – PRTFs. The Central, Southeast, and Southwest region had the highest number of counties where members with access was less than 90% for 24-hour pharmacies. There was little change from Q2 to Q3 2023 in the number of counties by region and provider specialty where members with access was less than 90%.

Counties with No Providers by Provider Type

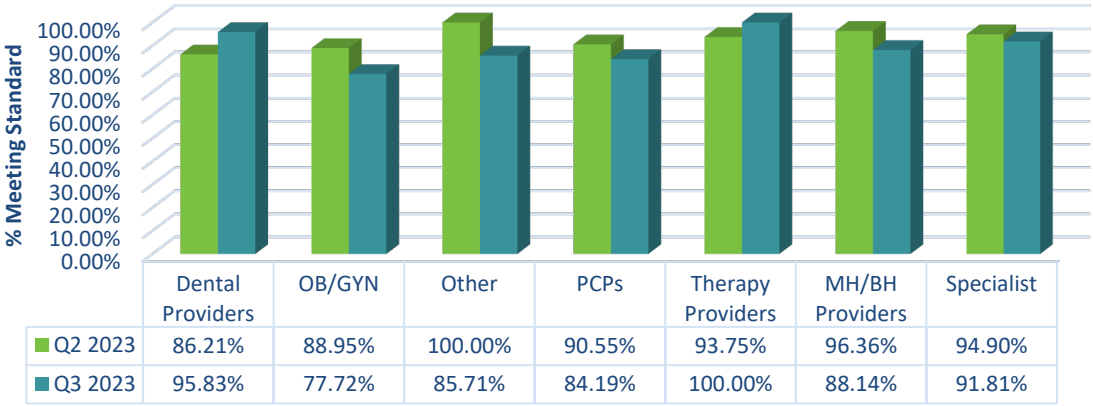
During the Myers and Stauffer analyses of PSHP's Provider Network, we found twelve counties in two regions that had no providers for two provider types within the county or in the covering counties. In the Atlanta region, Newton County has no BH – PRTFs and there are no facilities in the covering county. In the Southeast region, Brantley, Camden, Charlton, Glynn, Liberty, Long, McIntosh, Pierce, Toombs, Ware, and Wayne County do not have any 24-hour Pharmacies in the respective counties or their covering counties.

PSHP should identify alternate methods for members to achieve access. Peach State should also work to mitigate all areas of deficiency by identifying other providers in the county or state to meet access standards.

Appointment Waiting Time Standards

During the analysis conducted by Myers and Stauffer of provider network data from Q2 and Q3 of 2023, we were able to determine the average percentage of appointments meeting the waiting time standards by provider type across all regions. See *Figure 4* below for the average percentage of appointments meeting the waiting time standards by provider type across all regions.

Figure 4: Appointment Waiting Time Standards



	Dental Providers	OB/GYN	Other	PCPs	Therapy Providers	MH/BH Providers	Specialist
Q2 2023	86.21%	88.95%	100.00%	90.55%	93.75%	96.36%	94.90%
Q3 2023	95.83%	77.72%	85.71%	84.19%	100.00%	88.14%	91.81%

Myers and Stauffer determined that overall, Peach State meets the standards set in the contract with DCH for appointment waiting times. We found that Therapy providers had the highest percentage of appointments meeting the waiting time standards across Q2 and Q3 of 2023, with 93.75% and 100.00% respectively. Myers and Stauffer also discovered that OB/GYN providers had the lowest percentage of appointments meeting the waiting time standards across Q2 and Q3, with 88.95% and 77.72% meeting the standards respectively.

From Q2 to Q3 2023, Myers and Stauffer found that 'Other' providers, such as Urgent Care providers, had the largest decrease in appointments meeting the waiting time standards at 11.23% and that Dental providers had the largest increase in appointments meeting the waiting time standards at 9.62%.

Observations: Provider Network

- *PSHP has a 30 to 45-day turnaround target for standard contracts given to providers; however, this time may be longer if negotiations need to occur.*
- *PSHP negotiators utilize 7400 files, Google, Quest, phone calls, and emails to find providers to fill network deficiency gaps.*
    - *These activities are tracked in spreadsheets.*
- *PSHP has a TAT of 48 hours to log requests from the date of receipt.*
    - *Additionally, there is a 24-48 hour TAT for initial responses to providers by the date of the logged request.*

Provider Network

Myers and Stauffer evaluated PSHP's policies and procedures, documentation, and interviews for provider network and determined that PSHP was in compliance with the DCH contract; however, areas of concern identified during this engagement are referenced below in *Potential Findings: Provider Network*.

Our data analyses determined that PSHP's network appears to be robust; however, gaps do exist. Access to providers is enhanced with telemedicine to ensure compliance with the DCH contract for the provider data sample analyzed.

Potential Findings: Provider Network

- *It appears that PSHP was not in compliance with network standards based on Myers and Stauffer's analysis of provider network data for Q2 and Q3 of 2023.*
- *PSHP has minimal oversight of the Geoaccess network adequacy report. Additionally, little is done with feedback from DCH regarding report.*
- *PSHP does not complete a validation for OIG for provider exclusion, reflecting potential weaknesses in the enrollment process.*

Provider Services

Overview of Provider Services

Section 4.9.1 of the contract requires PSHP to provide information about Georgia Families® to all providers in order to operate in full compliance with the contract and all applicable federal and state regulations. PSHP is responsible for monitoring provider knowledge and understanding of provider requirements and taking corrective actions to ensure compliance with the requirements. The contract requires PSHP to provide all providers with a copy of the provider handbook and to provide a hard copy upon provider request. For the providers, the provider handbook serves as a source of information

regarding covered services, policies and procedures, statutes, regulations, telephone access, and special requirements to help ensure all contract requirements are being met.

PSHP, per policy, maintains provider services using Provider Relations (PR) Representatives and Provider Services Representatives. These representatives give providers information about Georgia Families® to both participating and non-participating providers. PR Representatives are assigned to territories and are responsible for face-to-face and virtual provider visits. PR Representatives are responsible for, and not limited to, responding to provider inquiries regarding contracting, maintenance of existing PSHP Provider Manual, physician and office staff orientation, hospital and hospital staff orientation and ongoing provider education, updates, and training. Provider Services Representatives are primarily responsible for responding to provider calls utilizing internal systems and other resources to respond to provider questions or concerns.

A toll-free provider service line is dedicated to provider service calls where. Providers, by calling the toll-free service line can, at a minimum, obtain assistance with member information; information regarding providers' rights and responsibilities; claims and payment; prior authorizations; provider information, filing complaints and appeals; and assistance with web portal functionality.

Observations: Provider Services

- *The Provider Services Call Center is staffed to respond to provider general questions in addition to calls regarding prior authorization and pre-certification requests, from 7:00 a.m. and 7:00 p.m. Eastern Standard Time Monday through Friday.*
- *After regular business hours, the Provider Services line is answered by an automated system with the capability to provide callers with operating hours information and instructions on how to verify enrollment for a member with an emergency or urgent medical condition.*
- *The visit metric for key accounts which include hospitals, independent physician associations, and facilities is ten visits per month. Seven of the 10 must be face-to-face visits.*
    - *The Provider Engagement Administrators for key accounts have been exceeding the monthly metric for visits, according to PSHP PR management.*
- *The current visit metric for non-key accounts/providers is 30 per month.*
- *Per PSHP, Provider Engagement Administrators met standards for provider visit production and in-person visit audits for the second, third, and fourth quarters of calendar year 2023.*
- *PR provider complaints audit resulted in 100% of responses completed within TAT specified by Compliance.*
- *P360 is the platform used to perform the following provider services functions:*
    - *Document all inquiries.*

- *Document all provider visits and provider engagements.*
- *Track all inquiries.*
- *Facilitate quality reviews of the Provider Engagement Administrator staff.*

- *PSHP reviews and updates policies and procedures for Provider Services annually and on an ad hoc basis for essential/urgent changes that may affect operations.*

Assessment: Provider Services

Upon assessment of PSHP's policies and procedures for provider services, Myers and Stauffer did not identify complete policies or SOPs for contract sections 4.9.1.2, 4.9.1.5, and 4.9.2.1.27. We recommend that PSHP, in accordance with their contract with DCH, create policies, SOPs and/or policy references to address the contract requirements outlined in these areas. An additional area of concern identified during this engagement is referenced below in *Potential Findings: Provider Services*.

Potential Findings: Provider Services

- *PSHP disclosed that provider complaints go to the compliance manager's work email box. This is an area of concern for oversight and access purposes.*

Quality Management and Performance Improvement

Overview of Quality Management and Performance Improvement

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

PSHP has programs and policies in place to ensure that their members receive the highest quality of care possible. These policies are in place to facilitate continued improvement in the member's health status; continued improvement in the quality of care, and improved member satisfaction. There are situations where improving the member's health status is not possible. These situations require the plan to take measures delay and/or prevent further deterioration of the member's health. Quality management and performance improvement policies and procedures, by directing member health care, a means by which the plan contains costs.

Observations: Quality Management and Performance Improvement

- *Member facing health coaches reach out to members to make them aware of the care gaps, while encouraging them to make appointments.*

- *Additional teams are located within provider's offices to help ensure calls are made to members and to make calls to members to schedule the appointments necessary to minimize or close the care gaps.*

- *PSHP's Quality Practice Advisors provide education and assist with any barriers that provider practices might have to closing care gaps.*
  - *There are 13 practice advisors stationed across Georgia in four regions.*
- *Member coaches make calls to members based on reports generated by the analytics team that allow them to see care gaps or any opportunities/issues that PSHP may to address.*
- *PSHP will work with the providers on educating them on appropriate medical documentations, coding, and how to upload missing documentation into the Peach State folder in order to sure up the gaps.*
- *Practice advisors are monitored and meeting the metric of 30 provider visits per month.*
- *PSHP has representatives in attendance to the monthly Quality Improvement Committee meeting; however, they are non-voting members.*
  - *PSHP also holds bi-monthly Quality Oversight Committee meetings.*
- *PSHP upper management utilizes reports broken down into different categories such as gender, age, etc. to gage performance based on National Committee for Quality Assurance thresholds.*
- *PSHP provides multiple dashboards for quality metrics monitoring and oversight.*
  - *Dashboards are updated monthly.*
- *PSHP has value added benefits that include monetary incentives for members and a provider incentive program called Partnership for Quality.*
- *Current Performance Improvement Plans include a prenatal program and a high risk obstetrics and gynecology program.*
  - *Post-partum intervention is an additional performance improvement project that tracks and communicates with new mothers regarding post-partum visits.*
- *PSHP partnered with Phoebe Putney Memorial Hospital to form Phoebe Mobile Wellness Clinics. These clinics provide:*
  - *In-person primary care and virtual specialty care.*
  - *Education on disease management, nutrition, and prevention.*
  - *Improved access to care.*
- *The team works with compliance to make sure the policies up to date, and an annual review is performed and sent to the compliance team.*

Assessment: Quality Management and Performance Improvement

Upon assessment of PSHP's policies and procedures for quality management and performance improvement, Myers and Stauffer did not identify complete policies or SOPs for contract Sections 4.12.12.1, 4.12.12.2, 4.12.12.3, 4.12.12.4, 4.12.12.5, 4.12.12.6, 4.12.12.7, 4.12.12.8, 4.12.12.9, 4.12.14.1, and 4.12.16.1. We recommend that PSHP, in accordance with their contract with DCH, create policies, SOPs and/or policy references to address the contract requirements outlined in these areas.

Regulatory Reporting and Monitoring

Overview of Regulatory Reporting Monitoring

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

As a result to this requirement, PSHP creates and submits ongoing and ad-hoc reporting for the activities mandated in the DCH contract. The reports created and subsequently submitted use required formats, including electronic formats, instructions, and timetables specified by DCH. Each regulatory report is assigned a business owner, and the business owner is responsible for ensuring the data within the report is accurate. The business owner submits the report to the Director of Compliance, Heather Dinapoli, who completes cursory review before submission to DCH. PSHP follows the timelines outlined in the contract; therefore, report submissions are weekly, monthly, quarterly, bi-annually, and annually.

Observations: Monitoring and Reporting

- *PSHP utilizes a compliance management system called Archer to track reports, business owners, and due dates for regulatory reports.*
- *There are six PSHP employees dedicated to generating reports and working with business units to gather data and compiling reports.*
- *Peach State Compliance can generate reports at any time.*
- *Approval for final reporting deliverables should be obtained a minimum of three calendar days before it is due to DCH.*
- *PSHP stated they will not submit a report with inaccurate data or other issues.*
    - *Prior to the due date, PSHP Compliance notifies the State of the issue and provides a new target date for submission with DCH approval.*
- *PSHP was issued CAPs for the following reports in June 2023:*
    - *Access and Availability Report.*

- *Encounter Data Report.*
- *Claims Processing Report.*
- *COB Update Report.*
- *These CAPs currently reflect a closed status.*

Assessment: Regulatory Reporting and Monitoring

Upon assessment of PSHP's policies and procedures for regulatory reporting and monitoring, Myers and Stauffer did not identify complete policies or SOPs for contract Sections 4.18.2.2.2, 4.18.2.2.3, 4.18.3.1, 4.18.3.2, 4.18.4.1, and 4.18.4.2. We recommend that PSHP, in accordance with their contract with DCH, create policies, SOPs and/or policy references to address the contract requirements outlined in these areas.

Utilization Management

Overview of Utilization Management

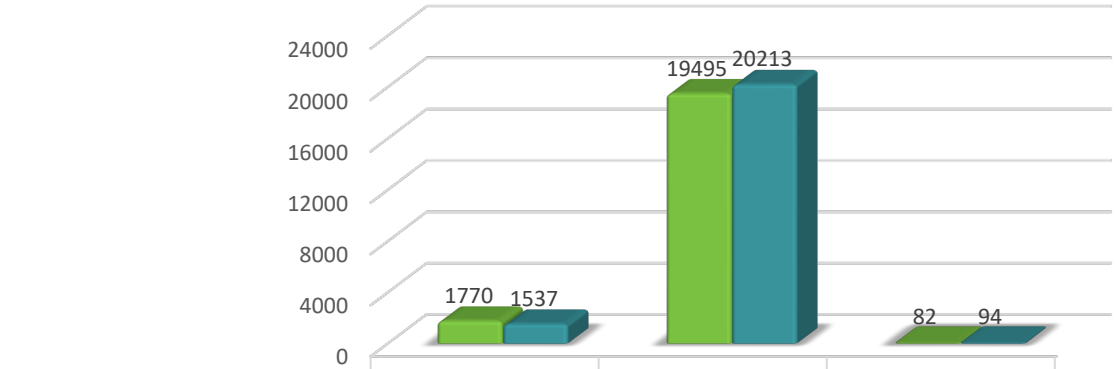
Section 4.11.1 of the contract requires PSHP to implement effective Utilization Management (UM) processes and procedures to ensure a high quality, clinically appropriate, highly efficient, and cost-effective health care delivery system. PSHP is required to provide ongoing evaluation of the cost and quality of medical services provided by providers and to identify potential over- and under-utilization of clinical services. Additionally, PSHP 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.

UM is the means by which PSHP maintains quality and the proper use of health care-related services to their members. All medical, dental, and BH services that require authorization for payment are evaluated for medical necessity, level of care, clinical appropriateness, and site appropriateness of healthcare services. PSHP UM policy ensures that all resources are being used appropriately while providing continuous quality care to PSHP members ensuring the wellbeing of all PSHP members.

Analyses: Utilization Management (Prior Authorizations)

PSHP prior authorizations are sorted into three categories. These three categories are Inpatient, Outpatient, and PRTF. In 2023 Q2 and Q3 the results were very similar with the majority of the authorizations being in the outpatient category. In Q2 PSHP had 19,945 authorizations in the outpatient category compared to 20,213 in Q3. For impatient authorizations, PSHP had 1770 in Q2 and saw a slight decrease to 1537 inpatient authorizations in Q3. PRTF authorizations PSHP saw a slight increase from Q2 to Q3 with the number of authorizations increasing from 82 to 94. The results for the number of requests for authorizations remained relatively similar from Q2 through Q3.

Figure 5: BH Authorizations Comparison of Q2 VS Q3 2023

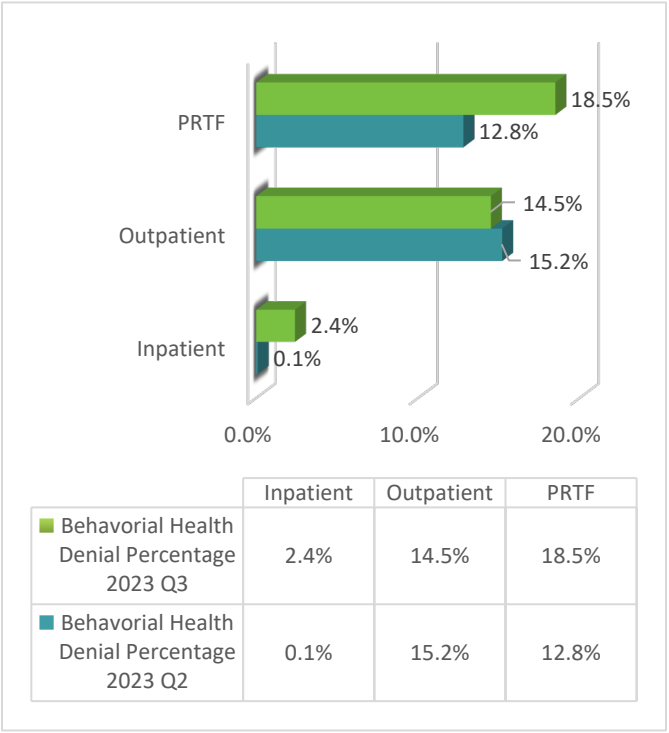


	Inpatient	Outpatient	PRTF
Behavorial Health Authourizations 2023 Q2	1770	19495	82
Behavorial Health Authourizations 2023 Q3	1537	20213	94

Authorization Status and Processing Time

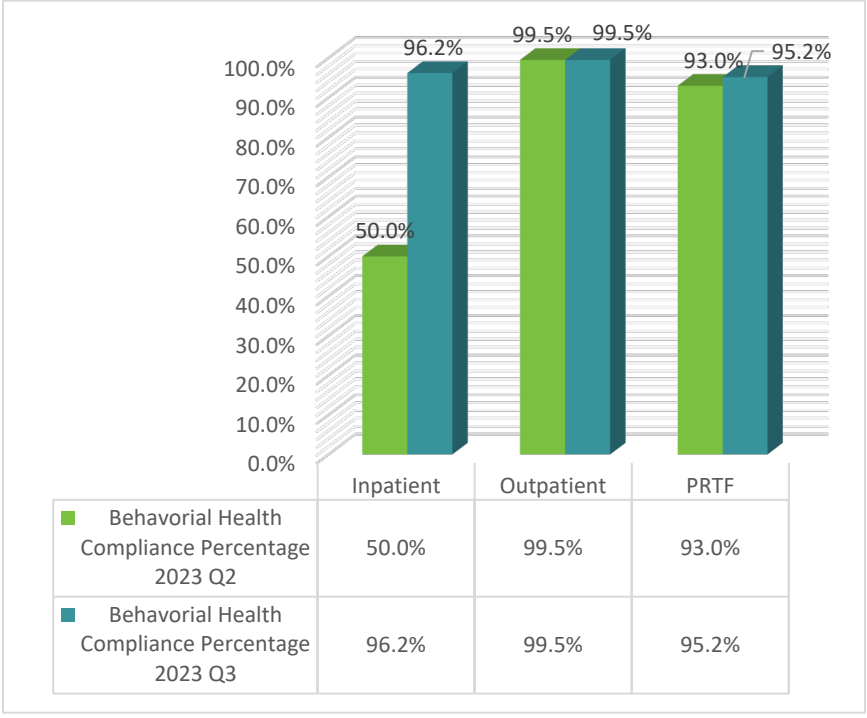
PSHP realized some variations in compliance percentage of their authorizations from Q2 to Q3. While Outpatient (99.5% for both quarters) and PRTF (12.8% for Q2 compared to 18.5% for Q3), Inpatient authorizations had a compliance percentage of 50% in Q2 of 2023, and a compliance percentage of 96.2% in the third quarter of 2023. The low compliance rates in Q2 were due to the public health emergency lasting until May. PSHP has retrained there staff in order to make sure issues like this do no reoccur. The denial percentage for PSHP authorizations did not vary much between the quarters. The denial percentages along with the percent of authorizations that meet compliance guidelines are listed on the graphs below.

Figure 6: Denial Percentage Q2 vs Q3 2023



	Inpatient	Outpatient	PRTF
Behavorial Health Denial Percentage 2023 Q3	2.4%	14.5%	18.5%
Behavorial Health Denial Percentage 2023 Q2	0.1%	15.2%	12.8%

Figure 7: Percent of Authorization in Compliance Q2 vs Q3

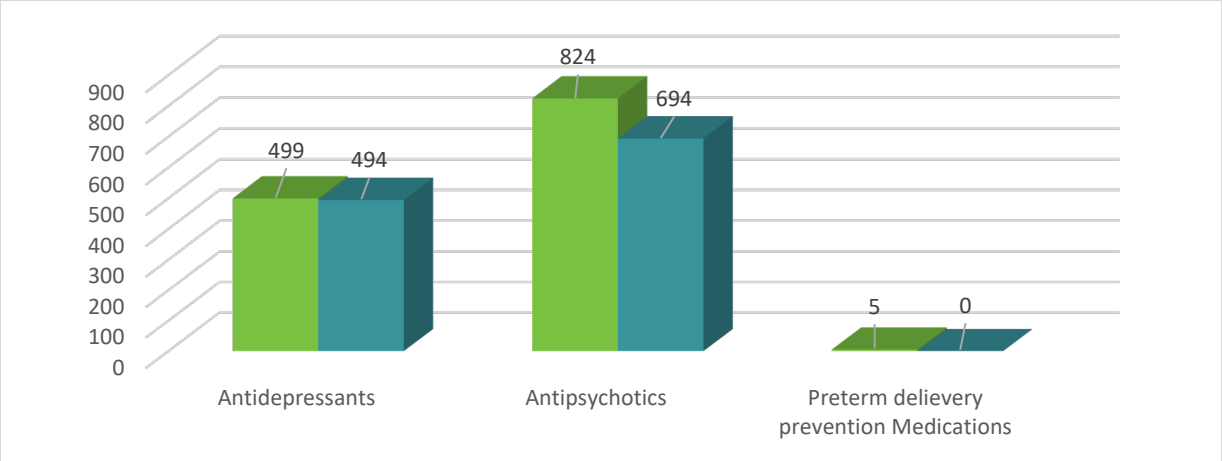


	Inpatient	Outpatient	PRTF
Behavorial Health Compliance Percentage 2023 Q2	50.0%	99.5%	93.0%
Behavorial Health Compliance Percentage 2023 Q3	96.2%	99.5%	95.2%

Pharmacy Authorizations by Category

Pharmacy authorizations requests were consistent through both 2023 Q2 and 2023 Q3. The most requested medicine was antipsychotics in both Q2 and Q3, with the second high requested medicine being antipsychotics and pre-term delivery prevention medications was third. In Q2, there were 499 authorization requests for antidepressants, and in Q3, there were 494 requests. In Q3, there were 824 authorization requests for antipsychotics, and 694 requests in Q3. Pre-term delivery prevention medications were requested five times in Q2 and zero times in Q3. PSHPs pre-term delivery prevention medications are no longer on the market after the FDA removed the approval for their medicine as of April 2023. The removal of this drug from the market explains why PSHP has no authorization requests for 2023 Q3.

Figure 8: Number of Pharmacy Authorizations by Category



Pharmacy Compliance and Denial Percentage

Pharmacy compliance percentages remained consistent across the board in Q2 through Q3 in 2023. There was almost zero change in the compliance rates on antidepressants going from 95.19% in Q2 to 96.15% in Q3. The compliance rate for antipsychotics was the exact same in Q2 and Q3 at 95.27%. The compliance rate for pre-term delivery prevention was 80% in Q2, and there were no authorization requests in Q3 due to PSHP pre-term delivery medications being removed from the market by the FDA. PSHP was very diligent with its expedited authorizations and trying to keep them under 25 hours. For antidepressants in Q2 only 24/499 of those authorization requests were over 25 hours and only 19/494 in Q3. Antipsychotics had 824 expedited authorization requests in Q2 and only 39 of those requests were over 25 hours and in Q3 only 29 out of 694 were over the 25 hour limit. PSHP has remained consistent in the pharmacy area when it comes to compliance and the percentage of claims that are being denied.

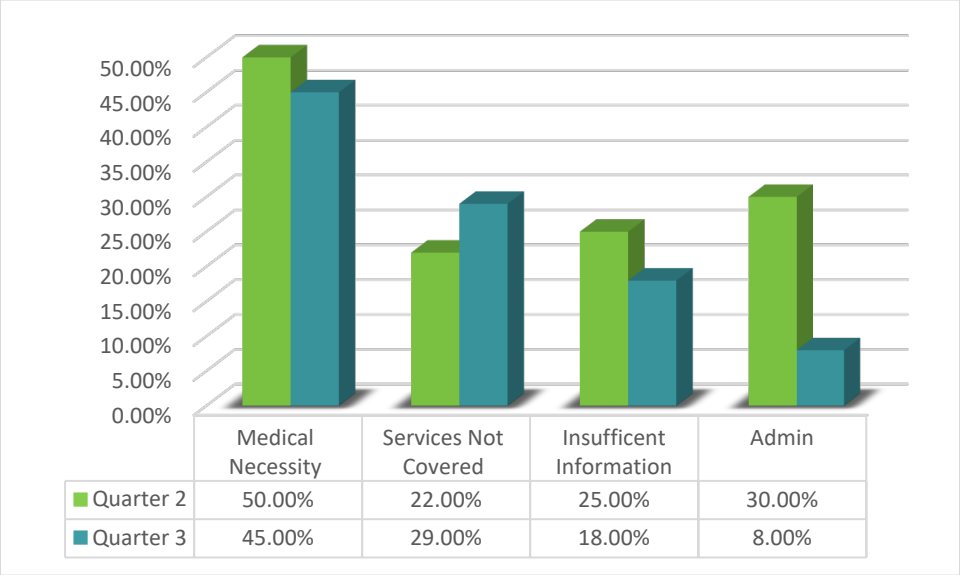
Table 5: Pharmacy Authorization Compliance/Denial Percentage by Drug Type

Category	Antidepressants	Antipsychotics	Pre-Term Delivery Prevention Medications
Pharmacy Denial Percentage 2023 Q2	39.08%	48.30%	0.00%
Pharmacy Denial Percentage 2023 Q3	39.68%	42.07%	0.00%
Pharmacy Compliance Percentage 2023 Q2	95.19%	95.27%	80.00%
Pharmacy Compliance Percentage 2023 Q3	96.15%	95.27%	N/a

Dental OB Authorizations and Compliance

Dental denials saw a slight increase from Q2 of 2023 to Q3 of 2023. The denial percentage rose from 26% to 34%. The denial reasons were roughly the same for both quarters. The leading cause for denial in Q2 and Q3 was medical necessity. The second leading cause for denial in Q2 was insufficient information while in Q3 it was services not covered. Dental denial percentages and the reasoning for denial remained consisted throughout Q2 and Q3 of 2023.

Figure 9: Dental OB Authorizations and Compliance



Observations: Utilization Management

- *All nurses for PSHP work exclusively in the Georgia market.*
- *PSHP has a team of 15 nurses and one supervisor managing the impatient members.*
- *PSHP assigns nurses to hospitals for continuity and they are in charge of processing the authorizations and ensuring the cases are being processed properly.*
- *The staff undergoes standard nurse training for clinical.*

- *The training is a four week virtual process, there is the standard training and time with the preceptor which is the team that they will be working with.*
- *After the four weeks they will shadow the nurse to learn all of the rules and other things that will help the staff learn to do there day to day assignments.*

- *Secondary reviews are conducted in the case of an authorization where the clinical information is not available, PSHP will send a request to the provider within 24 hours and will provide them with a date and time they need to send the information by.*
- *In order to ensure consistency across clinical reviewers, PSHP utilizes inner rater reliability (IRR); which is a measurement of agreement among two or more reviewers utilizing the same scale.*
- *PSHP has a UM committee that meets quarterly where policy updates, pharmacy trends, and UM metrics are discussed during this meeting.*
  - *The UM meetings do not include DCH.*
- *PSHP routinely reviews denied prior approvals to identify trends in the Georgia market.*
- *There is a weekly meeting with tele-performance discussing their metrics for the week prior.*

Assessment: Utilization Management

Upon assessment of PSHP's policies and procedures for utilization management, Myers and Stauffer did not identify complete policies or SOPs for contract Section 4.11.1.5.1.1. We recommend that PSHP, in accordance with their contract with DCH, create policies, SOPs and/or policy references to address the contract requirement outlined in this areas.

Our data analyses determined that PSHP's processing times for prior authorizations was in compliance with the DCH contract for the data sample analyzed.

Program Integrity Oversight

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

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

Overview of Program Integrity Oversight

Section 4.13.1.1 of the contract requires PSHP to maintain a PI program, including a mandatory compliance plan, designed to guard against fraud, waste, and abuse (FWA). This PI program shall include policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for confirmed and suspected cases of FWA in the administration and delivery of services under this contract.

PSHP maintains a PI program to address how they detect, report, prevent, and apply corrective action(s) to suspected cases of FWA in the provision of Medicaid services. PSHP's PI policies, procedures, and standards of conduct are documented and include corrective action of suspected cases of fraud and abuse as a means to ensure the integrity of their program. All PSHP officers, directors, managers and employees are required to know and understand the provisions of the Contractor's Fraud, Waste and Abuse Compliance plan. In compliance with the contract, PSHP maintains PI policy and procedures that support both the mandatory compliance program and the pharmacy lock-in program.

As mandated by the contract, PSHP designated a compliance officer who is accountable to PSHP's senior management and is responsible for maintaining policies establishing effective lines of communication between PSHP and DCH staff. Specific policies and procedures are in place to ensure DCH is informed of known or suspected fraud cases. Neither the plan nor the subcontractors are able to fully investigate or resolve suspected cases without the explicit permission of DCH.

During the Program Integrity interviews for pharmacy, Myers and Stauffer discussed expanded audits with Centene staff. The procedures for the expanded audits do not contain SLAs and/or TATs for completion. The addition of SLAs and/or TATs could increase the number of expanded audits within a given time period and potentially increase the rate of recoupment where credible FWA activities are identified.

Observations: Program Integrity

- *PSHP established and maintains a Program Integrity and Investigations Committee.*

- *PSHP and the Vendor Oversight team at Centene are both responsible for overseeing subcontractor PI activities.*
- *PSHP's Envolve Dental and Vision Subcontractors utilize the same FWA policies that Centene/PSHP utilize and are reviewed annually by both PSHP and the Subcontractors.*
- *The CPS Team utilizes their own policies, which are available for view by PSHP staff within the Archer system*
- *Any subcontractor delegated to make initial medical necessity determinations also has the capability to review clinical records as part of their delegated PI responsibilities.*
- *Program Integrity has a department-wide SLA for 365 days (155 days from approval to collect for Georgia).*
- *PSHP participates in monthly meetings led by DCH and including all CMOs.*
    - *Statuses and other information is shared including discussions of new and existing cases.*
- *PSHP does not dictate a FWA case volume threshold to subcontractors.*
    - *Subcontractors are expected to continuously analyze data and identify aberrant billing trends for investigation.*
- *All subcontractors are subject to an annual oversight review by Centene's Third-Party Risk Management Office performs.*
- *Subcontractors also submit quarterly reports that are consolidated into the PSHP Regulatory Report that is filed to DCH. Both of these reports are used to ensure FWA activity is being conducted, as well as giving PSHP insight into all cases in process at the subcontractor to ensure timeliness and submission for State approval has been obtained.*

Policy Assessment: Program Integrity

Myers and Stauffer evaluated PSHP's policies and procedures, documentation, and interview responses for program integrity and determined their compliance with the DCH contract.

Potential Findings: Program Integrity

- *Per discussion with Centene regarding PI within pharmacy operations, it appears there are no SLAs for case review or for CVS completing expanded audits (e.g., 155 days).*

Fraud, Waste, and Abuse Reporting

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

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

Myers and Stauffer examined four quarterly Fraud and Abuse Reports submitted by PSHP for the first quarter of calendar year 2023 through the fourth quarter of calendar year 2023. These reports comprised 201 FWA cases. We assessed the history of these cases in terms of the CMO's Special Investigative Unit (SIU) productivity, case mix, case outcomes, completeness, and consistency of reporting.

SIU Productivity

During the study period (January 2023 through December 2023), PSHP began with a backlog of 104 FWA cases, opened 97 additional cases, closed 81 cases, and ended with a backlog of 120 FWA cases. It appears the FWA case backlog increased steadily during the twelve months of the study period. The typical TAT (from open to close) for all cases closed during the study period was approximately 17 months.

Refer to Figure 10 and *Figure 11* for a visual depiction of SIU productivity during the study period.

Figure 10: Number of FWA Cases Opened and Closed During Each Month

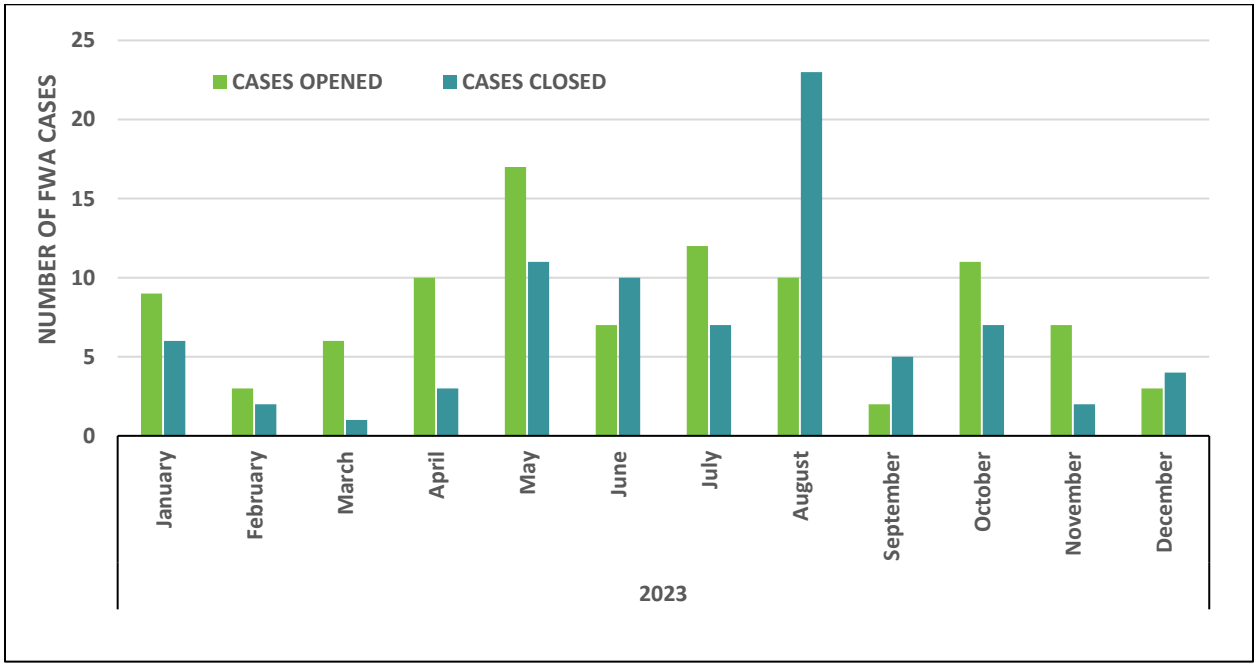
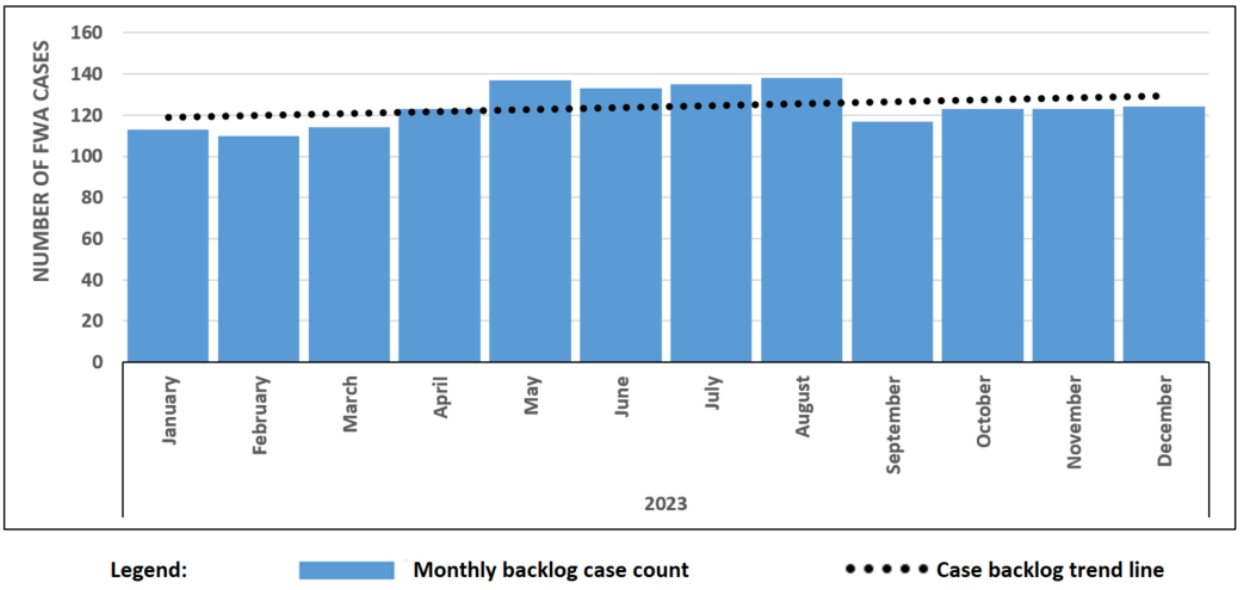


Figure 11: Number of Backlogged FWA Cases by Month



Additionally, it appeared that there was a delay in reporting some new cases, as they did not appear until after the report period of the case's date of complaint. Of the 97 new cases during the study period, 7 cases were not reported until after the report period in which the date of complaint occurred. We could not verify when investigation of these cases actually began and are unable to determine if

these reporting delays indicate a delay in the start of investigation of the case. *Table 6* indicates the reporting delay appeared to increase during the study period.

Table 6: FWA Case Reporting Delays

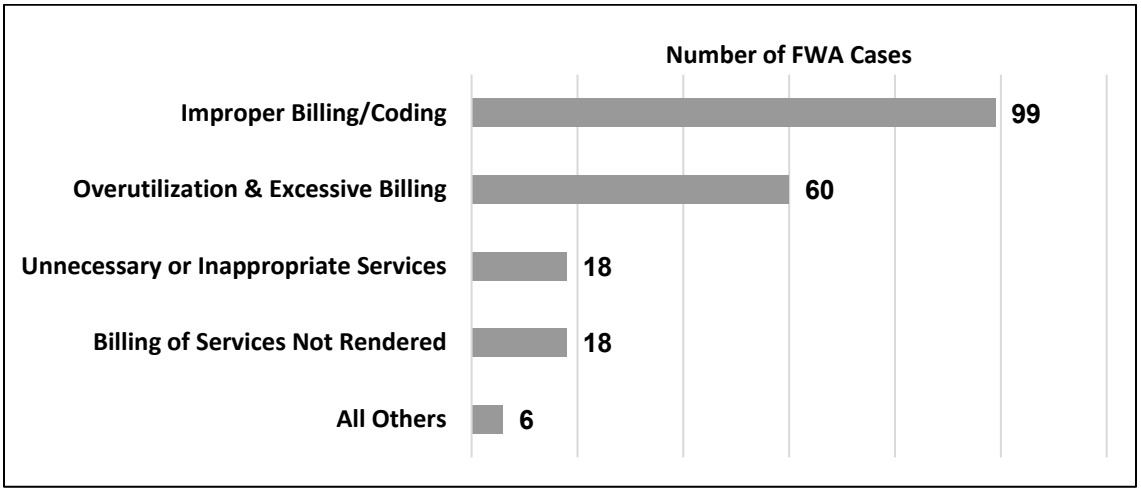
Number of FWA Cases with Reporting Delays					
Report Period	**< 31 Days**	**31 – 60 Days**	**61 – 90 days**	**> 90 Days**	**Total**
CY 2023 Q1					0
CY 2023 Q2	1				1
CY 2023 Q3	2	2	2		6
CY 2023 Q4					0
Total	**3**	**2**	**2**	**0**	**7**

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

FWA Case Mix

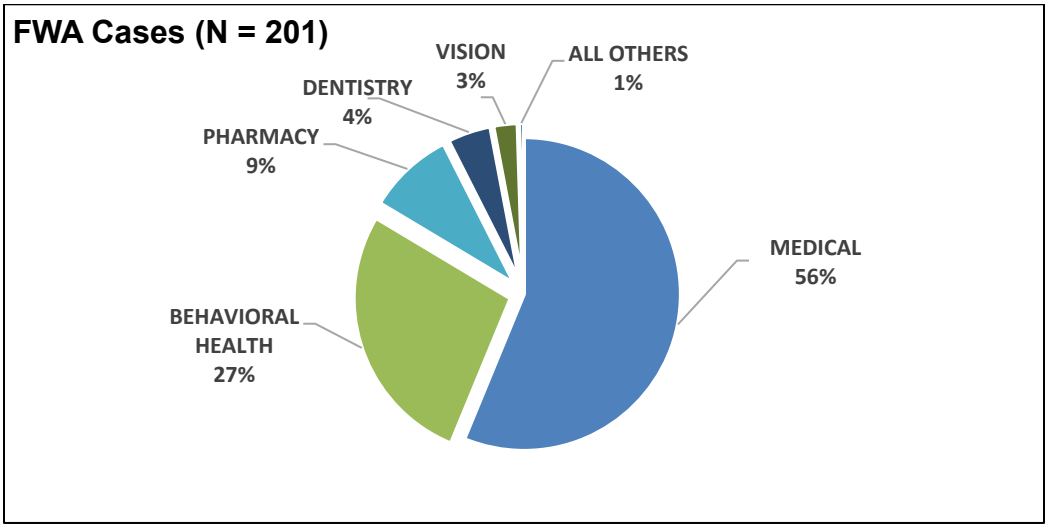
Myers and Stauffer examined the FWA case mix within the 201 active cases during the study period in terms of the alleged FWA schemes and the types of providers, individuals, and entities involved. Based on the nature of the complaint stated in the FWA quarterly reports, and ranked by the most to least frequent, the two most common identified schemes were improper billing and coding, and overutilization and excessive billing.

Figure 12: Nature of Complaints Documented for FWA Cases



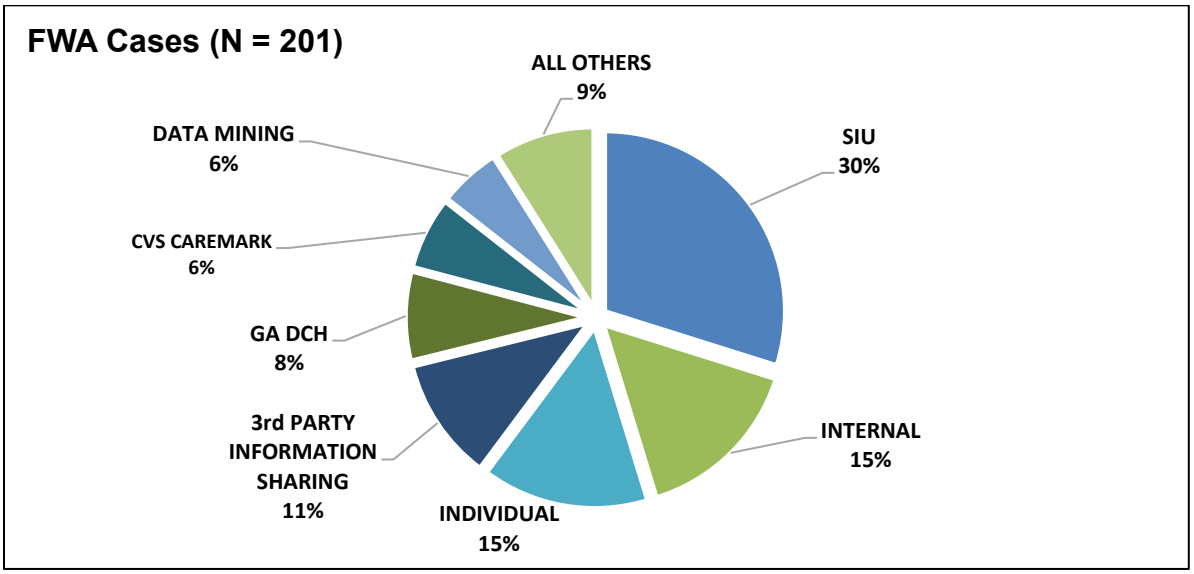
No member fraud cases appeared in FWA reports during the study period. The most common types of providers alleged to be engaging in FWA were medical, BH, and pharmacy providers, as shown in *Figure 13*.

Figure 13: Provider Types Involved in FWA Cases



The FWA cases reported during this twelve month period were sourced from multiple entities. The most common complaint sources being the SIU, individuals, and internal PSHP sources as shown in *Figure 14*. The "Individuals" category is comprised of names with no clear affiliation to another party in the source of complaint data.

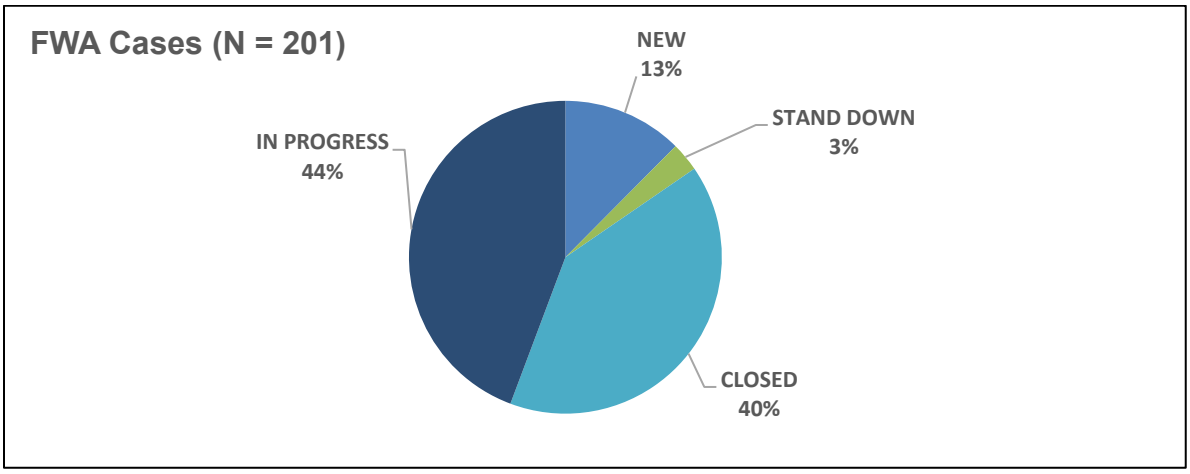
Figure 14: FWA Source of Complaint



FWA Case Outcomes

Myers and Stauffer examined the actions and outcomes PSHP reported for the 201 FWA cases active during the study period. We categorized each case's final status as new, stand down, ongoing, or closed as shown in *Figure 15*.

Figure 15: Final Status of FWA Cases



Actions taken by PSHP SIU as observed in the case records submitted included: education; prepay review; overpayment determination; recoupment; auto-denial of provider claims; suspension; and notification to the provider of termination without cause. Of the 81 FWA cases closed during the study period (January 2023 through December 2023), only one case did not have any disciplinary action reported. Out of the remaining 80 closed cases, 67 had multiple actions reported per case throughout the study period. The most common combination of disciplinary action was overpayment determination followed by education, recoupment, and prepay review.

Figure 16: Actions Taken Towards Closed FWA Cases by Number of Cases

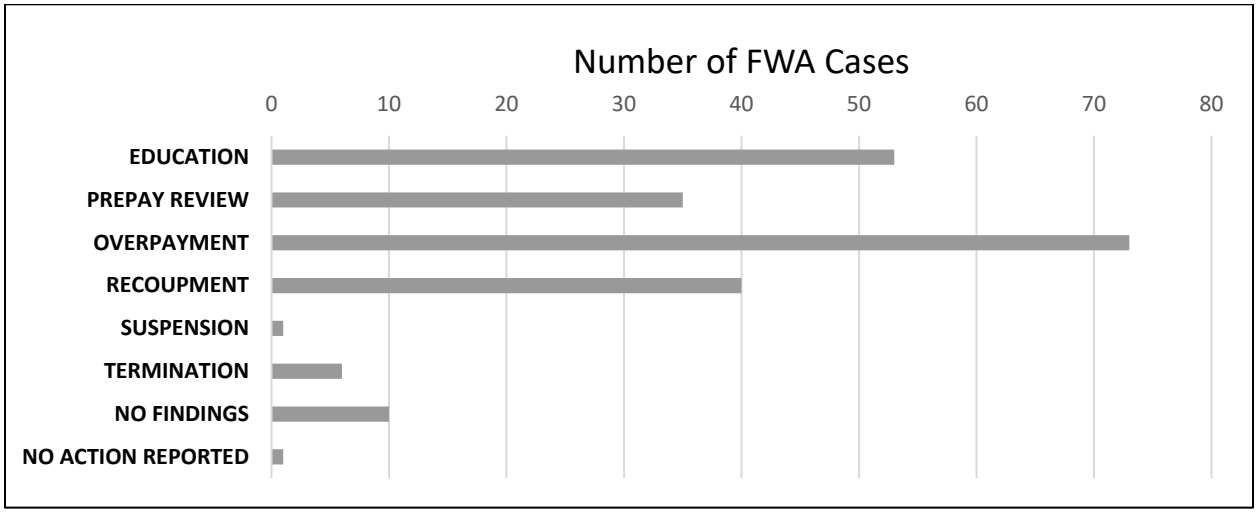
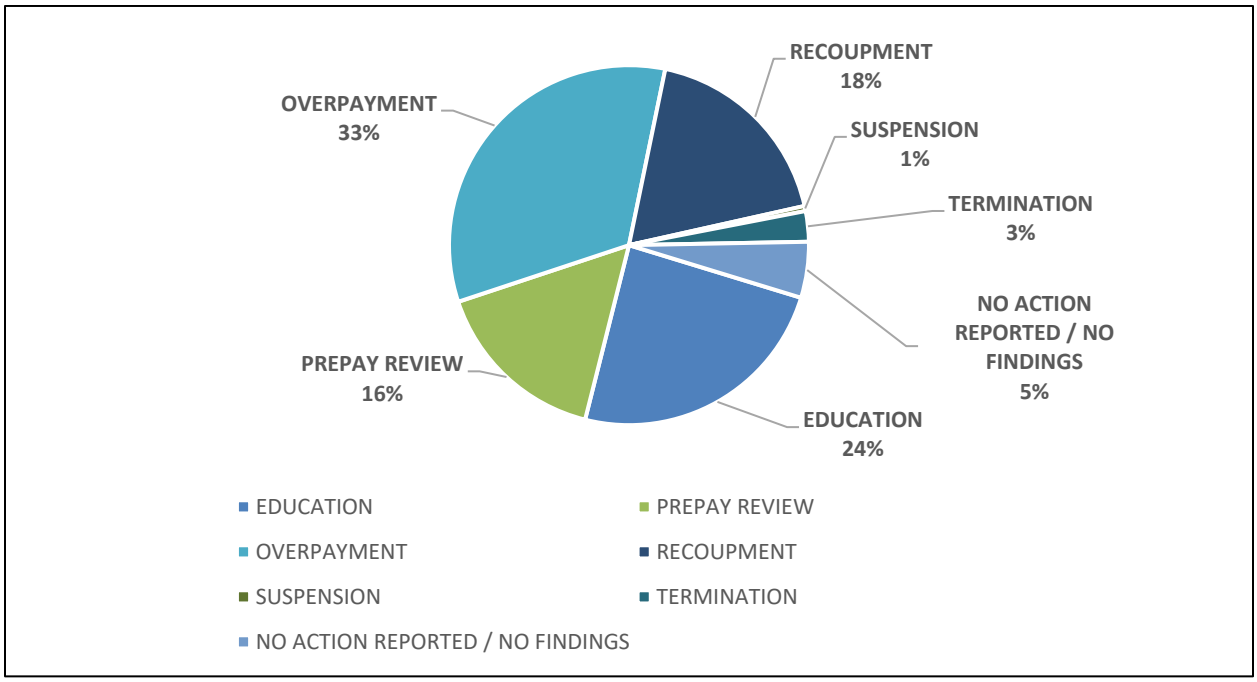


Figure 17: Actions Taken Towards Closed FWA Cases by Percentage of Total Actions



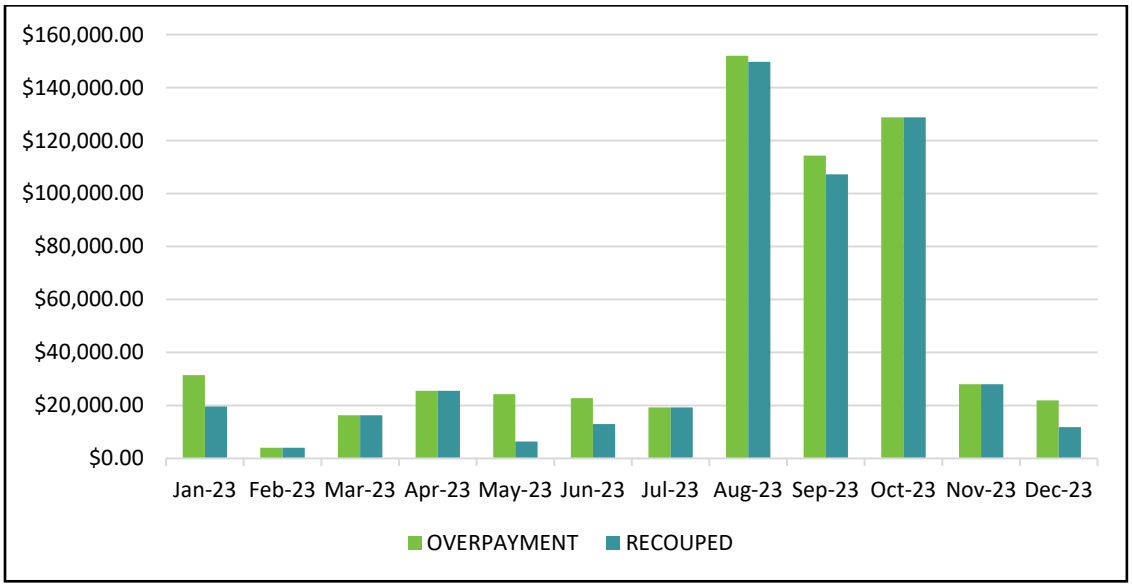
PSHP SIU reported an estimate of dollars involved for only one case, and was not consistent in reporting the overpayment and recoupment dollar amounts. The overpayment amounts were recorded for 50 closed cases, and recoupment amounts were recorded for 44 of these closed cases. The total amount recouped during the twelve month study period was approximately $529,000 as shown in *Table 7*.

Table 7: Approximate Dollar Amounts Documented in Quarterly Reports

FWA Financial Outcomes – Approximate Dollar Amounts Documented in Quarterly Reports						
Final Case Status	**Estimate of Dollar Amounts**		**Overpayment Determination**		**Recoupment**	
Closed	0 cases	n/a	50 cases	$588,000	44 cases	$529,000
In Progress	1 case	$514,000	0 cases	n/a	0 cases	n/a
New	0 cases	n/a	0 cases	n/a	0 cases	n/a
Stand-Down	0 cases	n/a	0 cases	n/a	0 cases	n/a
Totals	**1 case**	**$514,000**	**50 cases**	**$588,000**	**44 cases**	**$529,000**

During the 12-month study period August 2023, September 2023, and October 2023 had the largest recoupment totals. These three months had a combined recoupment amount of approximately $385,000 and an average recoupment rate of 97.4%. May 2023 and December 2023 had the lowest recoupment rates at 26.3% and 54.1% respectively.

Figure 18: Overpayment and Recoupment Values of Closed Cases



Subcontractor Oversight

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

In the contract between DCH and the CMO, Sections 18.1.1 and 18.1.3 through 18.1.6 outline the use of subcontractors in the Georgia Families® program. The CMO is required to conduct ongoing monitoring of each subcontractor's performance and perform scheduled periodic reviews. PSHP's subcontractors with their corresponding delegated functions are represented in *Table 8* below.

Table 8: CPS and Subcontractor Functions

CPS and Subcontractor Functions				
Delegated Function	**CPS**	**CVS Health (PBM)**	**Envolve (Dental)**	**Envolve (Vision)**
Claims Adjudication	X	X	X	X
Credentialing	X	X	X	X
Call Center Operations		X	X	X
Delegation Oversight	X			
Prior Authorization	X	X		
Program Integrity	X	X	X	X
Provider Complaints and Appeals		X	X	X
Provider Network Management		X	X	X
Quality Management			X	X
Utilization Management			X	X

Observations: Subcontractor Oversight

- *Performance metrics are typically monthly and quarterly reports, and come through the vendor mailbox.*
- *Pre-delegation oversight includes a due-diligence questionnaire, in depth examinations of functional areas. Corporate will issue a summary of the pre-delegation and communicate any market specific findings.*
- *Annual audits are performed by corporate on the national vendors. Review findings in Archer and receives a risk report.*
- *Decisions to select a vendor are a combined function of the corporate office and the local plan.*

Policy Assessment: Subcontractor Oversight

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. Any potential subcontractor issues identified will be referenced in the Potential Findings section of each subcontractor's assessment

Potential Findings: Subcontractor Oversight

- *Based on interview responses, we determined that PSHP doesn't appear to have a means validate vendor metrics.*

CVS Health

Overview of CVS Health

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

CVS is the PBM selected by PSHP to provide pharmacy services to its members. CPS helps with the management of the Pharmacy Network to ensure CVS meets the access standards outlined in the contract. The specific activities and responsibilities delegated to CVS Health are outlined in their contract with PSHP.

Observations: CVS Health

- *CVS sends out annual provider contracts; many providers reach out to the contracting team for negotiation.*
- *Re-credentialing is performed on an annual basis by CVS to ensure the provider network information is up-to-date.*
- *Inbound claims to CVS do not pend, yet they process in real time.*
- *CVS' inbound claims adjudicate with a final status of either paid or rejected*
- *CVS conducts site audits, in which they will audit the claims at the pharmacy and give the pharmacy the results. The pharmacy has the right to appeal the results if they do believe the results are correct.*
    - *All audits are scheduled, usually the pharmacies are given a 2 week notice ahead of time.*
- *CVS can initiate and expand the extent of an audit based on the results of their data mining.*
- *Centene receives the results of audits in the form of a summary and are notified if CVS is going to recoup any money.*

- *CVS does not do FWA, investigations, they do the audits on the compliance of the contract.*
- *CVS does not conduct prepayment reviews.*
- *CVS has agents that support member calls while a subset of agents support the pharmacy help desk.*
- *There are no outbound calls from the call center for pharmacy, helpdesk and member.*
- *The quality teams and supervisors will randomly select calls for each CCR that they support.*
    - *Two to four calls are selected per month to be reviewed, and more may be selected if deemed necessary.*
- *CVS has the ability to monitor live calls if needed.*
- *Centene is receiving call center metrics from CVS.*
    - *There is a weekly meeting in place between CVS and Centene to discuss call center metrics.*

Assessment: CVS Caremark Inc.

Myers and Stauffer evaluated CVS' policies and procedures, documentation, and interview responses for pharmacy services and determined their compliance with the DCH contract.

Envolve Dental

Overview of Envolve Dental

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

Observations: Envolve Dental

- *Envolve Dental provides UM; claims adjudication; program integrity; provider service call center provider network; quality management (complaints and grievances); and provider credentialing/re-credentialing services for PSHP.*
- *Cases with high dollar items and critical care issues will be prioritized first by the Program Integrity department.*

- *PI recoveries are tracked and reported within Health Care Fraud Shield and a monthly report is sent to Peach State that lists recovery information.*
- *In the month of October 2023, there were 10,433 dental authorizations submitted.*
    - *7,176 or 70% of these authorizations were approved.*
    - *3,169 or 30% of these authorizations were denied.*
    - *.003% of these authorizations were prioritized as expedited.*
    - *99.7% of these authorizations were prioritized as standard.*
- *Envolve Dental maintains a provider contact center, where representatives respond to provider inquires.*
    - *They have call centers stationed in North Carolina and Arizona and remote representatives who work from their homes.*
- *Envolve Dental contact center hours of operation are 7:00 AM to 8:00 PM. After hours calls are handled by the automated system available 24 hours a day and seven days a week.*
    - *Providers can leave voice messages and receive return calls within 24 hours of leaving the message.*

Assessment: Envolve Dental

Myers and Stauffer evaluated Envolve Dental's policies and procedures, documentation, and interview responses for dental services and determined their compliance with the DCH contract.

Overview of Envolve Vision

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

Observations: Envolve Vision

- *Envolve vision provides utilization management; claims adjudication; program integrity; provider service call center; provider services; quality management (complaints and grievances); and provider credentialing services for PSHP.*
- *Policies and procedures are reviewed annually and tracked in the Archer System.*
- *Calls from the provider call center come in through IVR system which routes calls to first available agent.*
- *93% score is the benchmark for passing quality controls.*

- *Appeals and complaints are monitored separately.*
- *Envolve Vision had four provider claim appeals for the calendar year of 2023.*
    - *Each of the provider appeals has been researched and closed.*
    - *One appeal was overturned and the claim was processed and paid, while the remaining three appeals were upheld due to missing the 30 calendar day submission deadline for appeals.*
- *There were no vision provider complaints for calendar year 2023.*
- *Call center hours of operation:*
    - *7:00 a.m. to 8:00 p.m.*
    - *24/7/365 the automated system is available with the capacity to record voicemail.*
- *Call Center staff are not required to answer a specific number of calls each day.*
    - *The average monthly call volume is approximately 1,200.*
    - *On average, each agent answers about 20 calls per month for Georgia Medicaid.*

Assessment: Envolve Vision

Myers and Stauffer evaluated Envolve Vision's policies and procedures, documentation, and interview responses for vision services and determined their compliance with the DCH contract.

Encounter Submissions and Payment Systems

Approach and Methodology

Overview

Myers and Stauffer's examination of PSHP'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 its 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 claims adjudicated under its purview, regardless of their outcome. Encounters are records of these adjudications, and each CMO is contractually required to submit complete, accurate, and timely encounters, including any subcontractor paid encounters, to the Medicaid Management Information System (MMIS), and to address curing encounters that have been rejected by the MMIS. Failure to do so impacts the State's analysis, decision making, rate setting, and regulatory reporting.

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

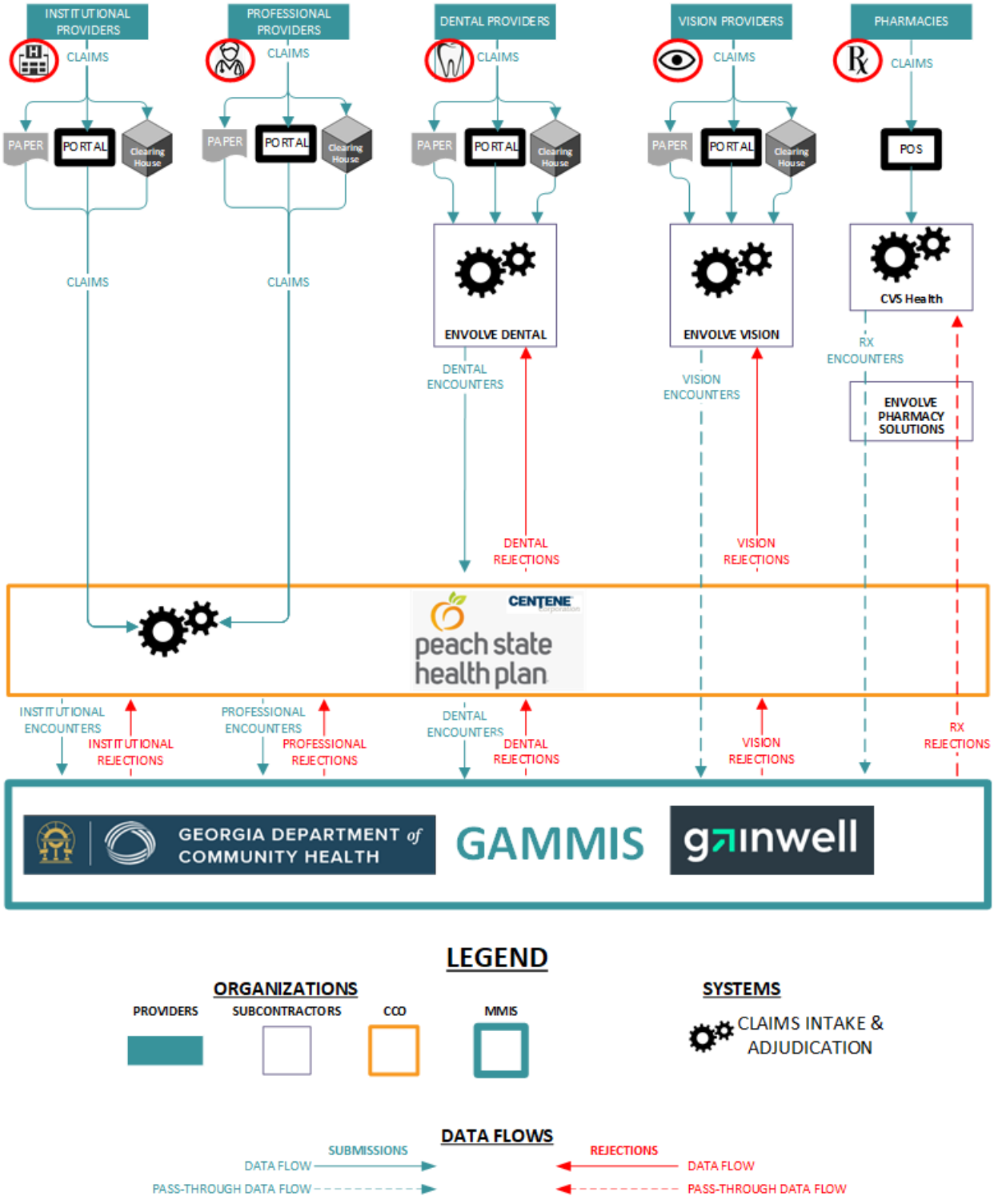
The analysis was limited to claims and encounters for member populations covered by PSHP having a service date during April 2023 or a paid date in May 2023. The CMO and its subcontractors were requested to provide all claims satisfying this criteria regardless of outcome (paid, denied, rejected) or version (original, adjusted, voided, replaced, final.)

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

Myers and Stauffer mapped the claim/encounter data flow from subcontractor to the CMO and into the MMIS by linking related claim lines at the different processing points in the claim life cycle. Claim lines were linked using a combination of unique data fields available and populated. Care was taken to differentiate between multiple versions and adjustments of each claim.

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

Figure 19: Claims and Encounters Data Flow Diagram



Claims/Encounters Completeness

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

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

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

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

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

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

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

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

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

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

Encounter Submission Accuracy

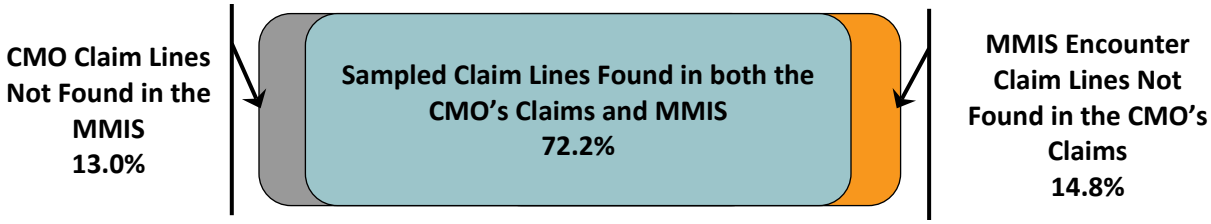
Myers and Stauffer compared data elements in the CMO and subcontractor claims to related encounter data within the claim/encounter life cycle to determine if the information in the originating system ultimately matched the information reported in the MMIS. We evaluated and documented differences in claim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

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

Encounter Submission Completeness

Myers and Stauffer inspected approximately 5.2 million claim lines adjudicated by PSHP 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	
72.2%†	**Percentage of sampled lines appearing in both the CMO's claims and the State's MMIS encounters.**
13.0%	**Percentage of sampled lines appearing only in the CMO's claims.**
	• ***Denied (7.9%)*** *– A claim line denied for payment by the CMO during their claim adjudication process due to authorization, eligibility, limits issues, or other reasons.* • ***Alternative Found (4.2%)*** *– Claim lines that did not appear to exist as encounters for which a different version or adjustment was found.* • ***Other (0.9%)*** *– A claim line with insufficient information available to explain their absence as an encounter.*
14.8%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**
	• ***Alternative Found (14.2%)*** *– Encounter lines that did not appear to exist as claim lines for which a different version or adjustment was found.* • ***Denied (0.6%)*** *– An encounter line denied for payment by the CMO during their claim adjudication process due to authorization, eligibility, limits issues, or other reasons.* • ***Other (0.1%)*** *– An encounter line with insufficient information available to explain its absence from the subcontractor's claims.*

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

CMO's claims not found in the MMIS encounters:

- ***Denied.*** *Approximately 412,400 (7.9%) PSHP FFS claim lines appeared to be denied in the CMO's claims but did not appear to exist in the MMIS. It appears that PSHP may not be submitting all denied claim lines to the MMIS.*
- ***Alternative Found.*** *Approximately 217,800 (4.2%) PSHP FFS claim lines in the CMO's claims did not appear to exist in the MMIS; however, an alternate version or adjustment of the claim line*

was found in the MMIS. Many of these claim lines (approximately 134,400; 2.6%) appeared to have alternate versions with matching line payment amounts when compared to the associated version identified in the MMIS. Approximately 42,800 (0.8%) additional claim lines appeared to have been adjudicated within seven days of the associated version identified in the MMIS. These claim lines may have been adjusted within the CMO's weekly cycle for encounter submissions and PSHP may have only submitted the most recent claim adjustment to the MMIS.

- ***Other.*** *Approximately 49,400 (0.9%) PSHP FFS claim lines in the CMO's claims did not appear to exist as encounter claim lines in the MMIS. A portion of these claim lines (approximately 20,200; 0.4%) were flagged as rejected by the MMIS, implying encounter submission was attempted but unsuccessful. There was no additional information present to explain the absence of these claim lines from the MMIS.*

MMIS encounters not found in the CMO's claims:

- ***Alternative found.*** *Approximately 738,200 (14.2%) PSHP FFS claim lines in the MMIS did not appear to exist in the subcontractor's claims; however, an alternate version or adjustment of the claim line was found in the CMO's claims. The majority of these claim lines (approximately 733,700; 14.1%) appeared to have alternate versions with matching line payment amounts and matching paid dates compared to the associated version identified in the CMO's claims.*
- ***Denied.*** *Approximately 30,300 (0.6%) PSHP FFS claim lines in the MMIS appeared to be denied but did not appear to exist in the CMO's claims.*

Encounter Submission Accuracy

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

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

- ***Date Claim Submitted to PSHP 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.*
- ***International Classification of Diseases (ICD) Diagnosis Codes*** *(Institutional and Professional Encounters). The majority of diagnosis codes billed on the PSHP extracts appeared to be reported in the detail lines in the MMIS encounters; however, the ordering of diagnosis codes in the MMIS encounters may not always match the ordering of diagnosis codes as reported in the PSHP extracts.*

- ***Payee Provider Tax ID*** *(Professional Encounters Only). Approximately 11.9% of professional claim lines in the PSHP encounters appeared to have payee provider tax IDs that were derived from the claim's rendering provider. They may not accurately reflect the claim payee/billing provider submitted on the claim itself.*
- ***Rendering Provider NPI*** *(Institutional Encounters Only). For approximately 11.3% of institutional claim lines in the PSHP encounters, the rendering provider's NPI did not match the value found in the claims extracts submitted by PSHP.*
- ***Referring Provider NPI*** *(Institutional Encounters Only). The referring provider NPI did not appear to be reported in the MMIS for PSHP institutional encounters.*
- ***Last Date of Service, Claim Header*** *(Institutional Encounters Only). For approximately 1.5% of institutional claim lines in the PSHP encounters, the claim header's last date of service did not match the value found in the claims extracts submitted by PSHP. Rather, the claim header's last date of service in the encounters appeared to be derived from the claim discharge date.*
- ***Discharge Date*** *(Institutional Encounters Only). For approximately 1.0% of institutional claim lines in the PSHP encounters, the discharge date did not match the value found in the claims extracts submitted by PSHP. 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.*
- ***Units Billed*** *(Institutional and Professional Encounters). For approximately 5.9% of detail lines in the PSHP encounters, the units billed appeared to be reported as zero and did not match the value found in the claims extracts submitted by PSHP.*
- ***NDC*** *(Professional Encounters Only). The NDC did not appear to be reported in the MMIS for PSHP professional encounters.*
- ***Procedure Code Modifier 1*** *(Institutional Encounters Only). Approximately 1.3% of institutional claim lines in the PSHP encounters had potentially invalid procedure code modifier values ("XX" or "XY"). The corresponding procedure code modifier values in the PSHP claim extracts were blank.*

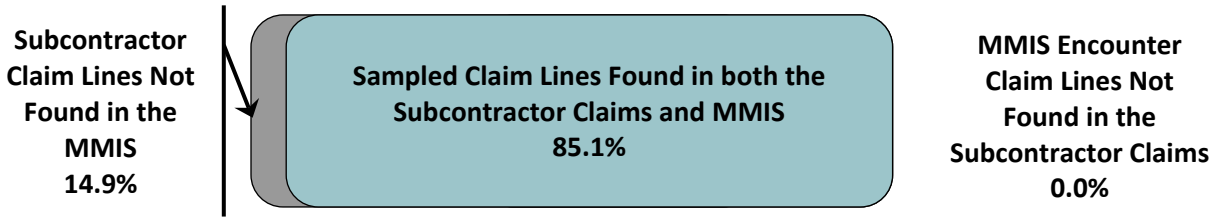
Exhibit II comprises additional detail concerning the accuracy of all data elements inspected for institutional encounters (*Table 19*) and professional encounters (*Table 20*).

Dental Claims – Envolve Dental

Encounter Submission Completeness

Myers and Stauffer examined approximately 682,100 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	
85.1%†	**Percentage of sampled lines appearing in both the subcontractor's claims and the State's MMIS encounters.**
14.9%	**Percentage of sampled lines appearing only in the subcontractor's claims.**
	• ***Denied (12.7%)*** *– 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 (2.2%)*** *– Claim lines that did not appear to exist as encounters for which a different version or adjustment was found.* • ***Other (0.1%)*** *– A claim line with insufficient information available to explain its absence as an encounter.*
0.0%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**
	All claim lines were found in the claims extracts, or in the claims extracts and the MMIS encounters.

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

Envolve Dental claims not found in the MMIS encounters:

- ***Denied****. Approximately 86,300 (12.7%) Envolve Dental claim lines appeared to be denied in the subcontractor's claims but did not appear to exist in the MMIS. It appears that PSHP may not be submitting all denied dental claim lines to the MMIS.*
- ***Alternative Found****. Approximately 14,600 (2.2%) 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. Approximately 1,600 (0.2%) of these claim lines appeared to have alternate versions with matching line payment amounts when compared*

to the associated version identified in the MMIS. Approximately 4,700 (0.7%) additional claim lines appeared to have been adjudicated within seven days of the associated version identified in the MMIS. These claim lines may have been adjusted within the subcontractor's weekly cycle for encounter submissions and PSHP may have only submitted the most recent claim adjustment to the MMIS.

Encounter Submission Accuracy

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

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

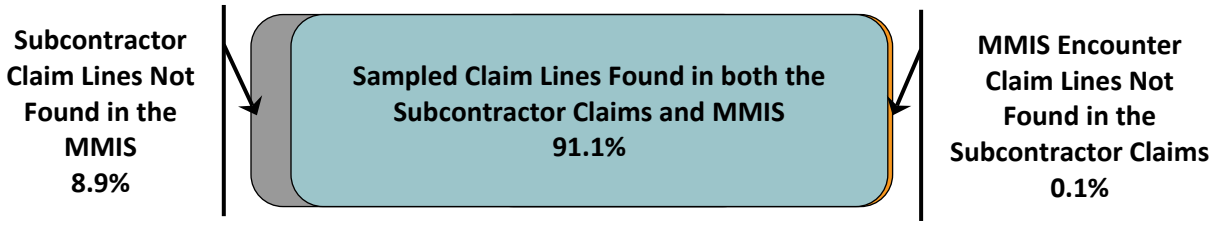
- ***Date Claim Submitted to Envolve Dental by the Provider.*** *The claim receipt date in the MMIS encounters appeared to have been consistently misreported as the same as the claim's paid date.*
- ***Interest Paid.*** *We normally expect interest paid amounts to be identified with an adjustment reason code. No identifiable interest amounts were observed to exist in the MMIS dental encounters for Envolve Dental.*
- ***Payee Provider Tax ID.*** *Approximately 7.3% 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 claim payee/billing provider submitted on the claim itself.*
- ***Rendering Provider NPI.*** *For approximately 2.5% of the detail lines in the Envolve Dental encounters the rendering provider's NPI did not match the value found in the claims extracts submitted by Envolve Dental.*
- ***Referring Provider NPI.*** *The referring provider NPI did not appear to be reported in the MMIS for Envolve Dental encounters.*
- ***Units Billed.*** *The units billed appeared to be reported as zero in the MMIS for all Envolve Dental encounters and did not match the values found in the claims extracts submitted by Envolve Dental.*

Exhibit II, Table 21 comprises additional detail concerning the accuracy of all dental data elements inspected.

Vision Claims – Envolve Vision

Encounter Submission Completeness

Myers and Stauffer examined approximately 85,300 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	
91.1%†	**Percentage of sampled lines appearing in both the subcontractor's claims and the State's MMIS encounters.**
8.9%	**Percentage of sampled lines appearing only in the subcontractor's claims.**
	• ***Denied (6.8%)*** *– 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 (1.5%)*** *– 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 greater than 0% but less than 0.1% are rounded up to 0.1%. Percentages greater than 99.9% but less than 100% are rounded down to 99.9%. Due to rounding, percentages may not always add to 100%.

Envolve Vision claims not found in the MMIS encounters:

- ***Denied***. *Approximately 5,800 (6.8%) Envolve Vision claim lines appeared to be denied in the subcontractor's claims but did not appear to exist in the MMIS. It appears that Envolve Vision may not be submitting all denied dental claim lines to the MMIS.*
- ***Alternative Found.*** *Approximately 1,290 (1.5%) 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 660 (0.8%) claim lines appeared to have been adjudicated within seven days of the associated version identified in the MMIS. These claim lines may have been adjusted within the subcontractor's weekly cycle for encounter submissions and Envolve Vision may have only submitted the most recent claim adjustment to the MMIS.*
- ***Other.*** *Approximately 480 (0.6%) Envolve Vision claim lines in the subcontractor's claims did not appear to exist as encounter claim lines in the MMIS. There was no additional information present to explain the absence of these claim lines from the MMIS.*

Encounter Submission Accuracy

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

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

- ***Date Claim Submitted to 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.*
- ***Payee Provider Tax ID.*** *Approximately 10.6% 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 claim payee/billing provider submitted on the claim itself.*

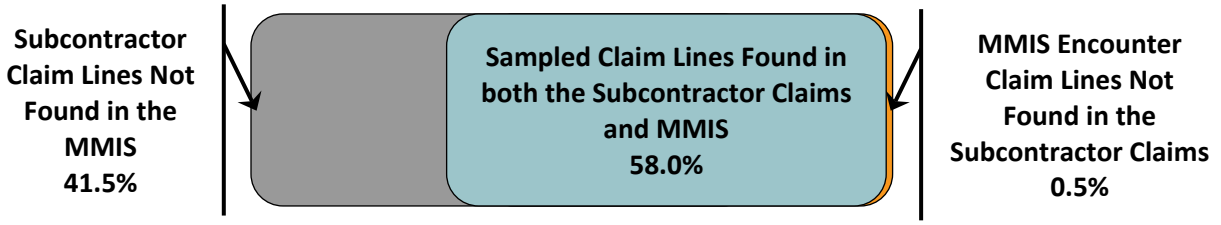
Exhibit II, Table 22 comprises additional detail concerning the accuracy of all vision data elements inspected.

Pharmaceutical Claims – CVS Health

Encounter Submission Completeness

Myers and Stauffer examined approximately 1,763,000 claim lines adjudicated by CVS Health for pharmaceutical claims. Encounter submission completeness is expressed as a percentage of the sampled claim lines appearing at multiple points in the claim/encounter life cycle. Sampled subcontractor claim

lines were compared to MMIS encounters and the percentage of lines appearing in both data sources or appearing in only one data source is outlined in the table below. The percentage of sampled lines appearing only in the subcontractor claims and the percentage of sampled lines appearing only in the MMIS encounters are further broken out in the bullets below each percentage. Additional observations are provided in the following section for percentages greater than 0.2%.



Encounter Submission Completeness	
58.0%†	**Percentage of sampled lines appearing in both the subcontractor's claims and the State's MMIS encounters.**
41.5%	**Percentage of sampled lines appearing only in the subcontractor's claims.**
	• ***Rejected or Denied (28.6%)*** *– A claim line rejected or denied for payment by the subcontractor during their claim adjudication process due to authorization, eligibility, limits issues, or other reasons.* • ***Alternative Version Found (12.9%)*** *– Claim lines that did not appear to exist as encounters for which a different version or adjustment was found.* • ***Other (0.1%)*** *– A claim line with insufficient information available to explain its absence as an encounter.*
0.5%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**
	• ***Denied (0.5%)*** *– An encounter line denied for payment by the subcontractor during their claim adjudication process due to authorization, eligibility, limits issues, or other reasons.* • ***Other (0.1%)*** *– An encounter line with insufficient information available to explain its absence from the subcontractor's claims.*

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

CVS Health claims not found in the MMIS encounters:

- ***Rejected or Denied.*** *Approximately 503,500 (28.6%) CVS Health pharmaceutical claim lines appeared to be rejected or denied in the subcontractor's claims but did not appear to exist in the MMIS. It appears that CVS Health may not be submitting all rejected or denied encounter claim lines to the MMIS.*

- ***Alternative Found.*** *Approximately 227,500 (12.9%) CVS Health pharmaceutical claim lines in the subcontractor's claims did not appear to exist in the MMIS; however, an alternate version or adjustment of the claim line was found in the MMIS. Of these claim lines, we observed instances of claim lines that appeared to be denied or rejected and a later version of the claim line appeared to be paid and reported in the MMIS. Alternatively, approximately 1,500 (0.1%) claim lines appeared to have alternate versions with matching line payment amounts when compared to the associated version identified in the MMIS.*

MMIS encounters not found in the CVS Health claims:

- ***Denied.*** *Approximately 9,100 (0.5%) CVS Health pharmaceutical encounter claim lines in the MMIS appeared to be denied but did not appear to exist in the subcontractor's claims.*

Encounter Submission Accuracy

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

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

- ***Payee Provider Tax ID.*** *Approximately 5.7% of the MMIS encounters for CVS Health appeared to have payee provider tax IDs that were derived from the claim's dispensing provider. They may not accurately reflect the claim payee/billing provider submitted on the claim itself.*
- ***Dispensing Provider NPI.*** *For approximately 1.3% of the MMIS encounters for CVS Health, the dispensing provider NPI did not match the value found in the claims extracts submitted by CVS Health.*
- ***Amount Billed.*** *The billed amount reported in the MMIS encounters for CVS Health did not appear to match the value found in the claims extracts submitted by CVS Health. The billed amount reported in the MMIS encounters appears to represent the sum of the ingredient cost submitted and the dispensing fee.*
- ***Gross Amount Due.*** *The gross amount due reported in the MMIS encounters for CVS Health did not appear to match the value found in the claims extracts submitted by CVS Health. The gross amount due reported in the MMIS encounters appears to represent the ingredient cost submitted.*
- ***Sales Tax Submitted.*** *The sales tax submitted appeared to be reported as zero in the MMIS for all CVS Health encounters. The occurrence of non-zero sales tax submitted was very rare (less than 0.01%). We observed 16 claim lines in the CVS Health claims extracts having a non-zero sales tax submitted, which did not match values reported in the MMIS encounters.*

Exhibit II, Table 23 comprises additional detail concerning the accuracy of all CVS Health pharmaceutical data elements inspected.

Cash Disbursement Journal Verification

Introduction

Georgia DCH requires that each of their contracted CMOs submit encounter data to the FAC, Gainwell Technologies. To assess the compliance with contractual provisions related to encounter submissions, Myers and Stauffer performs bi-monthly encounter data validations to ensure each CMO is in compliance. As part of this process, Myers and Stauffer analyzes Medicaid encounter data that has been submitted by the CMOs to Gainwell and performs a reconciliation of the encounters to CDJs provided by each CMO.

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

Methodology and Data Sources

In order to verify the CDJ data, Myers and Stauffer requested information from a separate accounting source (e.g., check register, bank statement, or general ledger), independent of the CDJ data, for payments and recoupments made during May 2023 (the sample month) from PSHP and their subcontractors for Georgia Families®.

Myers and Stauffer sent the request below to PSHP in September 2023:

- *"Myers and Stauffer is also requesting additional documentation to verify the CDJ data used to determine encounter completeness. Please provide a bank statement, check register, or similar accounting ledger for payments and recoupments made for Peach State Georgia Medicaid members in the month of May 2023. Please reconcile this information against the CDJ file submissions for the month and document any variance you identify. Note any variance you are unable to reconcile and clarify if CDJ resubmission(s) will be necessary.*

  Please provide the requested documentation for Medicaid claim expenditures and recoupments processed by PSHP, as well as its delegated vendors Envolve Dental, Envolve Vision, and CVS

Health. Please provide the requested data to Myers and Stauffer by October 27, 2023 via secure FTP."

Analysis and Recommendations

The validation documentation received from PSHP was compared to the PSHP and subcontractor CDJ submissions for the sample month of May 2023. A summary of the results of this analysis are presented in the following report sections devoted to our observations for specific subcontractors.

The results of our examination of cash disbursement data for PSHP and their subcontractors indicates that the sample month CDJ file submissions for PSHP medical services show variance when compared to the independent documentation. The CDJ files appear to be missing or to include additional records that do not reflect the check run summary documentation.

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

PSHP submitted May 2023 check run summary documentation for this examination, broken out by medical and BH services. The supplied documentation includes claims-based check and EFT payments and accounting adjustment summaries by check run date. PSHP also submitted detailed provider capitation expenditures processed on May 10, 2023.

The May 2023 PSHP CDJ medical expenditures included provider capitation transactions for the transaction date of May 10, 2023. The sum of the CDJ provider capitation transactions was $620,982, which matched the sum of the payment amounts reported in the detailed provider capitation expenditure documentation supplied by PSHP.

We summarized the CDJ files by transaction date, excluding provider capitation expenditures, and compared these to the check run summaries by check run date. The comparison for medical expenditures is shown in *Table 9* and the comparison for BH expenditures is shown in *Table 10*.

Table 9: PSHP FFS Medical CDJ to Verification Documentation Comparison

PSHP FFS Medical CDJ to Verification Documentation Comparison					
Verification Documentation		CDJ Submissions		Comparison	
Date Paid	Paid Amount	Transaction Date	Transaction Amount*	Variance	Verification Percentage
5/1/2023	$11,470,102	5/1/2023	$11,477,701	$7,599	99.93%
5/3/2023	$18,859,986	5/3/2023	$18,863,378	$3,392	99.98%
5/8/2023	$11,254,985	5/8/2023	$11,270,299	$15,315	99.86%
5/10/2023	$19,569,726	5/10/2023	$19,573,837	$4,110	99.98%
5/15/2023	$10,690,605	5/15/2023	$10,688,815	-$1,790	100.02%
5/17/2023	$20,650,350	5/17/2023	$20,650,350	$0	100.00%
5/22/2023	$11,406,277	5/22/2023	$11,414,606	$8,328	99.93%

PSHP FFS Medical CDJ to Verification Documentation Comparison					
Verification Documentation		CDJ Submissions		Comparison	
Date Paid	Paid Amount	Transaction Date	Transaction Amount*	Variance	Verification Percentage
5/24/2023	$17,337,026	5/24/2023	$17,337,026	$0	100.00%
5/29/2023	$15,396,267	5/29/2023	$15,400,043	$3,776	99.98%
5/31/2023	$16,650,448	5/31/2023	$16,650,510	$62	100.00%
TOTAL	**$153,285,773**		**$153,326,565**	**$40,793**	**99.97%**

**Please note that the CDJ Transaction Amount does not include provider capitation transactions.*

Table 10: PSHP FFS BH CDJ to Verification Documentation Comparison

PSHP FFS BH CDJ to Verification Documentation Comparison					
Verification Documentation		CDJ Submissions		Comparison	
Date Paid	Paid Amount	Transaction Date	Transaction Amount	Variance	Verification Percentage
5/1/2023	$1,300,360	5/1/2023	$1,300,360	$0	100.00%
5/4/2023	$2,439,990	5/4/2023	$2,439,990	$0	100.00%
5/8/2023	$1,247,871	5/8/2023	$1,247,871	$0	100.00%
5/11/2023	$2,664,832	5/11/2023	$2,664,832	$0	100.00%
5/15/2023	$1,079,110	5/15/2023	$1,079,110	$0	100.00%
5/18/2023	$2,558,983	5/18/2023	$2,558,983	$0	100.00%
5/22/2023	$1,246,697	5/22/2023	$1,246,697	$0	100.00%
5/25/2023	$2,168,561	5/25/2023	$2,168,561	$0	100.00%
5/29/2023	$1,341,624	5/29/2023	$1,341,624	$0	100.00%
TOTAL	**$16,048,028**		**$16,048,028**	**$0**	**100.00%**

Overall, the verification data for medical services reported approximately $40,700 less in payments when compared to the CDJ files, representing a potential over-reporting of payments in the CDJ. Alternatively, the verification data for BH services reconciled to the CDJ data with no variances. We inquired with PSHP about the observed variances for medical services. PSHP did not provide sufficient details to explain all observed variances, but did provide details of two instances that contributed to the overall variance:

- *PSHP informed Myers and Stauffer that a variance of approximately $13,000 for the May 8, 2023, transaction date is explained by a prospective payment not specifically related to a claim payment or claim adjustment and not reported in the CDJ.*
- *PSHP informed Myers and Stauffer that a variance of approximately $1,005 for the May 22, 2023, transaction date is explained by a missing refund transaction in the CDJ.*

For expenditures processed in May 2023, the net variance is a relatively small percentage of the overall reported payments; however, we were not able to identify the underlying reasons for all observed

variances, and potential issues with the CDJ files may contribute to significant variances for other months.

Dental Claims – Envolve Dental

Envolve Dental submitted May 2023 check register details as their verification documentation. We summarized the check register payments by the supplied expenditure date paid and the CDJ files by transaction date in *Table 11*.

Table 11: Envolve Dental CDJ to Verification Documentation Comparison

Envolve Dental CDJ to Verification Documentation Comparison					
Verification Documentation		**CDJ Submissions**		**Comparison**	
Date Paid	**Paid Amount**	**Transaction Date**	**Transaction Amount**	**Variance**	**Verification Percentage**
5/1/2023	$1,234,400	5/1/2023	$1,234,575	$175	99.99%
5/4/2023	$1,494,598	5/4/2023	$1,494,423	-$175	100.01%
5/8/2023	$1,241,132	5/8/2023	$1,241,132	$0	100.00%
5/11/2023	$1,574,824	5/11/2023	$1,574,824	$0	100.00%
5/15/2023	$1,009,342	5/15/2023	$1,009,342	$0	100.00%
5/18/2023	$1,464,726	5/18/2023	$1,464,726	$0	100.00%
5/22/2023	$1,096,911	5/22/2023	$1,096,911	$0	100.00%
5/25/2023	$1,414,669	5/25/2023	$1,414,669	$0	100.00%
5/29/2023	$1,055,289	5/29/2023	$1,055,289	$0	100.00%
TOTAL	**$11,585,890**		**$11,585,890**	**$0**	**100.00%**

Overall, the verification data reconciled to the CDJ data for the entire month of May 2023. There were two small variances which netted to zero. Envolve Dental explained these variances as the accrual of a negative balance on May 1, 2023, which resulted in a provider receivable on the total check for that payment processing date. Envolve Dental stated that they do not include checks with $0 paid amounts in the CDJ, which explains the variance on May 1, 2023. The negative balance was reported in the CDJ on May 4, 2023, as an offsetting provider adjustment to a net positive check to the provider.

The check register documentation supplied by Envolve Dental did not appear to include sufficient detail to tie the check transactions to an external source, such as a bank statement. To further verify the accuracy and completeness of the CDJ and supplied documentation, Myers and Stauffer performed an additional assessment of four randomly sampled Envolve Dental provider checks processed in May 2023. We requested additional supporting documentation for these sampled checks, including explanations of payment and a check scan or similar payment confirmation. For all sampled checks, we were able to tie the paid amounts reported in the CDJ and supplied check register documentation to supplied payment confirmation documentation.

Vision Claims – Envolve Vision

Envolve Vision submitted check register details for May 2023 as its verification documentation. We summarized the check register payments by the supplied expenditure paid date and the CDJ files by transaction date in *Table 12*.

Table 12: Envolve Vision CDJ to Verification Documentation Comparison

Envolve Vision CDJ to Verification Documentation Comparison					
Verification Documentation		CDJ Submissions		Comparison	
Paid Date	Paid Amount	Transaction Date	Transaction Amount	Variance	Verification Percentage
5/4/2023	$175,800	5/4/2023	$175,800	$0	100.00%
5/11/2023	$137,869	5/11/2023	$137,869	$0	100.00%
5/18/2023	$160,310	5/18/2023	$160,310	$0	100.00%
5/25/2023	$222,091	5/25/2023	$222,091	$0	100.00%
TOTAL	**$696,070**		**$696,070**	**$0**	**100.00%**

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

The check register documentation supplied by Envolve Vision did not appear to include sufficient detail to tie the check transactions to an external source, such as a bank statement. To further verify the accuracy and completeness of the CDJ and supplied documentation, Myers and Stauffer performed an additional assessment of four randomly sampled Envolve Vision provider checks processed in May 2023. We requested additional supporting documentation for these sampled checks, including explanations of payment and a check scan or similar payment confirmation. For all sampled checks, we were able to tie the paid amounts reported in the CDJ and supplied check register documentation to supplied payment confirmation documentation.

Pharmaceutical Claims – CVS Health

CVS Health submitted check register details for May 2023 as its verification documentation. We summarized the check register payments by the supplied expenditure payment date and the CDJ files by transaction date in *Table 13****Error! Reference source not found.***.

Table 13: CVS Health Verification Documentation to CDJ Comparison

CVS Verification Documentation to CDJ Comparison					
Verification Documentation		CDJ Submissions			Comparison
Payment Date	Paid Amount	Transaction Date	Transaction Amount	Variance	Verification Percentage
5/1/2023	$12,872	5/1/2023	$12,872	$0	100.00%
5/2/2023	$159,906	5/2/2023	$159,906	$0	100.00%

CVS Verification Documentation to CDJ Comparison					
Verification Documentation		CDJ Submissions			Comparison
Payment Date	Paid Amount	Transaction Date	Transaction Amount	Variance	Verification Percentage
5/3/2023	$6,124,954	5/3/2023	$6,124,954	$0	100.00%
5/4/2023	$250,024	5/4/2023	$250,024	$0	100.00%
5/5/2023	$687,706	5/5/2023	$687,706	$0	100.00%
5/6/2023	$62,158	5/6/2023	$62,158	$0	100.00%
5/7/2023	-$29,463	5/7/2023	-$29,463	$0	100.00%
5/8/2023	$27,431	5/8/2023	$27,431	$0	100.00%
5/9/2023	$50,375	5/9/2023	$50,375	$0	100.00%
5/10/2023	$6,172,943	5/10/2023	$6,172,943	$0	100.00%
5/11/2023	$69,433	5/11/2023	$69,433	$0	100.00%
5/12/2023	$859,086	5/12/2023	$859,086	$0	100.00%
5/13/2023	$135,170	5/13/2023	$135,170	$0	100.00%
5/14/2023	$3,274	5/14/2023	$3,274	$0	100.00%
5/15/2023	$6,760	5/15/2023	$6,760	$0	100.00%
5/16/2023	$178,250	5/16/2023	$178,250	$0	100.00%
5/17/2023	$5,820,867	5/17/2023	$5,820,867	$0	100.00%
5/18/2023	$37,331	5/18/2023	$37,331	$0	100.00%
5/19/2023	$837,627	5/19/2023	$837,627	$0	100.00%
5/20/2023	$102,194	5/20/2023	$102,194	$0	100.00%
5/21/2023	$11,395	5/21/2023	$11,395	$0	100.00%
5/22/2023	-$7,100	5/22/2023	-$7,100	$0	100.00%
5/23/2023	$136,945	5/23/2023	$136,945	$0	100.00%
5/24/2023	$6,358,868	5/24/2023	$6,358,868	$0	100.00%
5/25/2023	$180,711	5/25/2023	$180,711	$0	100.00%
5/26/2023	$762,174	5/26/2023	$762,174	$0	100.00%
5/27/2023	$140,277	5/27/2023	$140,277	$0	100.00%
5/28/2023	$9,926	5/28/2023	$9,926	$0	100.00%
5/29/2023	-$3,710	5/29/2023	-$3,710	$0	100.00%
5/30/2023	$81,456	5/30/2023	$81,456	$0	100.00%
5/31/2023	$5,723,078	5/31/2023	$5,723,078	$0	100.00%
TOTAL	**$34,962,918**		**$34,962,918**	**$0**	**100.00%**

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

Observation: CDJ

An area of concern was identified during the Data Analytics (CDJs) interview session. Myers and Stauffer found that PSHP has one individual performing the initial data analytics on the CDJ files. The data analyst receives the monthly CDJ files and runs queries to verify totals; however, there is no report generated showing the status or results of the file. An email stating that the CDJ data has been verified is sent to all necessary stakeholders. The data analyst disclosed that the department does not maintain internal

procedures for the CDJ data analytics functions discussed. He advised that he updates the standard operating procedures (SOPs) as needed and he is the sole individual making edits to those procedures. There is no peer review, supervisor review, nor managerial approval of the SOPs.

As a result of this finding, a corrective action plan (CAP) was assessed on PSHP. PSHP responded and provided additional context to address the finding. PSHP stated, “Our process includes oversight by multiple teams including medical economics, accounting, data analytics and reporting. Each department follows a series of steps to validate the data before it is submitted. Each department maintains their respective internal procedure for the CDJ data function. Each department is responsible for updating their respective components of the internal procedures. There is both a peer review and supervisor review that is maintained and tracked w/in our Archer system prior to reports submission. After data validation, all variances are identified, documented, and communicated to each department involved in the CDJ reconciliation process. We conduct an additional series of checks based on guidelines provided by Myers & Stauffer. For your review, included is document that highlights the monthly process and evidence various oversight measures. Additionally, below is a screenshot evidencing that all report submissions have required oversight and cannot be processed without a 2nd level review by leadership.”

After further review of the information provided by PSHP, it should be noted that this information was not provided during the interview. As a result, Myers and Stauffer recommends PSHP implement ongoing education and consistent awareness of departmental policies and procedures that impact front line staff for the performance and validation of data analytics functions. We recommend PSHP perform periodic review of the SOPs to ensure they are sufficient to maintain optimal and relevant data analytics results.

Findings and Recommendations

Table 14 summarizes the findings and recommendations identified during this engagement and are based on the data and documentation provided by PSHP and the information obtained during interviews. We assessed each finding and classified them by the following risk levels:

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

Table 14: Findings and Recommendations

Findings and Recommendations					
Entity	**Functional Area**	**Risk Level**	**Finding Page Number**	**Finding**	**Recommendation**
Centene - Corporate	**Program Integrity (Pharmacy)**	**Medium**	Pg. 42	Per interview responses, the Centene SIU group does not appear to follow any SLAs for reviewing potential cases or require CVS to follow SLAs for their expanded audits (e.g., 155 days).	Myers and Stauffer recommends that Centene review current policies and procedures for pharmacy program integrity and consider the inclusion of service level agreements to ensure timely follow up and resolution on expanded audits.
Centene - Corporate	**Data Analytics**	**Medium**	Pg.75	Interview responses indicated data analytics staff members were not aware of all policies and procedures related to data analytic functions.	Myers and Stauffer recommends review of current SOPs for data analytics to ensure they are accurate and complete. We recommend manager or

Findings and Recommendations					
Entity	**Functional Area**	**Risk Level**	**Finding Page Number**	**Finding**	**Recommendation**
					supervisor review and approval; in addition to periodic re-reviews and updates as new processes or updates to existing processes are necessary to maintain optimal and relevant data analytics results. During the CAP process, PSHP subsequently provided Myers and Stauffer with additional documentation outlining procedures for reviewing CDJ submissions, including the requirement for a second level review by leadership prior to submission. After further review of the information provided by PSHP, it should be noted that this information was not provided during the interview. As a result, Myers and Stauffer recommends PSHP implement ongoing education and consistent awareness of departmental policies and procedures that impact front

Findings and Recommendations					
Entity	**Functional Area**	**Risk Level**	**Finding Page Number**	**Finding**	**Recommendation**
					line staff for the performance and validation of data analytics functions. We recommend PSHP perform periodic review of the SOPs to ensure they are sufficient to maintain optimal and relevant data analytics results.
PSHP	**CDJ Verification**	**Low**	Pg. 71	Myers and Stauffer observed CDJ files that appear to be missing or to include additional records that do not reflect the check run summary documentation.	We recommend PSHP identify potential improvements to its financial reconciliation procedures for continuously monitoring the completeness and accuracy of PSHP and subcontractor CDJ files submissions against independent financial sources.
PSHP	**Encounter Submissions**	**Medium**	Pg. 59	Myers and Stauffer observed potentially missing data in the MMIS, in particular denied claim lines missing from the encounters submitted to the MMIS by PSHP and its subcontractors.	Myer and Stauffer recommends Peach State communicate its concerns and provide additional specific examples to DCH and Gainwell of encounter claims where denied lines are known or expected to cause issues with the submission of complete and accurate encounter records. We also recommend Peach State support DCH in

Findings and Recommendations					
Entity	**Functional Area**	**Risk Level**	**Finding Page Number**	**Finding**	**Recommendation**
					implementing updates to Gainwell's systems to ensure denied encounter claim lines can be submitting to the MMIS without causing duplicate rejection issues.
PSHP	**Encounter Submissions**	**Medium**	Pg. 85	Myers and Stauffer observed mismatching claim data elements between the PSHP FFS claims, subcontractor encounters extracts, and the MMIS encounters.	PSHP 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	**Member Services - Marketing and Communication**	**Low**	Pg. 21	Due to Member Services - Marketing and Communication interview responses, it was determined that no oversight or quality review is performed on the work activities of the plan's marketing specialists. Per PSHP, marketing is a function of both the local plan and corporate.	Myers and Stauffer recommends that policies and procedures for the oversight or quality monitoring activities be created for Marketing and Communications to include steps to assure that quality is consistent across all marketing specialists and identify areas where improvements can be made.

Findings and Recommendations					
Entity	**Functional Area**	**Risk Level**	**Finding Page Number**	**Finding**	**Recommendation**
					As a result of this finding, a corrective action plan (CAP) was assessed on PSHP. PSHP responded and provided additional context to address the finding. PSHP stated, "The Marketing and Communication team does have an oversight and quality review processes in place to review the work activities of the plan's marketing specialists. Monthly, the Marketing and Communications Director performs detailed audits on the staff which includes a full review of the materials that were requested, developed, and approved. This review evaluates whether the specialists followed the required steps to developing a marketing and communication piece (including 5th grade reading level requirements) as

Findings and Recommendations					
Entity	**Functional Area**	**Risk Level**	**Finding Page Number**	**Finding**	**Recommendation**
					well as collecting all required approvals including that of DCH. The results of these audits are a part of the team member's regular meetings with their director as well as performance goals." After further review of the information provided by PSHP, it should be noted that this information was not provided during the interview. As a result, Myer and Stauffer recommends that PSHP implement ongoing education and consistent awareness of the departmental policies and procedures for oversight and quality review of marketing and communications tasks.
PSHP	**Program Integrity**	**Low**	Pg. 43	Myers and Stauffer observed backlog of FWA cases during our examination of PSHP's FWA reporting activity.	Myers and Stauffer recommends PSHP increase SIU resources to decrease the FWA case backlog.

Findings and Recommendations					
Entity	**Functional Area**	**Risk Level**	**Finding Page Number**	**Finding**	**Recommendation**
PSHP	**Program Integrity**	**Low**	Pg. 48	Myers and Stauffer observed that many of the fields on the quarterly FWA reports are not being utilized or populated with data.	We recommend PSHP improve utilization of FWA report fields to increase consistency of reporting, with special emphasis on provider type, approximate dollars involved, overpayment, and recoupment fields.
PSHP	**Provider Network (Provider Data Maintenance)**	**Low**	Pg. 26	Based on Provider Network and Contracting interview responses, we determined that within the provider data management functions there is a potential weakness, as PSHP's Provider Data Maintenance Department does not validate OIG for provider exclusion.	Myers and Stauffer recommends updating current provider data maintenance procedures to include an OIG validation step. This step will ensure network providers are in good standing to provide Medicaid services with the added benefit of potentially decreasing incidents of provider fraud by keeping their provider roles free of excluded providers. As a result of this finding, a corrective action plan (CAP) was assessed on PSHP. PSHP responded and provided additional context to address

Findings and Recommendations					
Entity	**Functional Area**	**Risk Level**	**Finding Page Number**	**Finding**	**Recommendation**
					the finding. PSHP stated, "there is a process in place to validate for OIG provider exclusions. The process is owned by the Centene Credentialing department and not the Provider Data Maintenance department. The Credentialing department performs monthly OIG reviews and terminations for exclusions. This review includes all practitioners/providers listed in the Provider Data Management system, regardless of participation status." After further review of the information provided by PSHP, it should be noted that this information was not provided during the interview. As a result, Myer and Stauffer recommends that PSHP

Findings and Recommendations					
Entity	**Functional Area**	**Risk Level**	**Finding Page Number**	**Finding**	**Recommendation**
					implement ongoing education and consistent awareness of the departmental policies and procedures for credentialing providers which includes performing monthly OIG reviews and terminations for exclusions.

Exhibit I: 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 *Table 15* on the dates and at the locations indicated.

Table 15: PSHP Interviews

Date	Location	Interviewees	Title
12/06/2023	Atlanta Office	Heather DiNapoli	Director, Compliance
12/06/2023	Atlanta Office	Patricia Elder	Director, Compliance
12/06/2023	Atlanta Office	Yesenia Stokes	Manager, Compliance
12/06/2023	Atlanta Office	Christin Agnew	Supervisor, Compliance
12/06/2023	Atlanta Office	Kelly McNamara	Manager, Delegation Oversight
12/06/2023	Atlanta Office	Roxann Moore	Delegation Oversight Specialist
12/06/2023	Atlanta Office	Katrina Jones-Harden	Sr. Manager, Prior Authorizations
12/06/2023	Atlanta Office	Lisa Bridges	Manager, Utilization Management
12/06/2023	Atlanta Office	Remedios (Reme) Rodriguez	Vice President of Behavioral Health Operations
12/06/2023	Atlanta Office	Monet Harrell	Director, Quality Improvement
12/06/2023	Atlanta Office	Carla Smith	Manager, Quality Practice Advisor
12/06/2023	Atlanta Office	Kenyetta Smith	Fraud Waste & Abuse Program Manager
12/06/2023	Atlanta Office	Jacqueline Autie	SIU CIU Investigator Lead
12/07/2023	Atlanta Office	Jennifer Morris	Provider Relations Trainer II
12/07/2023	Atlanta Office	Blanca Rodriguez	Senior Manager, Provider Network Performance
12/07/2023	Atlanta Office	Manika Fitzpatrick	Manager, Contracting
12/07/2023	Atlanta Office	Kesa Jackson	Manager, Provider Data Management
12/07/2023	Atlanta Office	Stacy Potter	Supervisor, Provider Data Management
12/07/2023	Atlanta Office	Marisa Cole	Supervisor, Grievance and Appeals
12/07/2023	Atlanta Office	Tava Sparks	Senior Marketing and Communications Specialist
12/07/2023	Atlanta Office	Corliss Norman	Senior Marketing and Communications Specialist
12/07/2023	Atlanta Office	Eugina Lawrence	Member Relationship Liaison
12/08/2023	Atlanta Office	Lee Tookes	Manager Contact Center Operations
12/08/2023	Atlanta Office	Rashan Johnson	Supervisor, Contact Center Operations
12/08/2023	Atlanta Office	Michelle Brown	Manager, Claims
12/08/2023	Atlanta Office	Wills Frenelle	Data Analyst III
12/08/2023	Atlanta Office	Sonya Cuffie	Vice President of Finance
12/08/2023	Atlanta Office	Sandra Vermillion	Data Analyst IV
12/12/2023	Corporate	Arica Evans	Director, Ethics & Compliance
12/12/2023	Corporate	Michael Yemm	Manager, Internal Audit

Date	Location	Interviewees	Title
12/12/2023	Corporate	Jeff Bradford	Business Compliance Consultant, Program Management Oversight and Audit Support
12/12/2023	Corporate	Steven Newton	Manager, Special Investigations Unit
12/12/2023	Corporate	Ryan Wilhelm	Senior Special Investigation Unit Investigator
12/12/2023	Corporate	Megan Salkeld	Manager, Third Party Risk Management
12/12/2023	Corporate	Tiffany Walker, Dir. Compliance Oversight	Senior Director, Information Security Cyber Defense
12/12/2023	Corporate	Ramirez Hernando	Manager, Enrollment Operations & Reconciliation
12/12/2023	Corporate	Ashley Dykstra	Business Analyst I
12/12/2023	Corporate	Megan Whelan	Manager, BH Utilization Management
12/12/2023	Corporate	Hope Tomfohrde	Director, BH Utilization Management
12/12/2023	Corporate	Deanna Walker	Payment Integrity Program Manager IV
12/12/2023	Corporate	Jason Moseley	Process Owner, COB
12/12/2023	Corporate	Maurice Burns	Manager, Claims
12/12/2023	Corporate	Bryan Childress	Director, Claims Operations
12/12/2023	Corporate	Jun Lee	Senior Solutions Architect
12/12/2023	Corporate	Peter Milizia	Manager, Technology Enterprise Architecture
12/12/2023	Corporate	Papanasa Kathiresan	Manager - Compliance & Reporting for Identity and Access Management
12/12/2023	Corporate	Chris O'Brien	Manager, Healthcare Analytics
12/12/2023	Corporate	Steven Peterson	Health Plan Controller
12/12/2023	Corporate	Billy Ballestas	Manager Healthcare Analytics
12/13/2023	Corporate	Yolanda Singleton	Manager, Application Development Engineering
12/13/2023	Corporate	Margaret Richardson	Director, Application Development Engineering
12/13/2023	Corporate	Heather House	Senior Manager, Claims
12/13/2023	Corporate	Chris Cioffi,	Vice President, Internal
12/13/2023	Corporate	Stacy Suttles-Sansoucie,	Manager, Provider Reimbursement Audit
12/13/2023	Corporate	Jim Westmoreland	Director, Encounters
12/13/2023	Corporate	Timothy Douglas	Director, Healthcare Analytics
12/13/2023	Corporate	Christen Miranda	Senior Director Pharmacy Program Management
12/13/2023	Corporate	Sheri Ing	Senior Vice President, Pharmacy Program Management
12/13/2023	Corporate	Justin Stubstad	Vice President of Compliance
12/13/2023	Corporate	Margie Hartman	Senior Director of Compliance
12/13/2023	Corporate	Sheri Ing	Senior Vice President, Pharmacy Program Management
12/13/2023	Corporate	Adam Swartz	Senior Director, Pharmacy Program Management
12/13/2023	Corporate	Didra Verdugo	Manager, Pharmacy Network Operations
12/13/2023	Corporate	Steve McClure	Director, Application Development Engineering
12/13/2023	Corporate	Clinton Barry	Manager, Application Development Engineering

Date	Location	Interviewees	Title
12/13/2023	Corporate	Ryan Hull	Director, Application Development
12/14/2023	Corporate	Christen Miranda	Senior Director Pharmacy Program Management
12/14/2023	Corporate	Sheri Ing	Senior Vice President Pharmacy Program Management
12/14/2023	Corporate	Hardikkumar Patel	Manager Claims Research & Analysis
12/14/2023	Corporate	Maryam Bey	Business Analyst III

Interviews with Subcontractors

CVS Health

CVS Health provides PBM services for PSHP members. Myers and Stauffer met virtually with CVS Health staff on November 14, 2023. The individuals listed in *Table 16* were interviewed.

Table 16: CVS Health

Date	Interviewees	Interviewees
11/14/2023	Christie Raymond	Strategic Account Director
11/14/2023	Charles (Andrew) Long	Manager, Client Audit
11/14/2023	Christie Raymond	Strategic Account Director
11/14/2023	Ilene OReilly	Regulatory Affairs Government Services
11/14/2023	Christopher Chader	Manager, Network Management
11/14/2023	Ivan Dsouza	Director, IT Account Management
11/14/2023	Angeles Klein	Senior Manager, Network Management- Pharmacy Enrollment
11/14/2023	Shawn Smith	Director Network Management
11/14/2023	Beth Neiman	Director Client Operations
11/14/2023	Martin Mangin,	Executive Director, COA Configuration and Design
11/14/2023	Catherine McMillan	Senior Manager, Client Benefits
11/14/2023	Karl Reed	Senior Manager, Finance Operations
11/14/2023	James Kelly	Manager, Finance Operations
11/14/2023	Chris Hornberger	Manager, IT Account Management

Envolve Dental

Envolve Dental provides specialty PBM services. Myers and Stauffer met virtually with Envolve Dental staff on December 4, 2023. The individuals listed in *Table 17* were interviewed.

Table 17: Envolve Dental

Date	Interviewees	Title
12/4/2023	Jenny Mercedes Innocent	Supervisor, Contact Center Operations
12/4/2023	Bianca Rodriguez-Guzman	CS Advocate IV
12/4/2023	Christine Allard	Manager, Utilization Management

Date	Interviewees	Title
12/4/2023	Mark Drier	Manager, IT
12/4/2023	Eddie Edwards	Senior System Engineer
12/4/2023	Amy Greene	IT Assurance Analyst
12/4/2023	Wendy Glenda Broadnax-McCoy	Director, Claims Operations
12/4/2023	Markeya Baskerville	Manager, Claims Operations

Envolve Vision/Dental

Envolve vision and dental provides vision services to PSHP members. Myers and Stauffer met virtually with Envolve Vision/Dental on November 29 through 30, 2023. The individuals listed in *Table 18* were interviewed.

Table 18: Envolve Vision/Dental

Date	Interviewees	Title
11/29/2023	Jamie Hawkins	Auditor III
11/29/2023	Jules Sweaney	Account Manager
11/29/2023	Jennifer Kilbane	Senior Manager, Compliance
11/29/2023	Katina Black	Supervisor, Audit
11/29/2023	Rahim Winston	Manager, Special Investigation Unit
11/29/2023	Clarissa Jones	Senior Special Investigation Unit Investigator
11/29/2023	Michelle Brochu	Network Management
11/29/2023	Angel Richardson	Manager, Contact Center Operations
11/29/2023	Shelly Long	Senior Manager, Provider Relations
11/29/2023	LaCresha Martin	Supervisor, Call Center Ops
11/29/2023	Elizabeth Cobb	Director, Quality Improvement
11/29/2023	Christen Hubbert	Senior Manager, Quality Improvement
11/29/2023	Elizabeth Cobb	Director, Quality Improvement
11/29/2023	Sandra Vaughan	Manager, Grievance and Appeals
11/30/2023	Carol Cooper	Manager, Claims Ops
11/30/2023	Valerie Poland	Manager, Claims Admin
11/30/2023	Patrick Poland	Senior Manager., Data Analytics and Reporting
11/30/2023	Steven Livengood	Senior Manager, Data Analytics & Reporting
11/30/2023	Eddie Edwards	Senior Systems Engineer
11/30/2023	Amy Greene	IT Assurance Analyst

Exhibit II: Supporting Detail for Encounter Submissions and Payment Systems

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

- *Peach State Health Plan.*
  - ***Error! Reference source not found.****9 – Institutional (837I/UB04).*
  - *Table 20 – Professional (837P/CMS-1500).*
- *Envolve Dental.*
  - ***Error! Reference source not found.*** *– Dental (837D/ADA).*
- *Envolve Vision.*
  - *Table 22 – Vision (837P/CMS-1500).*
- *CVS Health.*
  - *Table 23 – Pharmaceutical (NCPDP).*

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

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

Table 19: PSHP FFS - Institutional (837I/UB04)

PSHP FFS – Institutional (837I/UB04) Claim Lines Examined = 1,082,100			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Plan by Provider	0.0	The claim receipt date reported in the PSHP FFS extracts for institutional claim lines did not match the claim receipt date reported in the MMIS encounters. In most cases (99.9%), the claim receipt date reported in the MMIS encounters may represent the date PSHP paid the claim, since the claim receipt date appears to be the same date as the encounter paid date.
2	Date Paid	99.6	
3	Amount Paid - Claim Header	99.4	
4	Amount Paid - Claim Detail Lines	99.3	
5	Interest Paid - Claim Header	97.2	We observed approximately 30,000 institutional claim lines (2.8%) where the claim header interest reported in the PSHP FFS claims extracts did not match the claim header interest reported in the MMIS encounters. Myers and Stauffer was not able to identify a potential cause for this difference.
6	Denial Indicator - Claim Header	99.9	
7	Member Medicaid ID	99.9	
8	Payee Provider Tax ID	99.2	
9	Rendering Provider NPI	88.7	We observed approximately 67,000 institutional claim lines (6.2%) 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 52,200 institutional claim lines (4.8%) where the rendering provider NPI reported in the MMIS encounters did not appear to match the rendering provider NPI in the PSHP claims extracts but did appear to match the payee provider NPI in the PSHP extracts.

PSHP FFS – Institutional (837I/UB04) Claim Lines Examined = 1,082,100			
	Claim Data Element	**% Match**	**Notes**
10	Referring Provider NPI	N/A	The referring provider NPI did not appear to be reported in the MMIS for PSHP institutional encounters. We observed the referring provider NPI reported on approximately 18,900 institutional claim lines in the PSHP FFS claims extracts (1.7%).
11	Attending Provider NPI	99.9	
12	Operating Provider NPI	99.9	
13	DRG Code	99.3	
14	Claim ICD Diagnosis Codes	99.4	The majority of diagnosis codes billed on the inbound claims appeared to be reported in the MMIS encounters; however, the ordering of secondary diagnosis codes in the MMIS encounters may not always match the ordering of secondary diagnosis codes as reported on the inbound claim.
15	Claim ICD Surgical Procedure Codes	99.9	
16	Type of Bill	99.9	
17	Medical Record Number	99.6	
18	Amount Billed - Claim Header	99.6	
19	Amount Billed - Claim Detail Lines	99.3	
20	Admission Date	99.9	
21	Discharge Date	98.4	The discharge date for approximately 11,300 institutional claim lines (1.0%) in the PSHP FFS claims extracts did not match the discharge date reported in the MMIS institutional encounters for PSHP; 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	

PSHP FFS – Institutional (837I/UB04) Claim Lines Examined = 1,082,100			
	Claim Data Element	**% Match**	**Notes**
23	Last Date of Service – Claim Header	98.4	For approximately 16,700 institutional claim lines (1.5%), it appeared the claim header last date of service in the PSHP FFS claims extracts did not match the claim header last date of service reported in the MMIS encounters. For most of these claim lines, the header last date of service reported in the MMIS encounters did not agree with the latest line date of service on the claim. For these claim lines, the header last date of service reported in the MMIS encounters may have been derived from claim discharge date and may not always accurately represent the claim last date of service.
24	First Date of Service – Claim Detail Lines	99.9	
25	Last Date of Service – Claim Detail Lines	99.9	
26	Claim Detail Line Number	94.4	We observed claims where one or more claim lines in the PSHP FFS 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 57,000 PSHP institutional claim lines (5.3%) appeared to have been either renumbered or reordered in the MMIS encounters.
27	Units Billed	92.1	For approximately 69,800 institutional claims lines (6.5%), the units billed were reported as non-zero in the PSHP FFS claims extracts but were reported as zero in the MMIS encounters.
28	Revenue Code	99.8	
29	Procedure Code	99.9	
30	Procedure Code Modifier 1	98.7	For approximately 14,100 institutional claim lines (1.3%), the procedure code modifier 1 did not appear to be reported in the PSHP FFS claims extracts, but appeared to be reported as a value of "XX" or "XY" in the corresponding PSHP MMIS institutional encounters.
31	Procedure Code Modifier 2	99.7	
32	Procedure Code Modifier 3	99.9	
33	Procedure Code Modifier 4	100.0	

PSHP FFS – Institutional (837I/UB04) Claim Lines Examined = 1,082,100			
	Claim Data Element	**% Match**	**Notes**
34	NDC	99.9	

Table 20: PSHP FFS - Professional (837P/CMS-1500)

PSHP FFS – Professional (837P/CMS-1500) Claim Lines Examined = 2,683,800			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Plan by Provider	0.0	The claim receipt date reported in the PSHP FFS extracts for professional claim lines did not match the claim receipt date reported in the MMIS encounters. In most cases (99.9%), the claim receipt date reported in the MMIS encounters may represent the date PSHP paid the claim, since the claim receipt date appears to be the same date as the encounter paid date.
2	Date Paid	99.6	
3	Amount Paid – Claim Header	99.2	
4	Amount Paid – Claim Detail Lines	99.5	
5	Interest Paid - Claim Header	99.2	
6	Denial Indicator - Claim Header	99.9	
7	Member Medicaid ID	99.9	
8	Payee Provider Tax ID	87.7	For approximately 319,500 professional claim lines (11.9%) it appeared the Payee Provider Tax ID in the MMIS encounters for PSHP was derived from the rendering provider. The payee provider in the MMIS may not accurately reflect the claim payee/billing provider reported on the claim submission.
9	Rendering Provider NPI	99.0	
10	Referring Provider NPI	99.0	
11	Claim ICD Diagnosis Codes	99.9	The majority of diagnosis codes billed on the inbound claims appeared to be reported in the MMIS encounters; however, the ordering of secondary diagnosis codes in the MMIS encounters may not always match the ordering of secondary diagnosis codes as reported on the inbound claim.
12	Amount Billed – Claim Header	99.7	
13	Amount Billed - Claim Detail Lines	99.9	
14	First Date of Service – Claim Header	99.9	

PSHP FFS – Professional (837P/CMS-1500) Claim Lines Examined = 2,683,800			
	Claim Data Element	**% Match**	**Notes**
15	Last Date of Service – Claim Header	99.7	
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	89.3	We observed claims where one or more claim lines in the PSHP FFS 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 282,900 PSHP professional claim lines (10.5%) appeared to have been either renumbered or reordered in the MMIS encounters.
19	Units Billed	93.4	For approximately 154,100 professional claims lines (5.7%), the units billed were reported as non-zero in the PSHP FFS claims extracts but were reported as zero in the MMIS encounters.
20	Place of Service	98.3	For approximately 45,300 professional claim lines (1.7%) the place of service in the PSHP FFS claims extracts did not appear to match the value in the corresponding MMIS PSHP professional encounters. For approximately 33,200 of these claim lines (1.2%), 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	99.5	
24	Procedure Code Modifier 3	99.9	
25	Procedure Code Modifier 4	99.9	
26	NDC	N/A	The NDC did not appear to be reported in the MMIS for PSHP professional encounters. We observed the NDC reported on approximately 138,600 professional claim lines (5.2%) in the PSHP FFS claims extracts.

PSHP FFS – Professional (837P/CMS-1500) Claim Lines Examined = 2,683,800			
	Claim Data Element	**% Match**	**Notes**
27	Claim Detail Line ICD Diagnosis 1	63.2	We observed approximately 986,800 professional claim lines (36.8%) in the PSHP professional claims extracts whose claim detail line diagnosis code 1 did not match the value for the corresponding claim line in the MMIS professional encounters. Myers and Stauffer was not able to identify a potential cause for this difference; however, this difference may be related to potential reordering of ICD claim diagnosis codes between the inbound claim receipt and submission of encounters to the MMIS.
28	Claim Detail Line ICD Diagnosis 2	76.7	We observed approximately 625,200 professional claim lines (23.3%) in the PSHP professional claims extracts whose claim detail line diagnosis code 2 did not match the value for the corresponding claim line in the MMIS professional encounters. Myers and Stauffer was not able to identify a potential cause for this difference; however, this difference may be related to potential reordering of ICD claim diagnosis codes between the inbound claim receipt and submission of encounters to the MMIS.
29	Claim Detail Line ICD Diagnosis 3	86.2	We observed approximately 369,900 professional claim lines (13.8%) in the PSHP professional claims extracts whose claim detail line diagnosis code 3 did not match the value for the corresponding claim line in the MMIS professional encounters. Myers and Stauffer was not able to identify a potential cause for this difference; however, this difference may be related to potential reordering of ICD claim diagnosis codes between the inbound claim receipt and submission of encounters to the MMIS.

PSHP FFS – Professional (837P/CMS-1500) Claim Lines Examined = 2,683,800			
	Claim Data Element	**% Match**	**Notes**
30	Claim Detail Line ICD Diagnosis 4	92.2	We observed approximately 208,400 professional claim lines (7.8%) in the PSHP professional claims extracts whose claim detail line diagnosis code 4 did not match the value for the corresponding claim line in the MMIS professional encounters. Myers and Stauffer was not able to identify a potential cause for this difference; however, this difference may be related to potential reordering of ICD claim diagnosis codes between the inbound claim receipt and submission of encounters to the MMIS.

Table 21: Envolve Dental (837D/ADA)

Envolve Dental (837D/ADA) Claim Lines Examined = 580,600			
	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. In most cases (99.9%), 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	100.0	
3	Subcontractor Amount Paid – Claim Header	99.9	
4	Subcontractor Amount Paid – Claim Detail Lines	99.9	
5	Interest Paid - Claim Header	100.0	Interest appeared to be reported as $0 for all records in the Envolve Dental claims extracts and the MMIS encounter data for Envolve Dental.
6	Denial Indicator - Claim Header	100.0	
7	Member Medicaid ID	100.0	

Envolve Dental (837D/ADA) Claim Lines Examined = 580,600			
	Claim Data Element	**% Match**	**Notes**
8	Payee Provider Tax ID	92.7	For approximately 42,400 dental claim lines (7.3%) it appeared the Payee Provider Tax ID in the MMIS encounters for Envolve Dental 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	97.5	We observed approximately 3,500 dental claim lines (0.6%) where the rendering provider NPI reported in the MMIS encounters for Envolve Dental did not appear to match the rendering provider NPI in the Envolve Dental claims extracts but did appear to match the payee provider NPI in the Envolve Dental extracts. We also observed approximately 3,000 dental claim lines (0.5%) where the rendering provider NPI in the MMIS encounters for Envolve Dental appeared to include a typo and appeared to be an incorrect representation of the rendering provider. We also observed approximately 2,100 claim lines (0.4%) where the rendering provider NPI in the MMIS encounters for Envolve Dental 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.
10	Referring Provider NPI	N/A	The referring provider NPI did not appear to be reported in either the Envolve Dental claims extracts or the MMIS encounters for Envolve Dental.
11	Claim ICD Diagnosis Codes	N/A	ICD Diagnosis codes do not appear to be reported in the MMIS encounter data. We observed approximately 19,700 dental claim lines (3.4%) where one or more ICD diagnosis codes appeared to be reported in the Envolve Dental claims extracts but did not appear to be reported in the MMIS encounters. This field may not be required for submission to the MMIS for dental claims.
12	Amount Billed - Claim Header	99.9	

Envolve Dental (837D/ADA) Claim Lines Examined = 580,600			
	Claim Data Element	**% Match**	**Notes**
13	Amount Billed - Claim Detail Lines	99.9	
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	90.6	We observed claims where one or more claim lines in the Envolve Dental 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 54,700 Envolve Dental claim lines (9.4%) appeared to have been either renumbered or reordered in the MMIS encounters.
19	Units Billed	0.0	The units billed appeared to be reported as zero for all MMIS encounters and did not appear to match the units billed reported in the Envolve Dental extracts.
20	Place of Service	100.0	
21	Procedure Code	100.0	
22	Procedure Code Modifier 1	N/A	Procedure code modifiers did not appear to be reported in either the Envolve Dental claims extracts or the MMIS encounters for Envolve Dental.
23	Procedure Code Modifier 2	N/A	
24	Procedure Code Modifier 3	N/A	
25	Procedure Code Modifier 4	N/A	
26	Tooth Number	99.9	
27	Tooth Surface Code 1	99.9	
28	Tooth Surface Code 2	99.9	
29	Tooth Surface Code 3	99.9	
30	Tooth Surface Code 4	99.9	
31	Tooth Surface Code 5	100.0	
32	Claim Detail Line ICD Diagnosis 1	N/A	ICD diagnosis codes did not appear to be reported in the MMIS for Envolve Dental encounters. We observed claim detail line ICD diagnosis code 1 reported on approximately 8,500 claim lines (1.5%) in the Envolve Dental claims extracts.

Envolve Dental (837D/ADA) Claim Lines Examined = 580,600			
	Claim Data Element	**% Match**	**Notes**
33	Claim Detail Line ICD Diagnosis 2	N/A	ICD diagnosis codes did not appear to be reported in the MMIS for Envolve Dental encounters. We observed claim detail line ICD diagnosis code 2 reported on approximately 300 claim lines (0.1%) in the Envolve Dental claims extracts.
34	Claim Detail Line ICD Diagnosis 3	N/A	ICD diagnosis codes did not appear to be reported in the MMIS for Envolve Dental encounters. We observed claim detail line ICD diagnosis code 3 reported on approximately 4 claim lines (less than 0.01%) in the Envolve Dental claims extracts.
35	Claim Detail Line ICD Diagnosis 4	N/A	ICD diagnosis codes did not appear to be reported in the MMIS for Envolve Dental encounters. We observed claim detail line ICD diagnosis code 4 reported on approximately 1 claim line (less than 0.01%) in the Envolve Dental claims extracts.

Table 22: Envolve Vision (837P/CMS-1500)

Envolve Vision (837P/CMS-1500) Claim Lines Examined = 77,600			
	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. In most cases (99.9%), 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	100.0	
3	Subcontractor Amount Paid – Claim Header	99.9	
4	Subcontractor Amount Paid – Claim Detail Lines	99.9	

Envolve Vision (837P/CMS-1500) Claim Lines Examined = 77,600			
	Claim Data Element	**% Match**	**Notes**
5	Interest Paid - Claim Header	100.0	The occurrence of interest payments on Envolve Vision claims was very rare (less than 0.01%). We observed three (3) claims in the Envolve Vision extracts having a non-zero interest amount, and all values reported in the Envolve Vision claims extracts appeared to match values reported in the MMIS encounters.
6	Denial Indicator - Claim Header	100.0	
7	Member Medicaid ID	100.0	
8	Payee Provider Tax ID	88.6	For approximately 8,200 vision claim lines (10.6%) it appeared the Payee Provider Tax ID 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	99.1	
10	Referring Provider NPI	99.3	
11	Claim ICD Diagnosis Codes	100.0	
12	Amount Billed - Claim Header	100.0	
13	Amount Billed - Claim Detail Lines	100.0	
14	First Date of Service – Claim Header	100.0	
15	Last Date of Service – Claim Header	99.9	
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	98.4	We observed claims where one or more claim lines in the Envolve Vision 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 1,200 Envolve Vision claim lines (1.5%) appeared to have been either renumbered or reordered in the MMIS encounters.
19	Units Billed	100.0	
20	Place of Service	100.0	
21	Procedure Code	100.0	
22	Procedure Code Modifier 1	99.9	
23	Procedure Code Modifier 2	100.0	

Envolve Vision (837P/CMS-1500) Claim Lines Examined = 77,600			
	Claim Data Element	**% Match**	**Notes**
24	Procedure Code Modifier 3	100.0	
25	Procedure Code Modifier 4	N/A	Procedure Code Modifier 4 did not appear to be populated in either the Envolve Vision claims extracts or the MMIS encounters for Envolve Vision. The sample examination period may not include any vision claim lines with more than three procedure code modifiers, which may explain the absence of values.
26	NDC	N/A	NDCs did not appear to be reported in either the Envolve Vision claims extract or the MMIS encounters for Envolve Vision. This field may not be required for vision claims.
27	Claim Detail Line ICD Diagnosis 1	99.9	
28	Claim Detail Line ICD Diagnosis 2	99.9	
29	Claim Detail Line ICD Diagnosis 3	100.0	
30	Claim Detail Line ICD Diagnosis 4	100.0	

Table 23: CVS Health (NCPDP)

CVS Health (NCPDP) Claim Lines Examined = 1,022,000			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Subcontractor by Provider	99.0	
2	Date Paid	99.9	
3	Subcontractor Amount Paid	100.0	
4	Denial Indicator	100.0	
5	Member Medicaid ID	99.9	
6	Payee Provider Tax ID	94.2	For approximately 58,800 pharmacy claim lines (5.7%) it appeared the Payee Provider Tax ID in the MMIS encounters for CVS Health was derived from the dispensing provider. The payee provider in the MMIS may not accurately reflect the claim payee/billing provider reported on the claim submission.

CVS Health (NCPDP) Claim Lines Examined = 1,022,000			
	Claim Data Element	**% Match**	**Notes**
7	Dispensing Provider NPI	98.6	We observed approximately 13,400 pharmacy claim lines (1.3%) in the CVS Health claims extracts where the dispensing provider NPI reported in the MMIS encounters appeared to be an older NPI associated with the Medicaid provider ID reported on the encounter. The NPI reported in the MMIS encounters may not be the most appropriate ID currently used by the dispensing provider.
8	Prescribing Provider	99.9	
9	Claim ICD Diagnosis Codes	N/A	ICD Diagnosis codes do not appear to be reported in the MMIS encounter data. We observed approximately 179,000 pharmacy claim lines (17.5%) where one or more ICD diagnosis codes appeared to be reported in the CVS Health pharmacy claims extracts but did not appear to be reported in the MMIS encounters. This field may not be required for submission to the MMIS for pharmacy claims.
10	Prescription Number	100.0	
11	Amount Billed	2.1	We observed approximately 1,000,900 pharmacy claim lines (97.9%) where the amount billed reported in the CVS Health claims extracts did not match the amount billed reported in the MMIS encounters. The amount billed reported in the MMIS encounters appeared to represent the sum of the ingredient cost submitted and the dispensing fee.
12	Date Filled	100.0	
13	Dispensed Units	100.0	
14	NDC	100.0	
15	Days' Supply	100.0	
16	Refill Number	100.0	
17	Dispensing Fee	100.0	
18	Ingredient Cost Submitted	100.0	
19	Professional Service Fee Submitted	N/A	This data element was not populated in the supplied claims extracts or in MMIS encounters.

CVS Health (NCPDP) Claim Lines Examined = 1,022,000			
	Claim Data Element	**% Match**	**Notes**
20	Sales Tax Submitted	99.9	The sales tax submitted appeared to be reported as zero for all CVS Health MMIS encounters. We observed approximately 16 pharmacy claim lines (less than 0.01%) where the sales tax submitted reported in the CVS Health claims extracts was non-zero and did not match the sales tax submitted reported in the MMIS encounters.
21	Gross Amount Due	0.8	We observed approximately 1,014,300 pharmacy claim lines (99.2%) where the gross amount due reported in the CVS Health claims extracts did not match the gross amount due reported in the MMIS encounters. The gross amount due reported in the MMIS encounters appeared to represent the ingredient cost submitted.
22	Provider Fee Amount	N/A	This provider fee amount was not populated in the supplied claims extracts or in MMIS encounters.
23	Patient Paid Amount	100.0	

Appendix A: Glossary

- ***837 Health Care Claim Transaction*** *– An electronic transaction designed to submit one or more encounters from the care management organization (CMO) to the fiscal agent contractor (FAC).*
- ***Peach State Health Plan (PSHP)*** *– An organization that has entered into a risk-based contractual arrangement with the Department to obtain and finance care for enrolled Medicaid and PeachCare for Kids® members. CMOs receive a per capita or capitation payment from the Department for each enrolled member.*
- ***Appeal*** *– A request for review of an action, as "action" is defined in 42 Code of Federal Regulations (CFR) §438.400.*
- ***Appeal Process*** *– The overall process that includes appeals at the contractor level and access to the state fair hearing process (the State's administrative law hearing).*
- ***Appeal System*** *– The system used to track and process appeals at the contractor level and access to the state fair hearing process (the State's Administrative Law Hearing).*
- ***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.*
- ***Centene Pharmacy Services*** *– Centene division providing comprehensive specialty drug management services focused on improving care and outcomes for patients living with complex conditions.*
- ***Children's Health Insurance Program (CHIP)*** *– Provides health coverage to children in families with incomes too high to qualify for Medicaid, but cannot afford private coverage.*
- ***Claim*** *– An electronic or paper record submitted by a Medicaid provider to the CMO detailing the health care services provided to a patient for which the provider is requesting payment. A claim may contain multiple health care services.*
- ***Claim Adjudication*** *– The determination of the CMO's payment or financial responsibility, after the member's insurance benefits are applied to a claim.*
- ***Claims Processing System*** *– A computer system or set of systems that determine the reimbursement amount for services billed by the Medicaid provider and adjudicates claims according to the applicable coverage and payment policies.*
- ***Claims Universe*** *– The population parameters for claims to be tested, including the type of claim, the categories of service, and paid dates.*

- ***Clean Claim*** *– A claim received by the CMO for adjudication, in a nationally-accepted format in compliance with standard coding guidelines, which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the CMO.*
- ***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.*
- ***Contract Compliance*** *– A form of contract management that seeks to ensure contractors are not in violation of the terms to which they have agreed.*
- ***Coordination of Benefits*** *– The practice of determining the order in which the health plans will pay when an individual is covered under multiple plans.*
- ***Credentialing Verification Organization (CVO)*** *– The entity contracted by DCH to determine the qualifications and ascribed privileges of providers to render specific health care services and make all decisions for whether a provider meets requirements to enroll in Medicaid and in Georgia Families®.*
- ***CVS Health (CVS)*** *– The PSHP subcontractor responsible for pharmacy benefit management (PBM) service.*
- ***Department of Community Health (DCH or Department)*** *– The Department within the state of Georgia that oversees and administers the Medicaid and PeachCare for Kids® programs.*
- ***Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit*** *– A comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children, and adolescents under age 21.*
- ***Encounter*** *– A distinct set of health care services provided to a member enrolled with a CMO on the dates that the services were delivered.*
- ***Encounter Claim (Encounter)*** *– A record of a health care service that was delivered to an eligible health plan member that is subsequently submitted by the CMO or the CMO's subcontractor to the Medicaid FAC to load and maintain in the Georgia Medicaid and PeachCare for Kids® MMIS. The Medicaid FAC does not generate a payment for the encounter claim, rather, it is maintained for program management, rate setting, and a variety of program oversight functions.*
- ***Enrollment*** *– The process by which an individual eligible for Medicaid or PeachCare for Kids® applies (whether voluntary or mandatory) to utilize the contractor's plan in lieu of the fee-for-service (FFS) program and such application is approved by DCH or its agent.*
- ***Envolve Dental*** *– The PSHP subcontractor responsible for managing dental services.*
- ***Envolve Vision*** *– The PSHP subcontractor responsible for managing vision services.*

- ***FFS Medicaid*** *– For purposes of this engagement, FFS delivery is the portion of the Medicaid and PeachCare for Kids® program which provides benefits to eligible members who were not participants in the Georgia Families® program and where providers were paid for each service.*
- ***FAC*** *– The entity contracted with the Department to process Medicaid and PeachCare for Kids® claims and other non-claim-specific payments, and receive and store encounter claim data from each of the CMOs. Also sometimes referred to as the fiscal intermediary.*
- ***Fraud, Waste, and Abuse (FWA)*** *– Intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, himself, or some other person (any act that constitutes fraud under applicable federal or state law); thoughtless or careless use, consumption, or spending of program resources; and improper use of program resources for personal gain or benefit.*
- ***Georgia Families®*** *– The risk-based managed care delivery program for Medicaid and PeachCare for Kids® where the Department contracts with CMOs to manage and finance the care of eligible members.*
- ***Grievance*** *– An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided or aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.*
- ***Grievance System*** *– The overall system that addresses the manner in which the CMO handles grievances at the contractor level.*
- ***Health Insurance Portability and Accountability Act (HIPAA)*** *– The 1996 Act and its implementing regulations (45 CFR sections 142, 160, 162, and 164), all as may be amended.*
- ***List of Excluded Individuals and Entities*** *– A list maintained by the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) comprising individuals and entities excluded from federally-funded health care programs pursuant to sections 1128 and 1156 of the Social Security Act.*
- ***Medicaid Fraud Control Unit (MFCU)*** *– Investigates and prosecutes Medicaid provider fraud, as well as patient abuse or neglect in health care facilities and board and care facilities. The MFCUs, usually a part of the State Attorney General's office, employ teams of investigators, attorneys, and auditors; are constituted as single, identifiable entities; and must be separate and distinct from the state Medicaid agency.*
- ***Medicaid Management Information System (MMIS)*** *– Computerized system used for the processing, collecting, analyzing, and reporting of information needed to support Medicaid and PeachCare for Kids® functions. The MMIS consists of all required subsystems as specified in the State Medicaid Manuals.*

- ***Member*** *– An individual who is eligible for Medicaid or PeachCare for Kids® benefits. An individual who is eligible for Medicaid or PeachCare for Kids® benefits might also be eligible to participate in the Georgia Families® program.*
- ***Member Call Center*** *– A toll-free number staffed by call center employees trained to accurately assist members with general inquiries, identify the need for crisis intervention, and provide referrals to the appropriate resources in order to meet the Medicaid member's needs.*
- ***Member Disenrollment*** *– The process by which an individual seeks to terminate their Medicaid or PeachCare for Kids® participation.*
- ***Member Enrollment*** *– The process by which an individual eligible for Medicaid or PeachCare for Kids® applies to become a Medicaid recipient/participant.*
- ***National Provider Identifier (NPI)*** *– A unique 10-digit identification number required in administrative and financial transactions adopted under HIPAA for covered health care providers.*
- ***Ombudsman*** *– PSHP employees responsible for coordinating services with local community organizations and working with local advocacy organizations to ensure members have access to covered and non-covered services and collaborating with DCH to identify and resolve issues such as access to health care service.*
- ***PeachCare for Kids®*** *– A comprehensive health care program for uninsured children living in Georgia. Premiums are required for children ages six and older.*
- ***Planning for Healthy Babies (P4HB)*** *– A DCH comprehensive prevention program to reduce the incidence of low birth weight infants.*
- ***Prescription Medication*** *– Medications prescribed for mental and substance use. There are many different types of medication for mental health problems, including anti-depressants, medication for attention issues, anti-anxiety medications, mood stabilizers, and antipsychotic medications.*
- ***Prior Authorization(PA)*** *– The process of reviewing a requested medical service or item to determine if it is medically necessary and covered under the member's plan.*
- ***Program Integrity (PI)*** *– Initiatives or efforts by the Department and the CMO to ensure compliance, efficiency, and accountability within the Georgia Families® program. Efforts may include detecting and preventing fraud, waste, and abuse (FWA) and ensuring Medicaid dollars are paid appropriately.*
- ***Prompt Pay Law*** *– Georgia's prompt pay law requires insurers to pay physicians within 15 days for electronic claims or 30 days for paper claims. If the insurer denies the claim, they must send a letter or electronic notice which addresses the reasons for failing to pay the claim.*

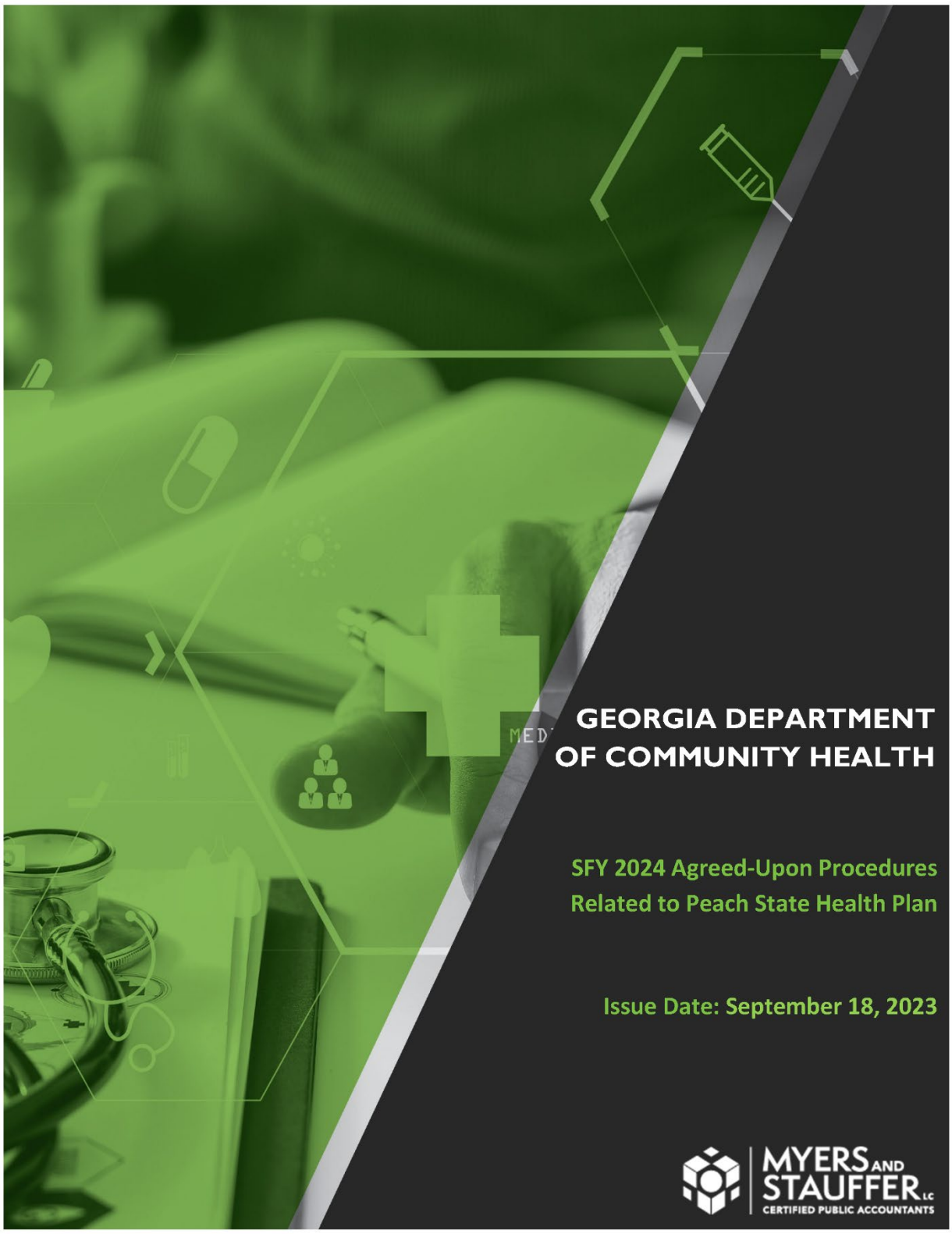
- ***Proposed Action*** *– The proposal of an action for the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure of the CMO to act within the timeframes provided in 42 CFR 438.408(b).*
- ***Provider*** *– Any person (including physicians or other health care professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or registered by the state of Georgia to provide health care services that has contracted with a CMO to provide health care services to members.*
- ***Provider Complaint*** *– A written expression by a provider which indicates dissatisfaction or dispute with the contractor's policies, procedures, or any aspect of a contractor's administrative functions.*
- ***Provider Network*** *– A provider network is a list of hospitals, physicians, and health care other that a CMO has contracted with to provide medical care to its members.*
- ***Provider Services –*** *The primary liaison between their organization and health care providers, such as medical doctors and dentists. Specific job duties vary, depending on the employer.*
- ***Quality and Performance Improvement*** *– Consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups with the intent to better services or outcomes, and prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement*
- ***Required Assessments and Screenings*** *– Assessments and screenings used as tools to identify immediate needs for members transitioning into and out of Georgia Families® 360°.*
- ***Special Investigations Unit*** *– PSHP/Anthem department responsible for the detection, prevention, investigation, reporting, correction, and deterrence of FWA.*
- ***State Fiscal Year*** *– The fiscal period utilized by the state of Georgia that begins on July 1 of each year and ends on June 30 of the following year.*
- ***Subcontracted Services*** *– Medical services the CMO pays to be performed by another company that are outside the normal day-to-day operations of their company.*
- ***Subcontractor*** *– A vendor who is overseeing or administering the approval, payment, and administration of medical, dental, vision, or other services to the Georgia Families® population on behalf of a CMO.*
- ***Subcontractor Oversight*** *– Procedures to ensure subcontractors supply the services agreed to under the financial terms and programmatic requirements outlined. Good oversight holds*

subcontractors accountable, while poor oversight may lead to waste, poor quality of care, fraud, and abuse of taxpayer dollars.

- ***Third-Party Liability (TPL)*** *– TPL refers to the legal obligation of any other health insurance plan or carrier (i.e., individual, group, employer-related, self-insured, commercial carrier, automobile insurance, and/or worker's compensation) or program to pay all or part of the member's health care expenses.*
- ***U.S. HHS-OIG*** *– The office of the federal government tasked with oversight of Medicare and Medicaid programs.*
- ***Utilization Management (UM)*** *– A service performed by the contractor which seeks to ensure covered services provided to members and P4HB participants are in accordance with, and appropriate under, the standards and requirements established by the contract, or a similar program developed, established, or administered by DCH.*
- ***Waiver Program*** *– Medicaid program(s) allowing health care professionals to provide care to members with disabilities and/or chronic health conditions in the home or community instead of a long-term care facility.*
- ***Waste*** *– Over-utilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.*

Appendix B: Agreed-Upon Procedures

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


GEORGIA DEPARTMENT OF COMMUNITY HEALTH
SFY 2024 Agreed-Upon Procedures Related to Peach State Health Plan
Issue Date: September 18, 2023
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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Peach State Health Plan – SFY 2024

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MYERS AND STAUFFER

Introduction

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

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

The following terms are used throughout this document:

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

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

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- ***Medicaid Management Information System (MMIS)*** – A computerized system used for the processing, collecting, analyzing, and reporting of information needed to support Medicaid and PeachCare for Kids® functions. The MMIS consists of all required subsystems as specified in the State Medicaid Manuals.
- ***Member*** – An individual who is eligible for Medicaid or PeachCare for Kids® benefits. An individual who is eligible for Medicaid or PeachCare for Kids® benefits might also be eligible to participate in the Georgia Families program.
- ***Member Call Center*** – A toll free number staffed by call center employees trained to accurately assist members with general inquiries, identify the need for crisis intervention and provide referrals to the appropriate resources in order to meet the Medicaid member's needs.
- ***PeachCare for Kids®*** – A comprehensive health care program for uninsured children living in Georgia. Premiums are required for children ages six and older.
- ***Peach State Health Plan (PSHP or Peach State)*** – Peach State Health Plan is a Care Management organization contracted by the Department of Community Health to deliver health care services to Georgia Families members.
- ***Planning for Healthy Babies (P4HB)*** – A DCH comprehensive prevention program to reduce the incidence of low birth weight infants
- ***Prior Authorization*** – The process of reviewing a requested medical service or item to determine if it is medically necessary and covered under the member's plan.
- ***Program Integrity*** – As mandated in section 4.13 of the contract between DCH and Peach State, a compliance program to be maintained by the CMO designed to guard against fraud and abuse. This Program Integrity program shall include policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for suspected cases of fraud and abuse in the administration and delivery of services under the contract.
- ***Provider*** – Any person (including physicians or other Health Care Professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or registered by the State of Georgia to provide Health Care Services that has contracted with a Care Management Organization to provide health care services to Members.
- ***Provider Complaint*** – A written expression by a Provider, which indicates dissatisfaction or dispute with the Contractor's policies, procedures, or any aspect of a Contractor's administrative functions.
- ***Provider Network*** – A provider network is a list of hospitals, physicians, and health care organizations that a CMO has contracted with to provide medical care to its members.

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- ***Provider Services –*** The primary liaison between their organization and health care providers, such as medical doctors and dentists. Specific job duties vary, depending on the employer.
- ***Quality Improvement*** – Consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups. The goal is to provide better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent, systemic problems and/or barriers to improvement for the targeted patient population.
- ***Subcontracted Services*** – Medical services the CMO pays to be performed by another company that are outside the normal day-to-day operations of their company.
- ***Subcontractor*** – A vendor who is overseeing or administering the approval, payment, and administration of medical services to the Georgia Families population on behalf of a CMO.
- ***Subcontractor Oversight*** – Procedures to ensure that subcontractors supply the services agreed to under the financial terms and programmatic requirements outlined. Good oversight holds subcontractors accountable while poor oversight may lead to waste, poor quality of care, fraud, and abuse of taxpayer dollars.
- ***Utilization Management*** – A service performed by the Contractor which seeks to assure that Covered Services provided to Members and Planning for Health Babies (P4HB) Participants are in accordance with, and appropriate under, the standards and requirements established by the Contract, or a similar program developed, established or administered by DCH.
- ***Waste*** – Over-utilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

Project Team

The following key personnel will be used for this engagement:

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

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

Objectives

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

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

Scope of Activities

The scope of the engagement will include the following activities:

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

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

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

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

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

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

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

AGREED UPON PROCEDURES

Agreed-Upon Procedures Related to
Peach State Health Plan – SFY 2024

Agreed Upon Procedures

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

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

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

2. We will request that Peach State and its subcontractors identify and provide their policies and procedures related to Claims Management including Encounter Submissions. We will also request claims data for analyses. The following procedures will be performed:
    - We will:
        i. Review then determine if the policies are in accordance with the contract between DCH and Peach State.
        ii. Review the information provided during the Peach State staff interviews then determine if responses are in accordance with the contract between DCH and Peach State.
        iii. Analyze the claims workflows and processes within Peach State and between Peach State and its subcontractors.
        iv. Analyze the encounter workflows and processes within Peach State and between Peach State and its subcontractors.
        v. Assess the effectiveness of internal controls used to ensure complete, timely, and accurate encounters are reported.

vi. Select a sample of encounters submitted to the Department's Fiscal Agent Contractor and trace the reported information to Peach State's (and subcontractor's) payment system.
vii. Research then determine the cause of any discrepancies.
viii. Analyze the claims payment system and accuracy of claim pay dates, particularly on adjustments and voids.

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

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

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

Environment for Interview Procedures

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

- One to four Myers and Stauffer engagement team members will be speaking directly to a single staff member. Exceptions may be made where representatives have shared responsibilities. This exception must be noted and approved in advance. A DCH staff member may choose participate in this engagement. All interviews are recorded for note taking purposes only.
- Documents may be requested at any time by the engagement team before, during, or after the interview process. Peach State should make every effort to provide those documents at its earliest convenience.
- Interviews, either planned or unplanned, may be requested during the staff interview sessions. We will be cautious to minimize interruptions to normal business operations.
- An attestation form is required to certify that the data, CDJ, and documentation provided, and statements made to Myers and Stauffer, DCH, and/or other DCH designated representatives by the management or staff of Peach State during the course of this engagement are accurate, complete, and truthful.

Other Information

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

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

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

Estimated Timelines
We anticipate the project will take approximately six to eight months for completion through the draft report phase. Peach State staff interviews are projected to begin in October 2023. Please note that this timeframe an estimate and subject to the on-going completion of activities by all parties, including the DCH, Myers and Stauffer, Peach State, and other parties. Dates may require adjustment based on project events and other unforeseen situations.

Appendix C: Georgia Families® Policy and Procedure Assessment

Contract Compliance

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

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

Internal Grievance/Appeal System

Internal Grievance/Appeal System	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
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.	Partial. There was no specific reference to PSHP submitting materials to DCH for review; however, interview responses from PSHP staff support these functions occurring.
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

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

Member and Provider Call Center Operations

Member and Provider Call Center Operations	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
Member Call Center Operations	
4.3.7.1 The contractor shall operate a toll-free telephone line to respond to Member questions and comments.	Yes
4.3.7.2 The contractor shall develop call center policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.	Yes
4.3.7.3 The contractor shall submit these call center policies and procedures, including performance standards, to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date, and as updated thereafter.	Partial. There was no specific reference to this section of the contract in the submitted policy documents; however, interview responses from PSHP staff support these functions occurring.
4.3.7.4 The call center must comply with Title IV of the Civil Rights Act. The call center shall be equipped to handle calls from non-English speaking callers, as well as calls from Members who are hearing impaired.	Yes
4.3.7.5 The contractor shall fully staff the call center between the hours of 7:00 a.m. and 7:00 p.m. EST, Monday through Friday, excluding State holidays. The call center staff shall be trained to accurately respond to Member questions in all areas, including, but not limited to, Covered Services, the Provider Network, and Non-Emergency Transportation (NET). Additionally, Amerigroup shall have an automated system available between the hours of 7:00 a.m. and 7:00 p.m. EST Monday through Friday and at all hours on weekends and State holidays. This automated system must provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. A Contractor's Representative shall return messages on the next Business Day.	Partial. There was no specific reference to PSHP submitting materials to DCH for review; however, interview responses from PSHP staff support these functions occurring.
4.3.7.6 The contractor shall achieve performance standards and monitor call center performance by recording calls and employing other Monitoring activities Amerigroup shall develop Call Center Quality Criteria and Protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the Toll-free Call Center. Amerigroup shall submit the Call Center Quality Criteria and Protocols to DCH Provider Services for review and approval annually. At a minimum, the standards shall require that, on a Calendar month basis:	Partial. There was no specific reference to PSHP submitting materials to DCH for review; however, interview responses from PSHP staff support these functions occurring.
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

Member and Provider Call Center Operations	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
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.	Partial. There was no specific reference to this section of the contract in the submitted policy documents; however, interview responses from PSHP staff support these functions occurring.
4.3.10.1 The Contractor shall provide oral interpretation services of information to any Member who speaks any non-English language regardless of whether a Member speaks a language that meets the threshold of a Prevalent Non-English Language. Amerigroup shall notify its Members of the availability of oral interpretation services and to inform them of how to access oral interpretation services. There shall be no charge to the Member for interpretation services.	Yes
Provider Call Center Operations	
4.9.5.1 The Contractor shall operate a toll-free call center to respond to Provider questions, comments, and concerns.	Yes
4.9.5.2 The Contractor shall develop call center Policies and Procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.	Yes
4.9.5.3 The Contractor shall submit these call center Policies and Procedures, including performance standards, to DCH for initial review and approval as updated thereafter.	Yes
4.9.5.4 The Contractor's call center systems shall have the capability to track call management metrics identified in Attachment K.	Yes
4.9.5.5 Pursuant to O.C.G.A. 33-20A-7.1(c), the call center shall be staffed twenty-four (24) hours a day, seven (7) days a week to respond to Prior Authorization and Pre-Certification requests. This call center shall have staff to respond to Provider questions in all other areas, including the Provider complaint system, Provider responsibilities, etc. between the hours of 7:00am and 7:00pm EST Monday through Friday, excluding State holidays.	Yes

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

Member and Provider Call Center Operations	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
sessions with DCH. The purpose of the calibration sessions is to ensure call center monitoring findings conducted by DCH and the Contractor are consistent.	support these functions occurring.

Member Services including Ombudsman

Member Services including Ombudsman	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
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
4.3.2.1 The Contractor shall make all written materials available in a manner that takes into consideration the Member's needs, including those who are visually impaired or have limited reading proficiency. The Contractor shall notify all Members that information is available in alternative formats and how to access those formats.	Yes
4.3.2.2 The Contractor shall make all written information available in English, Spanish and all other prevalent non-English languages, as defined by DCH. For the purposes of this Contract, prevalent means a non-English language spoken by a significant number or percentage of Medicaid and PeachCare for Kids® eligible individuals in the State, as defined by DCH.	Yes

Member Services including Ombudsman	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
4.3.2.3 All written materials distributed to Members shall include a language block, printed in Spanish and all other prevalent non-English languages, that informs the Member that the document contains important information and directs the Member to call the Contractor to request the document in an alternative language or to have it orally translated.	Yes
4.3.2.4 All written materials shall be worded such that they are understandable to a person who reads at the fifth (5th) grade level.	Yes
4.3.2.5 The Contractor shall provide written notice to DCH of any changes to any written materials provided to the Members. Written notice shall be provided at least thirty (30) Calendar Days before the effective date of the change.	Yes
4.3.2.6 The Contractor must submit all written materials, including information for the Contractor's Web site, to DCH for approval prior to use or mailing. DCH will approve or identify any required changes to the Member materials within thirty (30) Calendar Days of submission. DCH reserves the right to require the discontinuation of any Member materials that violate the terms of this Contract.	Yes
4.3.3.1 The Contractor shall provide a Member Handbook, a P4HB participant Handbook, and other programmatic information to Members. The Contractor shall make the Member and P4HB participant Handbook available to Members through the Contractor's web site. Upon request, the Contractor shall mail a hard copy of the Member Handbook to enrolled Member households and a P4HB participant information packet to P4HB participant households.	Yes
4.3.3.2 The Member Handbook shall include all requirements set forth in 42 CFR 438.10.	Yes
4.3.6.1 The Contractor shall mail via surface mail a Member ID Card to all new Members according to the following timeframes: 4.3.6.1.1 Within seven (7) Calendar Days of receiving the notice of Enrollment from DCH or the Agent for Members who have selected a CMO and a PCP.	Yes
4.3.6.3 The Contractor shall reissue the Member ID Card within seven (7) Calendar Days of notice if a Member reports a lost card, there is a Member name change, the PCP changes, or for any other reason that results in a change to the information disclosed on the Member ID Card.	Yes
4.3.6.4 The Contractor shall submit a front and back sample Member ID Card to DCH for initial review and approval, within sixty (60) Calendar Days of the Contract Effective Date and approval and as updated thereafter.	Yes
4.3.6.5 The Contractor shall mail via surface mail a P4HB participant ID Card to all new P4HB participants in the Demonstration within Seven (7) Calendar Days of receiving the notice of Enrollment from DCH or its Agent. The P4HB participant's ID Card will meet the requirements set forth for Member ID Cards in Sections 4.3.6.2 (excluding Section 4.3.6.2.4), 4.3.6.3 and 4.3.6.4, and	Yes

Member Services including Ombudsman	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
will identify the Demonstration component in which the P4HB participant is enrolled:	
4.3.6.5.1 A Pink color will signify the P4HB participants as eligible for Family Planning Services Only.	Yes
4.3.6.5.2 A Purple color will signify the P4HB participants as eligible for Interpregnancy Care Services and Family Planning Services.	Yes
4.3.6.5.3 A Yellow color will signify the P4HB participant as eligible for Case Management – Resource Mothers Outreach Only.	Yes
4.3.6.6 Each time the P4HB participant's ID card is issued or re-issued to a P4HB participant, the Contractor shall provide written materials that explain the meaning of the color coding of the ID card and its relevance to Demonstration benefits.	Yes

Program Integrity

Program Integrity	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
4.13.1.1 The Contractor shall have a Program Integrity Program, including a mandatory compliance plan, designed to guard against Fraud and Abuse. This Program Integrity Program shall include policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for suspected cases of Fraud, Waste and Abuse in the administration and delivery of services under this Contract.	Yes
4.13.1.2 The Contractor shall submit its Program Integrity Policies and Procedures, which include the compliance plan and pharmacy lock-in program described below.	Yes
4.13.1.3 The Contractor shall provide DCH with a copy of any Program Integrity settlement agreement entered into with a Provider including the settlement amount and Provider type within seven (7) Business Days of the settlement.	Yes
4.13.2.1 The Contractor's compliance plan shall include, at a minimum, the following:	
4.13.2.1.1 The designation of a Compliance Officer who is accountable to the Contractor's senior management and is responsible for ensuring that policies to establish effective lines of communication between the Compliance Officer and the Contractor's staff, and between the Compliance Officer and DCH staff, are followed.	Yes

Program Integrity	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
4.13.2.1.2 Provision for internal monitoring and auditing of reported Fraud , Waste and Abuse violations, including specific methodologies for such monitoring and auditing;	Yes
4.13.2.1.3 Policies to ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's Fraud, Waste and Abuse compliance plan;	Yes
4.13.2.1.4 Policies to establish a compliance committee that meets quarterly and reviews Fraud, Waste and Abuse compliance issues;	Yes
4.13.2.1.5 Policies to ensure that any individual who reports CMO violations or suspected Fraud, Waste and Abuse will not be retaliated against;	Yes
4.13.2.1.6 Policies of enforcement of standards through well-publicized disciplinary standards;	Yes
4.13.2.1.7 Provision of a data system, resources and staff to perform the Fraud, Waste and Abuse and other compliance responsibilities;	Yes
4.13.2.1.8 Procedures for the detection of Fraud, Waste and Abuse that includes, at a minimum, the following: 4.13.2.1.8.1 Prepayment review of claims; 4.13.2.1.8.2 Claims edits; 4.13.2.1.8.3 Post-processing review of Claims; 4.13.2.1.8.4 Provider profiling; 4.13.2.1.8.5 Quality Control; and 4.13.2.1.8.6 Utilization Management.	Yes
4.13.2.1.9 Written standards for organizational conduct;	Yes
4.13.2.1.10 Effective training and education for the Compliance Officer and the organization's employees, management, board Members, and Subcontractors;	Yes
4.13.2.1.11 Inclusion of information about Fraud, Waste and Abuse identification and reporting in Provider and Member materials;	Yes
4.13.2.1.12 Provisions for the investigation, corrective action and follow-up of any suspected Fraud, Waste and Abuse reports;	Yes
4.13.2.1.13 Procedures for notification to DCH Office of the Inspector General requesting permission before initiating an investigation, notifying a provider of the outcome of an investigation, and/or recovery of any overpayments identified; and	Yes
4.13.2.1.14 Procedures for reporting suspected Fraud, Waste and Abuse cases to the Georgia Medicaid Fraud Control Unit, through the State Program Integrity Unit, including timelines and use of State approved forms.	Yes
4.13.2.2 As part of the Program Integrity Program, the Contractor may implement a pharmacy lock-in program. The policies, procedures and criteria for establishing a lock-in program shall be submitted to DCH for review and approval as part of the Program Integrity Policies and Procedures described in Section 4.13.1. The pharmacy lock-in program shall:	Yes

Program Integrity	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
4.13.2.2.1 Allow Members to change pharmacies for good cause, as determined by the Contractor after discussion with the Provider(s) and the pharmacist. Valid reasons for change should include recipient relocation or the pharmacy does not provide the prescribed drug;	Yes
4.13.2.2.2 Provide Case Management and education reinforcement of appropriate medication use;	Yes
4.13.2.2.3 Annually assess the need for lock in for each Member;	Yes
4.13.2.2.4 Require that the Contractor's Compliance Officer report on the program on a monthly basis to DCH; and	Yes
4.13.2.2.5 Not allow a Member to transfer to another pharmacy, PCP, or CMO while enrolled in their existing CMO's pharmacy lock-in program.	Yes
4.13.3.1 The Contractor shall cooperate and assist any State or federal agency charged with the duty of identifying, investigating, or prosecuting suspected Fraud, Waste and Abuse cases, including permitting access to the Contractor's place of business during normal business hours, providing requested information, permitting access to personnel, financial and Medical Records, and providing internal reports of investigative, corrective and legal actions taken relative to the suspected case of Fraud and Abuse.	Yes
4.13.3.2 The Contractor's Compliance Officer shall work closely, including attending quarterly meetings, with DCH's PI staff to ensure that the activities of one entity do not interfere with an ongoing investigation being conducted by the other entity.	Yes
4.13.3.3 The Contractor shall inform DCH immediately about known or suspected fraud cases and it shall not investigate or resolve the suspicion without making DCH aware of, and if appropriate involved in, the investigation, as determined by DCH.	Yes
4.13.4.1 The Contractor shall submit to DCH a quarterly Fraud and Abuse Report, as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein. This Report shall include information on the pharmacy lock-in program described in Section 4.13.2.2. This report shall also include information on the prohibition of affiliations with individuals debarred and suspended described in Section 33.20.	Yes

Provider Network

Provider Network	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
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	Yes

Provider Network	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
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.	
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

Provider Services

Provider Services	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
4.9.1.1 The Contractor shall provide information to all Providers about Georgia Families in order to operate in full compliance with the GF Contract and all applicable federal and State regulations.	Yes
4.9.1.2 The Contractor shall monitor Provider knowledge and understanding of Provider requirements, and take corrective actions to ensure compliance with such requirements.	No. According to PSHP, "PSHP does not have a formal policy; however, PSHP would utilize various methods (Provider Newsletter, resend of historical letters, provider trainings, etc.)

Provider Services	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
	to issue reminders or knowledge refreshers to providers."
4.9.1.3 Within sixty (60) Calendar Days of the Contract Effective Date, the Contractor shall submit to DCH for initial review and approval all materials and information to be distributed and/or made available to Providers about Georgia Families. Any proposed revisions to such materials and information thereafter shall also be submitted to DCH for prior review and approval. DCH will attempt to complete its review of such materials within thirty (30) Calendar Days of its receipt of such materials.	Yes
4.9.1.4 All Provider Handbooks and bulletins must be in compliance with State and federal laws.	Yes
4.9.1.5 Contractor must seek DCH's written approval of the Contractor's interpretation of policies in the Georgia Medicaid Policy Manual when such policies are referenced in Provider contracts or communications. DCH's review and response will be completed within sixty (60) Calendar Days of the Contractor's written request for approval of its policy interpretation. DCH's written response shall be final regarding any dispute of the meaning of that policy language. In the event the Contractor misinterprets a Medicaid policy which is communicated to Providers, the Contractor must submit a written corrective action plan to DCH within three (3) Business Days of notice from DCH. Contractor will be required to retroactively correct and adjust any previously adjudicated Claims or correct any other actions resulting from the misinterpreted policy language within thirty (30) Calendar Days of approval of the corrective action plan.	No. According to PSHP, "PSHP does not have a formal policy; however, PSHP would request clarification on contract interpretation from DCH through our Compliance Officer."
4.9.2.1 The Contractor shall provide a Provider Handbook to all Providers. Upon request, the Contractor shall mail a hard copy to the Provider. The Provider Handbook shall serve as a source of information regarding GF Covered Services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all Contract requirements are being met. At a minimum, the Provider Handbook shall include the following information:	
4.9.2.1.1 Georgia Families Covered Services;	Yes
4.9.2.1.2 Member eligibility categories;	Yes
4.9.2.1.3 Medical Necessity standards and practice guidelines;	Yes
4.9.2.1.4 Role of the PCP;	Yes
4.9.2.1.5 Link to the NCQA and Joint Commission web sites;	Yes
4.9.2.1.5 Role of the Dental Home;	Yes
4.9.2.1.6 Emergency Service responsibilities;	Yes
4.9.2.1.7 Health Check/EPSDT Benefit;	Yes
4.9.2.1.8 Prior Authorization, Pre-Certification, and Referral procedures;	Yes
4.9.2.1.9 Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;	Yes

Provider Services	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
4.9.2.1.10 Physical Health and Behavioral Health Coordination including the requirement for Behavioral Health Providers to send status reports to PCPs and PCPs to send status reports to Member's Behavioral Health Providers;	Yes
4.9.2.1.11 Provider Complaint System Policies and Procedures, including, but not be limited to, specific instructions for contacting the Contractor's Provider services to file a complaint and which individual(s) have the authority to review a complaint;	Yes
4.9.2.1.12 Policies and procedures for the Provider Grievance and Appeals process;	Yes
4.9.2.1.13 Information on the Member Grievance System, including the Member's right to a State Administrative Law Hearing, the timeframes and requirements, the availability of assistance in filing, the toll-free numbers and the right to request continuation of Benefits while utilizing the Grievance System;	Yes
4.9.2.1.14 The role of the CVO and link to the CVO web site;	Yes
4.9.2.1.15 Information about the GaHIN including how information will be used by the CMOs and DCH and an explanation of any service limitations or exclusions from coverage;	Yes
4.9.2.1.16 Link to the DCH web site;	Yes
4.9.2.1.17 Role of the DCH fiscal agent and link to the fiscal Agent's web site;	Yes
4.9.2.1.18 Information about the Georgia Families Value-based Purchasing;	Yes
4.9.2.1.19 Transition of Care Planning;	Yes
4.9.2.1.20 Care Coordination Policies;	Yes
4.9.2.1.21 Protocol for Encounter Claims element reporting/records;	Yes
4.9.2.1.22 Medical Records standards;	Yes
4.9.2.1.23 Claims submission protocols and standards, including instructions and all information necessary for a clean or complete Claim;	Yes
4.9.2.1.24 Payment policies;	Yes
4.9.2.1.25 The Contractor's Cultural Competency Plan;	Yes
4.9.2.1.26 Member rights and responsibilities;	Yes
4.9.2.1.27 Other Provider or Subcontractor responsibilities; and	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interview responses from PSHP staff support these functions occurring.
4.9.2.1.28 Information about the 1115 Demonstration, Planning for Healthy Babies, including:	Yes
4.9.2.1.28.1 Demonstration description;	Yes
4.9.2.1.28.2 Covered Demonstration Services;	Yes
4.9.2.1.28.3 Practice protocols;	Yes

Provider Services	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
4.9.2.1.28.4 Other Provider responsibilities;	Yes
4.9.2.1.28.5 Coding requirements;	Yes
4.9.2.1.28.6 Prior Authorization, Pre-Certification, and Referral procedures; and	Yes
4.9.2.1.28.7 P4HB participants' rights and responsibilities.	Yes
4.9.2.2 The Contractor shall disseminate bulletins as needed to incorporate any needed changes to the Provider Handbook. These bulletins can be mailed hard copy or can be disseminated via email, provided hard copies are available and Providers are informed of how to request in hard copy.	Yes
4.9.2.3 The Contractor shall submit the Provider Handbook to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date and as updated thereafter. Any updates or revisions shall be submitted to DCH for review and approval at least thirty (30) Calendar Days prior to distribution.	Yes
4.9.3.1 The Contractor shall provide training to all Providers and their staff regarding the requirements of the Contract and special needs of Members. The Contractor shall conduct initial training within thirty (30) Calendar Days of executing a contract with a newly contracted Provider. The Contractor shall also conduct ongoing training which may include webinars and web-based tutorials, as deemed necessary by the Contractor or DCH in order to ensure compliance with program standards and the GF Contract and meet the needs of Providers.	Yes
4.9.3.2 The Contractor shall also provide Provider workshops, data, trainings and technical assistance, webinars and web-based tutorials about the emergence and ongoing operations of Medical Homes and other service delivery innovations, evidence-based and emergency best practices, delivering a person-centered approach to care and the System of Care approach to care delivery.	Yes
4.9.3.3 The Contractor shall provide training to all Demonstration Family Planning and IPC service Providers and their staffs regarding the requirements of the Demonstration and the Contract provisions related to the Demonstration and special needs of the P4HB participants. The Contractor shall conduct initial training within thirty (30) Calendar Days of placing a newly contracted Provider on active status. The Contractor shall also conduct ongoing training as deemed necessary by the Contractor or DCH in order to ensure compliance with the Demonstration's standards and the Contract.	Yes
4.9.3.4 The Contractor's Demonstration Provider network will utilize the Preconception Care Toolkit for Georgia for preconception health education and counseling available at http://fpm.emory.edu/preventive/research/projects/index.html.	Yes
4.9.3.5 The Contractor shall develop and submit the Provider Training Manual and Training Plan, including topics, schedule and languages spoken, to DCH	Yes

Provider Services	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
for initial review and approval at least thirty (30) Calendar Days prior to any scheduled trainings and as updated thereafter.	
4.9.3.6 DCH may attend any training sessions specific to this Contract at its discretion.	Yes
4.9.4.1 The Contractor shall establish and maintain a formal Provider relations function to timely and adequately respond to inquiries, questions and concerns from network Providers. The Contractor shall implement policies addressing the compliance of Providers with the requirements included in this RFP and institute a mechanism for Provider dispute resolution and execute a formal system of terminating Providers from the network.	Yes
4.9.4.2 The Contractor shall provide for at least one (1) Provider Relations Liaison per Service Region to Conduct the Provider Relations functions.	Yes

Quality Management

Quality Management and Performance Improvement	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
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

Quality Management and Performance Improvement	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
4.12.1.4.1 The Contractor shall establish a multi-disciplinary Quality Oversight Committee to oversee all Quality functions and activities. This committee shall meet at least quarterly, but more often if warranted. The formal organizational structure must include at a minimum, the following: 4.12.1.4.1.1 A designated health care practitioner, qualified by training and experience, to serve as the QM Director; 4.12.1.4.1.2 A committee which includes representatives from the provider groups as well as clinical and non-clinical areas of the organization; 4.12.1.4.1.3 A senior executive who is responsible for program implementation; 4.12.1.4.1.4 Substantial involvement in QM activities by the Contractor's Medical Director; and 4.12.1.4.1.5 Accountability to the governing body of the organization to which it reports on activities, findings, recommendations, actions, and results on a scheduled basis.	Yes
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 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	

Quality Management and Performance Improvement	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
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 record reviews is determined by the specifications for each hybrid measure.	Yes
4.12.3.3 DCH establishes Performance Measure Targets for each measure. It is important that the Contractor continually improve health outcomes from year to year. The performance measure targets, as amended from time to time, for each performance measure can be accessed at http://dch.georgia.gov/medicaid-quality-reporting. Performance targets are based on national Medicaid Managed Care HEDIS® percentiles as reported by NCQA or other benchmarks as established by DCH.	Yes
4.12.3.4 DCH may also require a Corrective Action (CA) or Preventive Action (PA) form that addresses the lack of performance measure target achievements and identifies steps that will lead toward improvements. This evidence-based CA or PA form must be received by DCH within thirty (30) 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	Yes

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

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

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

Quality Management and Performance Improvement	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
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 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.	Yes
4.12.8.2 The Contractor shall submit to DCH for review and prior approval and as updated thereafter all Clinical Practice Guidelines in use, which shall include a methodology for measuring and assessing compliance as part of the QAPI program plan.	Yes
4.12.8.3 The Contractor shall disseminate the guidelines to all affected Providers and, upon request, to Members.	Yes
4.12.8.4 The Contractor shall ensure that decisions for Utilization Management, Member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	Yes
4.12.9.5 To ensure consistent application of the guidelines, the Contractor shall require Providers to utilize the guidelines, and shall measure compliance with the guidelines, until ninety percent (90%) or more of the Providers are consistently in compliance. The Contractor will conduct this review on a quarterly basis. The Contractor may use Provider incentive strategies to improve Provider compliance with guidelines.	Yes
4.12.9.6 To further ensure consistent application of the Clinical Practice Guidelines, the Contractor shall perform a review of a minimum random	Yes

Quality Management and Performance Improvement	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
sample of fifty (50) Members' medical records per evidence-based CPG, each quarter.	
4.12.9 Focused Studies 4.12.9.1 Focused Studies examine a specific aspect of health care (such as prenatal care) for a defined point in time. These studies are usually based on information extracted from medical records or Contractor administrative data such as Enrollment files and Encounter/claims data. Steps that may be taken by the Contractor when conducting focused studies are: 4.12.9.1.1 Selecting the Study Topic(s) 4.12.9.1.2 Defining the Study Questions or Aim Statement 4.12.9.1.3 Selecting the Study Indicator(s) 4.12.9.1.4 Identifying a representative and generalizable study population 4.12.9.1.5 Documenting sound sampling techniques utilized (if applicable) 4.12.9.1.6 Collecting reliable data 4.12.9.1.7 Analyzing data and interpreting study results	Yes
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.	Yes
4.12.10.2 At a minimum, the Patient Safety Program process shall: 4.12.10.1.4.1 Report and analyze the patient safety programs and outcomes in place within the CMO's network of hospitals; 4.12.10.1.4.2 Report and analyze Medication recalls; 4.12.10.1.4.3 Report and analyze Medication errors; 4.12.10.1.4.4 Describe the results of site Inspections; and 4.12.10.1.4.5 Report and analyze Patient Quality of Care Concerns, including those arising from patient grievances.	Yes
4.12.10.3 The Contractor shall submit the Patient Safety Plan to DCH for initial review and approval and as updated and submit to DCH on an annual basis no	Yes

Quality Management and Performance Improvement	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
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.	
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.	No. According to PSHP, "Peach State does not have a policy to address VBP, at this time. Although these requirements are in the contract, the DCH has not implemented this program."
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. According to PSHP, "Peach State does not have a policy to address VBP, at this time. Although these requirements are in the contract, the DCH has not implemented this program."
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. According to PSHP, "Peach State does not have a policy to address VBP, at this time. Although these requirements are in the contract, the DCH has not implemented this program."
4.12.12.4 Through the VBP Performance Management Team, the Contractor and DCH shall meet at least quarterly to discuss progress on initiatives. Rapid cycle feedback is key to the success of a VBP model. The Contractor shall regularly review and provide real-time information focused on the initiatives it is undertaking to achieve required targets on a monthly and quarterly basis to DCH. The Contractor shall provide ongoing and ad hoc reports to DCH to highlight status and progress of initiatives, as well as successes and challenges. Regularly reviewing data is necessary for DCH and the Contractor to identify where initiatives are not resulting in improvements necessitating adjustments to the implemented approach. When adjustments are necessary,	No. According to PSHP, "Peach State does not have a policy to address VBP, at this time. Although these requirements are in the contract, the DCH has not implemented this program."

Quality Management and Performance Improvement	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
the Contractor shall report to DCH changes the Contractor will make to continually work towards improvements.	
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. According to PSHP, "Peach State does not have a policy to address VBP, at this time. Although these requirements are in the contract, the DCH has not implemented this program."
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. According to PSHP, "Peach State does not have a policy to address VBP, at this time. Although these requirements are in the contract, the DCH has not implemented this program."
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. According to PSHP, "Peach State does not have a policy to address VBP, at this time. Although these requirements are in the contract, the DCH has not implemented this program."
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. According to PSHP, "Peach State does not have a policy to address VBP, at this time. Although these requirements are in the contract, the DCH has not implemented this program."

Quality Management and Performance Improvement	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
4.12.12.9 The Contractor shall comply with the requirements set forth in the VBP Operations Manual.	No. According to PSHP, "Peach State does not have a policy to address VBP, at this time. Although these requirements are in the contract, the DCH has not implemented this program."
4.12.13 Monitoring and Oversight Committee 4.12.13.1 The Contractor shall participate in the Georgia Families Monitoring and Oversight Committee ("GFMOC") and associated subcommittees as requested by DCH. The GFMOC and associated subcommittees will assist DCH in assessing the performance of the Contractor and developing improvements and new initiatives specific to the Georgia Families program. The GFMOC will serve as a forum for the exchange of best practices and will foster communication and provide opportunity for feedback and collaboration between State agencies, the Contractor and external stakeholders. Members of the GFMOC will be appointed by the DCH Commissioner or his designee. The GFMOC meetings must be attended by Contractor decision makers defined as one or more of the following: Chief Executive Officer, Chief Operations Officer, or equivalent named position; and Chief Medical Officer.	Yes
4.12.14 Member Advisory Committee 4.12.14.1 The Contractor shall establish and maintain a Member Advisory Committee consisting of persons served by the Contractor including current and past Members and/or Authorized Representatives, and representatives from community agencies that do not provide Contractor-covered services but are important to the health and well-being of Members. The Committee 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.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interview responses from PSHP staff support these functions occurring.
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	Yes

Quality Management and Performance Improvement	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
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.	
4.12.16 Reporting Requirements 4.12.16.1 Contractors must submit the following data reports as indicated. 1. Performance Improvement Project Proposal(s), Annually October 31, DCH PQO Unit 2. Quality Assurance Performance Improvement Plan, Annually June 30, DCH PQO Unit 3. Quality Assessment Performance Improvement Program Evaluation, Annually June 30, DCH PQO Unit 4. Performance Improvement, Project Report, Annually June 30, EQRO vendor 5. Performance Measures Report, Annually June 30, DCH PQO Unit 6. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys, Annually July 31, DCH PQO Unit	Partial. There was no specific reference to PSHP submitting materials to DCH for review; however, interview responses from PSHP staff support these functions occurring.
4.12.16.2 If an extension of time is needed to complete a report, the Contractor may submit a request in writing to the DCH PQO Unit.	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

Regulatory Reporting and Monitoring

Regulatory Reporting and Monitoring	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
4.18.1.1 The Contractor shall support DCH in its program monitoring and reporting efforts for program performance and trending analyses through submission of ongoing, dashboard and ad hoc reports to DCH for all activities described in the Contract. The Contractor shall provide ad hoc reports to DCH upon request and within timeframes agreed to by DCH and the Contractor.	Yes
4.18.1.2 The Contractor shall meet with DCH Business Owners during implementation to discuss all data requirements and the Contractor's recommended reports. The Contractor shall accommodate DCH's requests for data and reporting based on implementation decisions as well as for ongoing requests during operations.	Yes
4.18.2.1 The Contractor shall collect, validate and report required program data to DCH in an accurate and timely manner. The Contractor's Chief Executive or Financial Officer, or a designee vested with their authority, shall attest to the accuracy and completeness of all submitted reports, in accordance with 42 CFR §438.604. In addition, the Contractor shall comply with all state and federal requirements set forth in this Section and throughout this Contract.	Yes
4.18.2.2 The Contractor shall comply with all the reporting requirements established by this Contract and shall submit all Reports included in this Contract. The Contractor shall create Reports using the formats, including electronic formats, instructions, and timetables as specified by DCH, at no cost to DCH. DCH may modify reports, specifications, templates, or timetables as necessary during the Contract year. Contractor changes to the format must be approved by DCH prior to implementation. The Contractor shall transmit and receive all transactions and code sets required by the HIPAA regulations in accordance with Section 23.2. The Contractor's failure to submit the Reports as specified may result in the assessment of liquidated damages as described in Section 25.0.	Yes
4.18.2.2.1 The Contractor shall submit the Deliverables and Reports for DCH review and approval according to the following timelines, unless otherwise indicated.	Yes
4.18.2.2.1.1 Weekly Reports shall be submitted on the same day of each week as determined by DCH;	Yes
4.18.2.2.1.2 Monthly Reports shall be submitted within fifteen (15) Calendar Days of the end of each month;	Yes
4.18.2.2.1.3 Quarterly Reports shall be submitted by April 30, July 30, October 30, and January 30, for the quarter immediately preceding the due date;	Yes
4.18.2.2.1.4 Annual Reports shall be submitted within thirty (30) Calendar Days following the twelfth (12th) month of the contract year ending June 30th;	Yes
4.18.2.2.1.5 Ad-Hoc, as determined by DCH; and	Yes

Regulatory Reporting and Monitoring	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
4.18.2.2.1.6 Other Reports (bi-annual, according to the due date of the respective report).	Yes
4.18.2.2.2 For reports required by DOI and DCH, the Contractor shall submit such reports according to the DOI schedule of due dates, unless otherwise indicated. While such schedule may be duplicated in this Contract, should the DOI schedule of due dates be amended at a future date, the due dates in this Contract shall automatically change to the new DOI due dates.	No. According to PSHP, "GA.COMP.07 does not have this specific language; however, the policy has been updated as of 10/23/2023 to reflect this requirement and business process. The updated policy that is outside of the audit lookback can be provided upon request."
4.18.2.2.3 The Contractor shall, upon request of DCH, generate any additional data or reports at no additional cost to DCH within a time period prescribed by DCH. The Contractor's responsibility shall be limited to data in its possession.	No. According to PSHP, "GA.COMP.07 does not have this specific language; however, the policy has been updated as of 10/23/2023 to reflect this requirement and business process. The updated policy that is outside of the audit lookback can be provided upon request."
4.18.3.1 DCH will periodically publish information or receive requests from audiences such as legislators that may require data from the Contractor. DCH will provide the Contractor with information about the data DCH would like to publish or must produce, and the Contractor shall produce all reports or summary data for DCH to incorporate into a larger report. The Contractor shall develop these reports considering the audience to be targeted.	No. According to PSHP, "GA.COMP.07 does not have this specific language; however, the policy has been updated as of 10/23/2023 to reflect this requirement and business process. The updated policy that is outside of the audit lookback can be provided upon request."
4.18.3.2 The Contractor shall not publish reports on its website or any other forum without prior consent from DCH.	No. According to PSHP, "GA.COMP.07 does not have this specific language; however, the policy has been updated as of 10/23/2023 to reflect this requirement and business process. The updated policy that is outside of the audit lookback can be provided upon request."
4.18.4.1 The Contractor must be prepared to participate in regularly scheduled meetings with DCH staff to review decisions, resolve issues and define operational enhancements. These meeting schedules will be determined by DCH.	No. According to PSHP, "GA.COMP.07 does not have this specific language; however, the policy has been updated as of 10/23/2023 to reflect this

Regulatory Reporting and Monitoring	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
	requirement and business process. The updated policy that is outside of the audit lookback can be provided upon request."
4.18.4.2 The Contractor and its various levels of staff as determined by DCH must also attend an onsite meeting at DCH to report on all activities, trends, opportunities for improvement and recommendations for programmatic and policy changes at the frequency determined by DCH. Contractors must provide best practices and lessons learned to reach GF program goals.	No. According to PSHP, "GA.COMP.07 does not have this specific language; however, the policy has been updated as of 10/23/2023 to reflect this requirement and business process. The updated policy that is outside of the audit lookback can be provided upon request."

Subcontractor Oversight

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

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

Utilization Management

Utilization Management	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
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
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.	Yes

Utilization Management	
Contract Language	**PSHP Policy Is Consistent with Contract Requirement(s)** ***Yes / No / Partial***
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.	
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.	Partial. There was no specific reference to PSHP submitting reports of the UM Committee activities to DCH for review; however, interview responses from PSHP staff support these functions occurring.
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