



Myers and Stauffer_{LC}

Certified Public Accountants

REPORT 6:

GEORGIA FAMILIES PROGRAM

PHYSICIAN CLAIMS

**INDEPENDENT ACCOUNTANT'S REPORT ON
APPLYING AGREED-UPON PROCEDURES**

FINAL DRAFT - MARCH 27, 2009

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Independent Accountant's Report On Applying Agreed-Upon Procedures

Georgia Department of Community Health:

The Department of Community Health (DCH or Department) engaged Myers and Stauffer LC to apply agreed-upon procedures for the purpose of testing the accuracy of payments for a sample of physician and specialist claims adjudicated by the Georgia Families Program contracted Care Management Organizations. Claim payments were analyzed to determine if the payment was made according to the contract between the CMO and physician or specialist provider. The Department will determine the applicability and use of the results from applying these agreed-upon procedures. DCH's management is responsible for the Department's policies and procedures, as well as vendor management functions.

We have performed the agreed-upon procedures described in Exhibit 1 dated October 8, 2008, which were agreed to by the Department. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in the report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

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

- **Adjudicate** – A determination by the Care Management Organization of the outcome of a health care claim submitted by a health care provider. Claims may pay, deny, or in some cases have an alternative adjudication outcome.
- **Care Management Organization (CMO)** – A private organization that has entered into a risk-based contractual arrangement with DCH to obtain and finance care for enrolled Medicaid or PeachCare for Kids™ members. CMOs receive a per capita or capitation claim payment from DCH for each enrolled member.
- **Claims Processing System** – A computer system or set of systems that determine the reimbursement amount for services billed by the health care provider.
- **Confidence Interval** – An estimated range of values that is likely to include an unknown population parameter, the estimated range being computed from sample data with inferences made to the population.

- **Current Procedural Terminology (CPT) Codes** – A listing of five character alphanumeric codes for use in reporting medical services and procedures performed by health care providers. CPT codes generally begin with a numeric character.
- **Denied Claim** – A claim submitted by a health care provider for reimbursement that is deemed by the payor to be ineligible for payment under the terms of the contract between the health care provider and payor.
- **Dr. David Bivin** – Associate Professor of Economics, at Indiana University-Purdue University Indianapolis who specializes in econometrics. Dr. Bivin used statistical techniques to consider the statistical strategies and methods, and to perform quality assurance on the statistical findings.
- **Dr. Ye Zhang** – Assistant Professor, Department of Economics, Indiana University – Purdue University Indianapolis, who assisted in the evaluation of statistical strategies and the performance of quality assurance measures on the statistical findings.
- **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program** - A Title XIX mandated program that covers screening and diagnostic services to determine physical and mental deficiencies in members less than 21 years of age, and health care, treatment, and other measures to correct or ameliorate any deficiencies and chronic conditions discovered. [Also known as Health Check.] (from GA CMO contract definitions)
- **Extrapolation** – The application of the mean dollar amount in error from a sample of claims to a population of claims.
- **Fee-For-Service (FFS)** – A health care delivery system in which a health care provider receives a specific reimbursement amount from the payor for each health care service provided to a patient.
- **Fee-For-Service (FFS) Claim** - A document, either paper or electronic, from a health care provider detailing health care services. Claims are submitted to a payor by a health care provider after a service has been provided to a patient covered by the payor. In some cases, the service must be authorized in advance. A FFS claim consists of one or more line items that detail all specific health care service(s) provided.
- **Georgia Families (GF)** – The risk-based managed care delivery program for Medicaid and PeachCare for Kids™ in which the Department contracts with Care Management Organizations to manage the care of eligible members.

- **Health Care Common Procedure Coding System Level II Codes (HCPCS Codes)** – A listing of five character alphanumeric codes for use in reporting medical services, supplies, devices, and drugs utilized by health care providers.
- **Health Check** -- The State of Georgia’s Early and Periodic Screening, Diagnostic, and Treatment program pursuant to Title XIX of the Social Security Act.
- **In-Network Provider** -- A Provider that has entered into a Provider Contract with the CMO to provide services.
- **Margin of Error** - The half width of the confidence interval.
- **Medicaid Management Information System (MMIS)** – Claims processing system used by the Department’s fiscal agent claims processing vendor to process Georgia Medicaid and PeachCare for Kids™ FFS claims and capitation claims.
- **Mispayment** – A payment amount for a health insurance claim that is either higher or lower than the expected payment amount.
- **Outpatient Services** – Medical procedures, surgeries, or tests that are performed in a qualified medical center without the need for an overnight stay.
- **Paid Claim** – A claim submitted by a health care provider for reimbursement that is deemed by the payor to be eligible for payment under the terms of the contract between the health care provider and payor.
- **PeachCare for Kids™ Program (PeachCare)** – The Georgia DCH’s State Children’s Health Insurance Program (SCHIP) funded by Title XXI of the Social Security Act, as amended.
- **Pended (or Pend or Suspended) Claim** – A claim that has been submitted to the health plan for reimbursement but has not been adjudicated. The claim is typically in this status so that the health plan may review additional information regarding the services provided prior to adjudicating the claim.
- **Physician Services** – Health care services provided by a licensed or otherwise authorized medical practitioner.
- **Point Estimate of the Population Total** – The sample average error scaled up by the number of observations (claims or lines) in the population.
- **Provider Manual** – A document created by a health care payor that describes the coverage and payment policies for health care providers that provide health care services to patients covered by the payor.

- **Provider Number (or Provider Billing Number)** – An alphanumeric code utilized by health care payors to identify providers for billing, payment, and reporting purposes.
- **Revenue Codes** – A listing of three digit numeric codes utilized by institutional health care providers to report a specific room (e.g. emergency room), service (e.g. therapy), or location of a service (e.g. clinic).
- **Uniform Billing (UB or UB-92 or UB-04) Claim Form** – Document most often required by payors to be utilized by hospitals and other institutional providers for submission of a claim request for reimbursement to the health care payor. The UB-92 version of the claim form was replaced by the UB-04 version in 2007. CMS refers to the UB-92/UB-04 claim form as the CMS-1450 claim form.

Background

In July 2005, the Department contracted with AMERIGROUP Community Care (AMGP), Peach State Health Plan (PSHP) and WellCare of Georgia (WellCare), (hereinafter referenced as “CMOs”) to provide health care services under the Georgia Families care management program. This risk-based managed care program is designed to bring together private health plans, health care providers, and patients to work proactively to improve the health status of Georgia’s Medicaid and PeachCare for Kids™ members. Approximately 600,000 members in the Atlanta and Central regions of the state began receiving health care services through Georgia Families on June 1, 2006. Georgia Families was expanded statewide to the remaining four regions, and approximately 400,000 additional members, on September 1, 2006.

DCH’s contract with the CMOs delineates the requirements to which each CMO must adhere, which are summarized below.

- The covered benefits and services that must be provided to the Medicaid and PeachCare for Kids™ members.
- The provider network and service requirements for the CMOs.
- Medicaid and PeachCare for Kids™ enrollment and disenrollment requirements.
- Allowed and disallowed marketing activities.
- General provider contracting provisions.
- Quality improvement guidance.
- Reporting requirements and other areas of responsibility.

In return for the CMOs satisfying the terms of the contract, the Department pays each CMO a monthly capitation payment for each enrolled Medicaid and PeachCare for Kids™ member, as well as kick payments for newborns.

The table below illustrates the participation of the three CMOs by coverage region.

Table 1: CMO Participation by Coverage Region

Region	AMGP	PSHP	WellCare
Atlanta	√	√	√
Central		√	√
East	√		√
North	√		√
Southeast	√		√
Southwest		√	√

The Department of Community Health engaged Myers and Stauffer LC to study and report on specific aspects of the GF program, including certain issues presented by providers, selected claims paid or denied by CMOs, and selected GF policies and procedures. The initial phase of the engagement focused on hospital provider subjects. Previously issued reports, available online at <http://dch.georgia.gov>, assessed payment and denial trends of hospital claims, as well as certain CMO policies and procedures. This report addresses the payment accuracy of physician claims by applying agreed-upon procedures to a sample of claims. Subsequent phases of the engagement will likely include similar analyses related to other provider categories.

This report, as well as the previously issued reports, focused on the first several months of the Georgia Families program, from December 1, 2006 through January 31, 2008. DCH anticipates conducting a subsequent analysis of physician claims data for the Georgia Families program to determine if there have been changes in the adjudication of physician claims in the post implementation period.

In consultation with the Department, we analyzed the data and documentation received from the CMOs, and we did not independently validate or verify the information. Each CMO attested and warranted that the information they provided was “accurate, complete, and truthful, and [was] consistent with the ethics statements and policies of DCH”. Each of the CMOs was given an opportunity to provide comments related to the findings of this report. Those comments are incorporated as Exhibit 3 of this report.

Methodology

The objective of this engagement is to apply agreed-upon procedures to test the accuracy of payments for a sample of physician and specialist claims adjudicated by CMOs that administer the GF program. These claim payments were analyzed to determine if the payment was made according to the contract between the CMO and the provider. If a claim was paid incorrectly, we estimated the amount of the underpayment or overpayment (collectively referred to as “mispayments”) for the claim in consultation with the CMO, the Department, and/or the provider.

In order to identify claims for analysis, we randomly selected a sample of providers from five provider cohorts, using the provider directories submitted by the CMOs. Cohorts included Family Practice, Internist, Obstetrics/Gynecology, Pediatrician, and all others. Claims were then randomly sampled for selected providers.

The claims universe from which the sample was drawn included CMO paid and denied claims of both Medicaid and SCHIP members for the first several months of the Georgia Families program, but excluding the initial start-up period. Therefore, for physician and specialists claims paid or denied, claims were eligible for selection if they had dates of service between December 1, 2006 and January 31, 2008. Claims that were paid or denied by the CMOs with dates of service between June 1, 2006 and November 30, 2006 were excluded from the universe.

It should be acknowledged that claims selected for these periods are likely to have different mispayments and potential issues than claims selected from a more recent period, due to Georgia Families start-up and implementation issues. We understand that considerable efforts have been made by providers, CMOs, and the Department to address start-up related issues and improve the accuracy of claim payments made by CMOs.

The sampling methodology and statistical procedures used for this analysis were developed in consultation with Dr. David Bivin and Dr. Ye Zhang, statistical consultants to Myers and Stauffer. Dr. Bivin had previously developed the methodology for sampling and estimating the mispayments related to hospital claims. That analysis used results from a prior study of fee-for-service claims as the basis for determining the minimum sample size. As expected, there was little correlation between mispayments in the fee-for-service delivery system and the Georgia Families delivery system. Therefore, it was determined that a beta sample should be used to select physician and specialists claims.

The sample for the beta test was equal to 500 claims per CMO. This sample implies a probability of approximately 90 percent for selecting a claim with a mispayment, under the assumption of a mispayments rate of at least two percent. Based on the results of the beta sample, additional sampling and testing could be used to expand upon or address specific issues or problems identified in the beta period. The variation of the mispayments identified in the beta test, could be used to estimate a margin of error on a larger sample, if authorized.

The selection and analysis of 500 claims per CMO would provide confidence intervals at the 95 percent level for the mean dollar amount of mispayment per claim and the total dollars in mispayments per CMO. Because prior testing results of mispayments were not available, it was not possible to achieve a desired level of precision on the estimated margins of error. The final margins of error would be based on the distribution and variability of the mispayments in the physician and specialists claims processed by the CMOs, which are a function of each CMO, CMO claims processing and adjudication, and other unique factors specific to the CMOs and physician and specialist claims.

The Department authorized the sample of 500 claims per CMO, distributed as follows:

Table 2: Sample Sizes for CMO Physician and Specialist Claims

Care Management Organizations	Universe * Claim Count	Sample
AMERIGROUP		
Family Practice	8,558	100
Internist	11,813	100
OB/GYN	25,423	100
Pediatrician	98,590	100
Other	3,348	100
AMGP Subtotal	147,732	500
PEACH STATE HEALTH PLAN		
Family Practice	6,095	100
Internist	10,881	100
OB/GYN	20,060	100
Pediatrician	47,793	100
Other	1,036	100
PSHP Subtotal	85,865	500
WELLCARE		
Family Practice	22,327	100
Internist	16,637	100
OB/GYN	37,427	100
Pediatrician	113,886	100

Care Management Organizations	Universe * Claim Count	Sample
Other	11,030	100
WC Subtotal	201,307	500
Total Line Item Claim Count	434,904	1,500

**Includes only those detail claim lines for the group of providers randomly selected from the CMO provider directories.*

A data request was prepared for each CMO that included the entire universe of physician and specialists paid and denied claims for the specified period, as well as all rate files and reference data necessary to analyze claim payments and denials. As required, the CMOs provided an attestation that the data they provided was “accurate, complete, and truthful, and [was] consistent with the ethics statements and policies of DCH”. Claims data was loaded into our SQL Server environment. Several meetings were held with the CMOs to address questions, obtain additional information, or resolve various issues involving the claims data submitted.

Once the claim universe was determined to be reasonably complete, a random sample of paid and denied claims was drawn from the universe of claims using a random selection function in SQL Server. Separate samples were drawn for each CMO and service category, as listed in Table 2 above. Prior to analysis, we performed various procedures on the samples to confirm that the correct number of claims had been selected from each service and CMO.

Each sampled claim was selected and tested at the “detail” level, which refers to information that is contained on the claim filed by the provider. We analyzed the final payment amount (i.e., net of all known adjustments as of date the CMOs submitted the claims data) made to the provider by the CMO. We analyzed each claim in the sample based on the contract between the CMO and the provider using the following steps:

- 1) We determined the payment status of the claim.
- 2) If the claim payment status was “denied” or “suspended”, we analyzed the reason and attempted to determine, with the information available, whether the denial or suspension was appropriate.
- 3) If the claim payment status of “denied” or “suspended” appeared to be inappropriate, we computed the expected payment for the detail claim line based on the contract between the physician and the CMO.
- 4) If the claim payment status was ‘paid’, we computed the expected payment for the claim detail line based on the contract between the physician and the CMO.
- 5) We computed the dollar value of the mispayment, as applicable, for the detail claim line.
- 6) The identified potential mispayments were sent to the CMO and/or physician for comment. We requested that each CMO compute the expected payment

amount for each potential mispayment. In some cases, we relied on the follow-up information received from the CMO in determining whether the potential mispayment was, in fact, a confirmed mispayment and for the dollar value of the mispayment. We reserved the right to not accept this information from the CMO in the event that circumstances required special consideration or handling. In the event of a dispute between Myers and Stauffer and the CMO regarding the correct adjudication or payment amount on a claim, the Department's decision regarding the adjudication determination constituted the final decision.

- 7) If significant anomalies occurred in the sample, or at the Department's request, the sample size could be expanded to a larger set of detail claim lines as appropriate.

Upon completing the analysis for each sampled claim, the results were sent to Dr. Bivin to complete the analyses of the mean per claim mispayment amounts, total mispayment amounts, and confidence intervals for each CMO. Dr Zhang performed quality assurance procedures to confirm Dr. Bivin's findings. Meetings were held to discuss the results and to confirm the steps of the analyses. The reports of Drs. Bivin and Zhang are included as Exhibit 2 to this report.

For additional information regarding the study design, analysis, testing, or assumptions, please refer to the agreed-upon procedures attached as Exhibit 1 to this report. The findings from applying these agreed-upon procedures are described in the following section.

Findings

The objective of this engagement was to apply agreed-upon procedures to test the pricing accuracy of payments for a sample of primary care and specialty care provider claims adjudicated by the CMOs that administer the GF program. These claims were analyzed to determine if the payment or denial was made according to the terms of the contract between the CMO and the provider.

For confirmed mispayments, we determined the estimated amount of the underpayment (liability to the CMO) or overpayment (receivable to the CMO) for the claim. All potential errors were provided to the CMOs and the CMOs were asked to provide a detailed response illustrating how the claim was adjudicated, including providing all applicable documentation (e.g., screen shots). We consulted with the Department, and/or the CMO as necessary on the claims.

The claims universe included CMO paid and denied claims of both Medicaid and PeachCare members. For all physician claims, paid or denied claims have dates of service between December 1, 2006 and January 31, 2008.

The following tables display the findings by CMO.

Table 3: Summary of Claims Payment Accuracy – Dates of Service from 12/1/06 through 1/31/08

	AMGP	PSHP	WELLCARE
Sample Size	500	500	500
Claim Detail Lines Paid/Denied Correctly	489	441	429
Percent of Claim Detail Lines Paid/Denied Correctly	97.8%	88.2%	85.8%

The primary issues that influenced the claims payment accuracy rates for each of the CMOs include:

- AMGP – Providers “tied” to wrong agreement ID, resulting in incorrect rates being paid.
- PSHP – Contracted reimbursement rates being loaded incorrectly into the claims processing system.
- WellCare – Contracted reimbursement rates being loaded incorrectly. It should also be noted that the payment accuracy rate of WellCare was impacted by

responses that they could not provide within the required timeframes. These timeframes were extended several times in an attempt to obtain this information.

While the payment accuracy rates in Table 3 are based on a beta sample of 500 claims, they are an important reflection of the physician and specialist claims pricing accuracy of the CMOs for the first few months of the program. If authorized by the Department, other samples of physician and specialist claims from the same period would likely yield similar results. However, we understand that considerable efforts have been made by providers, CMOs, and the Department to address start-up related issues and improve the accuracy of claim payments made by CMOs. Therefore, we would anticipate that samples derived from more recent periods would yield accuracy rates that reflect these efforts.

Table 4: Summary Statistics of Claim Mispayments

Confidence Interval Total Population Mispayments	AMGP	PSHP	WELLCARE
Total Sample Liabilities	-\$3.15	-\$329.13	-\$264.91
Total Sample Receivables	\$63.11	\$216.26	\$2,265.45
Total Sample Mispayments	\$59.96	\$112.87	\$2,000.54
Claim Detail Lines in Sample	500	500	500
Claim Detail Lines with Mispayments	11	59	71
Percent Claim Detail Lines with Mispayments	2.2%	11.8%	14.2%
Mean Mispayment	\$0.08	\$0.67	\$3.01
Claim Detail Lines in Population	4,952,692	5,806,963	6,161,583
95% Lower Bound - Liabilities	(\$61,117)	(\$1,913,658)	(\$5,263,143)
95% Upper Bound - Liabilities	\$0	(\$321,927)	(\$184,482)
Point Estimate - Liabilities	(\$24,946)	(\$1,117,793)	(\$2,723,813)
Margin of Error - Liabilities	±\$36,171	±\$795,866	±\$2,539,330
95% Lower Bound - Receivables	\$0	\$2,331,439	\$0
95% Upper Bound - Receivables	\$1,056,592	\$7,710,397	\$44,737,911
Point Estimate - Receivables	\$445,843	\$5,020,918	\$21,280,691
Margin of Error - Receivables	±\$610,749	±\$2,689,479	±\$23,457,220

Note: Confidence interval boundaries may be adjusted to logical limits.

Other Observations

In addition to the tables of payment accuracy results presented above there were a number of additional observations made during the course of performing these agreed-upon procedures for each of the CMOs. While the observations listed below may not directly impact the calculation of payment accuracy in the sample claims, some of these items may contribute to confusion and uncertainty among the providers regarding how claims are supposed to be paid by each of the CMOs. DCH may wish to have each CMO provide responses and/or proposed corrective actions to each of the observations.

AMERIGROUP

- AMERIGROUP representatives stated that the claims processing system, Facets, was not configured to deduct member copayments for FQHC and RHC services. AMERIGROUP also stated that they may reconfigure the system at some future date to deduct these copayments. The providers have not been notified.
- One physician was confirmed by AMERIGROUP to be credentialed as an OB/GYN, but the contract for this physician indicated the provider's specialty as Pediatrics.
- Explanation of Benefits (EOB) codes are not always clear. For example, one EOB stated "Billing Error", but did not provide adequate information in order for the physician to file a corrected claim.
- There appear to be instances where EOB codes are not correct. An example of this included the denied claim with the EOB "Deny All Lines", but CMO representatives confirmed that the appropriate denial should have stated "No Authorization on File".

Peach State Health Plan

- It appears that there were instances of claim detail lines that had copayments deducted inappropriately, according to the copayment logic submitted by PSHP. This included claim detail lines with a pregnancy diagnosis, lines that had an outpatient place of service, and lines with procedure codes other than Evaluation and Management codes. In all the cases above, a copayment should not have been deducted. Please note that the claim lines on which we observed these issues were not a part of our sampled claim detail lines and are not included in the error calculations.
- It appears that PSHP is the only CMO deducting copayments from physician provider claims.

- PSHP stated that they are reimbursing physician claims based on the location billed on the claim. This pricing methodology was not clear in the documentation provided to us.

WellCare

- Myers and Stauffer selected the providers to be included in these procedures from the provider directories submitted by each of the CMOs. There were 13 instances where we selected a provider from the WellCare provider directory but were subsequently informed that the provider was not a WellCare participating provider.
- We noted an instance where a denial contained an inappropriate EOB code. The denial itself appeared to be appropriate; however, the explanation given was not correct.
- All of the physician claims submitted by WellCare included an indicator that, according to the data dictionary provided by the CMO, indicated that the claim was an adjustment to a previous claim. This issue was shared with WellCare but remains unresolved as of the date of this report.
- The manner in which WellCare applies contract components to the physician claims was not always clear. For example, if a contract contained multiple reimbursement terms it was not always clear what factors were used by the claims logic to determine which reimbursement terms were to be utilized in pricing the claim.

Recommendations

We make the following observations and recommendations regarding physician claim pricing. As stated previously, this sample of claims analyzed as part of the agreed-upon procedures is from the first several months of the Georgia Families program. Claims selected for these periods are likely to have different mispayments and potential issues than claims selected from a more recent period, due to Georgia Families start-up and implementation issues.

Recommendations Applicable to the CMOs

- 1) Contracts between CMOs and providers should clearly identify all of the parameters used to determine when the contract terms are effective, specifically whether the effective date is based on service date of the claim or whether it is based on the adjudication or paid date of the claim. In the situation where service date is the appropriate parameter, the contract should specify whether the date is the first or last date of service. In addition, all factors used when determining the payment of a claim should be clearly outlined.
- 2) We recommend that each CMO carefully review the claims identified with mispayments for each physician specialty and implement corrective actions, system enhancements or modifications, rate file changes, or other measures that will address the reasons for the mispayments. It may also be necessary to provide policy clarifications or to work with the physicians on provider education.
- 3) In the event a CMO makes a business decision to not apply one of its written policies, effected providers and DCH should be notified. The CMO's procedures for addressing Instances of deviations from written policy should be outlined in the CMO's contract with all providers.
- 4) The CMO should take steps to ensure that EOB codes includes on the claims are accurate and sufficiently informative for the provider to clearly identify the reason why a claim denies or pays differently than anticipated.
- 5) The CMOs should take adequate care to ensure that the information contained in the provider directories is current and accurate. We observed a number of instances where the provider directory contained incorrect information. We recommend that the CMOs complete a comprehensive review of their directories to ensure their accuracy.

Recommendation Applicable to Physician Providers

- 1) In some cases, the contracts between the CMOs and physicians, as well as the provider manuals and written policies of the CMOs, include terms and information that might be subject to interpretation. Physicians have ultimate responsibility for the contracts they execute and should exercise increased due diligence before signing contracts with the CMOs. Physician providers should review contracts with the CMOs and ensure that all provisions are clear and unambiguous within the contract itself, and any verbal assurances by a representative of a health plan are detailed in writing within the contract.

Analytical Limitations

- There were approximately 1.1M claims in the universe that could not be identified with a particular specialty (i.e., a specialty was not included on the claim and we could not tie these claims back to a particular specialty). These claims were not included in the universe totals for the calculations in the tables above.
- In some cases, the CMOs may have adjusted, reprocessed, or corrected claims that we identified as potential mispayments after we submitted the list of claims to each CMO. Therefore, as of the date of this report, the mispayment dollar amounts included in this report may not be reflective of the actual amount owed to physician providers by the CMO's or owed by these providers to CMOs.
- Due to limited information and documentation, we were not able to test the interest payment calculations from the CMOs.
- Each CMO was provided with a list of claims and given the opportunity, via e-mail and conference calls, to provide additional clarification and documentation to resolve the potential errors. For a number of claims, there was limited information and documentation, which prevented us from being able to determine the appropriate reimbursement, even after consultation with the CMO. Because we were not able to confirm the correct reimbursement, these claims are included as errors.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the physician claims adjudicated by the Georgia Families program contracted Care Management Organizations. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Georgia Department of Community Health and is not intended to be and should not be used by anyone other than this specified party.

Myers and Stauffer LC
Atlanta, Georgia
November 24, 2008

Exhibits

DRAFT
EXHIBIT 1

**Department of Community Health
State Fiscal Year (SFY) 2009
Georgia Families Program
Primary Care and Specialty Care Provider Claims Testing
October 8, 2008**

This document provides a summary of the study methodology and agreed-upon procedures used for Georgia Families Program claims testing performed for the Department of Community Health (the "Department"), including a computation of the estimated liabilities and receivables related to those claims adjudicated by the Care Management Organizations between December 1, 2006 and January 31, 2008 as addressed by these procedures. 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 may be used throughout this document:

- Adjudicate – A determination of the outcome of a healthcare claim. Claims may pay, deny, or in some cases have an alternative adjudication outcome.
- Capitation Claim - A per Medicaid and/or PeachCare for member fixed payment amount made by the Department to a care management organization in return for the administration and provision of health care services rendered to the enrolled Medicaid and/or PeachCare for member.
- Care Management Organization (CMO) – A private organization that has entered into a risk-based contractual arrangement with DCH to obtain and finance care for enrolled Medicaid recipients or PeachCare for members. CMOs receive a per capita or capitation claim payment from DCH for each enrolled member.
- Denied Claim – A claim submitted by a healthcare provider for reimbursement that is deemed by the payor to be ineligible for payment under the terms of the contract between the healthcare provider and payor.
- Fee-For-Service (FFS) – A healthcare delivery system in which a healthcare provider receives a specific reimbursement amount from the payor for each healthcare service provided to a patient.
- Fee-for-service (FFS) claim - A payment made by a payor to a health care provider after a service has been provided to a patient covered by the payor. In

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EXHIBIT 1

some cases, the service must be authorized in advance. A FFS claim consists of one or more line items that detail specific health care service(s) provided.

- Georgia Families (GF) – The risk-based managed care delivery program for Medicaid and PeachCare for in which the Department contracts with Care Management Organizations to manage the care of eligible recipients.
- Medicaid Management Information System (MMIS) – Claims processing system used by the Department’s fiscal agent claims processing vendor to process Georgia Medicaid and PeachCare for FFS claims and capitation claims.
- Paid Claim – A claim submitted by a healthcare provider for reimbursement that is deemed by the payor to be eligible for payment under the terms of the contract between the healthcare provider and payor.
- PeachCare for program (PeachCare) – The Georgia DCH’s State Children’s Health Insurance Program (SCHIP) funded by Title XXI of the Social Security Act, as amended.
- Suspended Claim – A claim submitted by a healthcare provider for reimbursement that is queued by the payor for examination, or where additional information is necessary to adjudicate the claim.

Project Team

The following key personnel will be used for this engagement:

Jared Duzan – co project director
Keenan Buoy, CPA – co project director
Beverly Kelly, CPA – co project manager
Ryan Farrell – co project manager
Shelley Llamas – co project manager
Kevin Londeen, CPA – quality assurance
Ron Beier, CPA – quality assurance
David Bivin, PhD – statistician
Ye Zhang, PhD - statistician

Objective

The objective of this engagement is to apply agreed-upon procedures to test the accuracy of payments for a sample of primary care and specialty care provider claims adjudicated by CMOs that administer the GF program. These claim payments will be analyzed to determine if the payment was made according to the contract between the CMO and the provider. If a claim is paid incorrectly, a determination will be made of the amount of the underpayment (liability) or overpayment (receivable) for the claim in consultation with the CMO, the Department, and/or the provider.

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EXHIBIT 1

Claims Universe

The claims universe will include CMO paid and denied claims of both Medicaid and PeachCare members for primary care and specialty care provider claims. The claims will have dates of service between December 1, 2006 and January 31, 2008. A sample of primary care and specialty care providers will be selected from a directory submitted by the CMOs, and only claims from this list of providers will be eligible for sampling and testing. The results of the sample will be applied to the full universe of primary care and specialty care claims from each CMO. The selection of the sample providers is described elsewhere in these procedures.

Deliverables

Total liabilities, total receivables, and total net mispayments will be computed for the samples selected. The average dollar amount of mispayment per claim by CMO will be used to compute an estimate of total mispayments applicable to the universe of claims for each CMO. A confidence interval, margin of error, point estimate, lower bound, and upper bound will be prepared for each CMO. This information will generally be presented as illustrated in the example tables below by CMO.

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EXHIBIT 1

CMO 1	Claims
Claims Sample	
Sample Liabilities	
Sample Receivables	
Sample Net Mispayments	
Claims in Sample	
Claims with Mispayments	
Percent Claims with Mispayments	

CMO 1	Claims
Confidence Interval Total Population Mispayments	
Mean Mispayment	
Claims in Population	
95% Lower Bound - Liabilities	
95% Upper Bound - Liabilities	
95% Point Estimate - Liabilities	
Margin of Error - Liabilities	
95% Lower Bound - Receivables	
95% Upper Bound - Receivables	
95% Point Estimate - Receivables	
Margin of Error - Receivables	
95% Lower Bound - Net Mispayments	
95% Upper Bound - Net Mispayments	
95% Point Estimate - Net Mispayments	
Margin of Error - Net Mispayments	

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EXHIBIT 1

Sampling Methodology and Testing Procedures – Primary Care and Specialty Care Provider Claims

Claims Universe

The universe of claims from which we will select the sample claims will be narrowed to include only those claims for a group of pre-selected providers. These providers were selected from a provider directory submitted by the CMOs. The focus of the selection was to obtain representation from each of the physician specialties and to facilitate the CMOs' ability to provide a contract for the selected providers. The selection of providers within each specialty was random.

A random sample of paid and denied claims, based on specialty, will be drawn from the provider set of claims and the liability, receivable, and net mispayment for the sample will be computed for each CMO. The sample period will include paid or denied claims with dates of service between December 1, 2006 and January 31, 2008. The sample of claims for each CMO will include claims from each of the following physician specialties:

- Family Practice
- Internist
- OB/GYN
- Pediatrician
- Other (includes cardiologists, allergists, etc.)

All claims will be tested at the detail line level. The accuracy of any other detail lines on the claim will not be tested. Each detail claim line in the sample will be independently re-priced based on the contract between the CMO and the physician or practice group using the following steps:

- 1) Determine the payment status of the claim
- 2) If claim payment status is 'denied' or 'suspended', analyze the reason and attempt to determine, with the information available, whether the denial or suspension is appropriate.
- 3) If the claim payment status of 'denied' or 'suspended' appears to be inappropriate, compute the expected payment for the detail claim line based on the contract between the physician and the CMO.
- 4) If claim payment status is 'paid', compute the expected payment for the claim detail line based on the contract between the physician and the CMO.
- 5) Compute the dollar value mispayment, as applicable, for the detail claim line.
- 6) Identified mispayments will be sent to the CMO and/or physician for comment. Unless indicated otherwise, we will rely on the follow-up information received from the CMO in determining whether the potential mispayment is, in fact, a confirmed mispayment and the dollar value of the mispayment. We reserve the right to not accept this information from the CMO in the event that circumstances require special consideration or handling. CMOs have been required to attest to the accuracy and reliability of the information they have provided for this initiative. In the event of a dispute between Myers and Stauffer and the CMO regarding the correct adjudication

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or payment amount on a claim, the Department's decision regarding the adjudication determination will constitute the final decision.

- 7) If significant anomalies occur in the selected sample, or at the Department's request, the sample size can be expanded to a larger set of detail claim lines as appropriate.

M&S Workpapers

To test the volume of claims within the available time, spreadsheet tools, formulas, databases, and computerized algorithms will be utilized as a means to re-price claims. These tools are proprietary and are for Myers and Stauffer LC internal use only.

Data Sources

Each CMO will provide the data and reference file information needed for this engagement and will attest to the accuracy of this information. Based on the CMO's signed attestation, Myers and Stauffer LC will accept this information as accurate and reliable. The CMO may provide additional information on the selected claims as necessary.

Sample Size of Primary Care and Specialty Care Provider Claims

The total line item claim count from all CMOs and physician service/specialty care provider categories is 434,904. The agreed upon sample size is 500 line item claims per CMO. In order to provide a sample that includes representation from each of the specialties indicated above, 100 claims from each specialty will be randomly selected without replacement. It should be noted that achieving any estimated margin of error might not be possible due to the variability of the observed mispayments, which are a function of each CMO, CMO claims processing and adjudication, and other unique factors specific to the CMOs and physician claims. The sample size was not prepared to achieve a desired margin of error and as such, may indicate findings that are significantly different than those that would be achieved by utilizing a larger sample size. Based on the initial results of the analysis, Myers and Stauffer or DCH may choose to increase the sample size for one or all of the CMOs in order to reduce the margin of error on the estimates.

Sample Sizes for CMO Claims		
Care Management Organizations	Universe	Sample
AMERI GROUP	Claim Count	Sample Size
Family Practice	8,558	100
Internist	11,813	100
OB/GYN	25,423	100
Pediatrician	98,590	100
Other	3,348	100
AG Subtotal	147,732	500
PEACH STATE		

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Sample Sizes for CMO Claims		
Care Management Organizations	Universe	Sample
Family Practice	6,095	100
Internist	10,881	100
OB/GYN	20,060	100
Pediatrician	47,793	100
Other	1,036	100
PSHP Subtotal	85,865	500
Sample Sizes for CMO Claims		
Care Management Organizations	Universe	Sample
WELLCARE		
Family Practice	22,327	100
Internist	16,637	100
OB/GYN	37,427	100
Pediatrician	113,886	100
Other	11,030	100
WC Subtotal	201,307	500
Total Line Item Claim Count	434,904	1,500

Timeline for Physician Claims

Testing of physician claim payments will begin upon the Department's approval of these agreed upon procedures and continue through approximately mid-November 2008. Approximately 10 weeks will be used to complete this analysis.

Exhibit II

Report on Georgia Medicaid Receivables and Liabilities for the Georgia Families Program *****REVISED*****†

by
David Bivin
Professor of Economics, IUPUI
November 26th, 2008

This report assesses the accuracy of claims paid to providers by Amerigroup, Peach State, and WellCare. The period of analysis is December 1, 2006 through January 31, 2008. 500 observations (claim detail lines) over this period were drawn from each CMO and examined to determine whether the amount of the original claim was correct, too large (resulting in a receivable to the CMO) or too small (resulting in a liability). For each CMO, 100 claim detail lines were drawn from each of the following five provider specialty categories:

- Family Practice
- Internist
- Obstetrics/Gynecology
- Pediatrician
- Other

Myers and Stauffer evaluated these claim detail lines and provided data on the original amount of the claim detail line, the revised amount of the claim detail line, and the provider specialty. In addition, population data by provider specialty was provided for the total number of line items for each CMO. Line items (rather than claims) were the item of analysis.

Two assumptions are required for the analysis. First, only claims submitted by a randomly selected sub-sample of providers were considered for the original sample. The assumption is that these providers represent the population of providers. The second assumption is that errors among line items within a claim are independent so that knowledge of an error on one item does not indicate a greater likelihood of an error among the remaining line items within a claim. In the absence of information to the contrary, these are both natural assumptions.

The results below provide not only estimates of population liabilities and receivables, but also the 95% margin of error and the implied confidence band as a measure of reliability calculated under the assumption of normally distributed liabilities and receivables. Of

† This revision differs from the Nov. 18th, 2008 report only in that it relies on recently provided data from WellCare. The results for Amerigroup and Peach State are the same as in the earlier report.

Exhibit II

course, liabilities cannot be positive and receivables cannot be negative. But the calculation of confidence bands under the assumption of normality is mechanical and may yield upper or lower bounds that are wrong-signed. These are kept in the table below but, as a practical matter, the values should be interpreted as zero.

Confidence Interval Total Population Mispayments	AMERIGROUP	PEACH STATE	WELLCARE
Total Sample Liabilities	-\$3.15	-\$329.13	-\$264.91
Total Sample Receivables	\$63.11	\$216.26	\$2,265.45
Total Sample Mispayments	\$59.96	\$112.87	\$2,000.54
Claim detail lines in Sample	500	500	500
Claim detail lines With Mispayments	11	59	71
Percent Claim detail lines with Mispayments	2.2%	11.8%	14.2%
Mean Mispayment	\$0.08	\$0.67	\$3.01
Claim detail lines in Population	4,952,692	5,806,963	6,161,583
95% Lower Bound - Liabilities	-\$61,117	-\$1,913,658	-\$5,263,143
95% Upper Bound - Liabilities	\$11,224	-\$321,927	-\$184,482
Point Estimate - Liabilities	-\$24,946	-\$1,117,793	-\$2,723,813
Margin of Error - Liabilities	\$36,171	\$795,866	\$2,539,330
95% Lower Bound - Receivables	-\$164,906	\$2,331,439	-\$2,176,528
95% Upper Bound - Receivables	\$1,056,592	\$7,710,397	\$44,737,911
Point Estimate - Receivables	\$445,843	\$5,020,918	\$21,280,691
Margin of Error - Receivables	\$610,749	\$2,689,479	\$23,457,220

AMERIGROUP

During the sample period, there were 4,952,692 claim detail lines from providers to Amerigroup. Of the 500 claims in the sample, 11 were in error, implying an error rate of 2.2%. The average mispayment was \$0.08.

Total liabilities for the population were estimated to be -\$24,946. The 95% margin of error was \$36,171 implying an upper bound of \$11,224 (effectively zero) and a lower bound of -\$61,117.

Total receivables for the population were estimated to be \$445,843. The 95% margin of error was \$610,749 implying an upper bound of \$1,056,592 and a lower bound of -\$164,906 (effectively zero).

Exhibit II

PEACH STATE

During the sample period, there were 5,806,963 claim detail lines from providers to Peach State. Of the 500 claims in the sample, 59 were in error, implying an error rate of 11.8%. The average mispayment was \$0.67.

Total liabilities for the population were estimated to be $-\$1,117,793$. The 95% margin of error was $\$795,866$ implying an upper bound of $-\$321,927$ and a lower bound of $-\$1,913,658$.

Total receivables for the population were estimated to be $\$5,020,918$. The 95% margin of error was $\$2,689,479$ implying an upper bound of $\$7,710,397$ and a lower bound of $\$2,331,439$.

WELLCARE

During the sample period, there were 6,161,583 claim detail lines from providers to Wellcare. Of the 500 claims in the sample, 71 were in error, implying an error rate of 14.2%. The average mispayment was \$3.01.

Total liabilities for the population were estimated to be $-\$2,723,813$. The 95% margin of error was $\$2,539,330$ implying an upper bound of $-\$184,482$ and a lower bound of $-\$5,263,143$.

Total receivables for the population were estimated to be $\$21,280,691$. The 95% margin of error was $\$23,457,220$ implying an upper bound of $\$44,737,911$ and a lower bound of $-\$2,176,528$ (effectively zero).

For quality control purposes, Ye Zhang, Assistant Professor of Economics at IUPUI undertook an independent analysis of the same data. His calculations are in agreement with those reported for Amerigroup and Peach State (within a few dollars). He has not reviewed the revised results for WellCare. However, the results were replicated to the dollar when calculated in Excel.