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Myers and Stauffer<sub>LC</sub>

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Certified Public Accountants

## **REPORT 4:**

**GEORGIA FAMILIES PROGRAM**

# **HOSPITAL CLAIMS**

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

**FINAL DRAFT - MARCH 27, 2009**

# TABLE OF CONTENTS

Table of Contents.....	2
Independent Accountant’s Report On Applying Agreed-Upon Procedures .....	3
Background.....	7
Methodology.....	9
Findings.....	12
Recommendations .....	21
Exhibits.....	25
• Exhibit 1: Agreed-Upon Procedures .....	26
• Exhibit 2: Statistician Reports .....	35
• Exhibit 3: Responses from CMOs (to be added at a later date).....	

## 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 inpatient hospital and outpatient hospital 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 the hospital 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 February 19, 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. Robert Sandy** – Professor, Department of Economics, at Indiana University-Purdue University Indianapolis and Assistant Executive Vice President of Indiana University is a statistical specialist who computed the sample size, and target margin of error.
- **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.
- **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.

- **Kick Payment** – A one-time payment made to a CMO for a newborn baby. This payment is in addition to the monthly capitation payment for the newborn and is intended to help offset the cost of labor and delivery.
- **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.
- **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. Subsequent phases of the engagement will likely include similar analyses related to other provider categories.

Previously issued reports, which are available online at <http://dch.georgia.gov>, covered payment and denial trends of hospital claims, as well as certain CMO policies and procedures. This report addresses the payment accuracy of inpatient hospital and outpatient hospital claims by applying agreed-upon procedures to a sample of claim. This report, as well as the previously issued reports, focused on the first several months of the Georgia Families program, June 1, 2006 through August 31, 2007 for Children's Healthcare of Atlanta and December 1, 2006 through August 31, 2007 for all other hospitals.<sup>1</sup> DCH anticipates conducting a subsequent analysis of hospital claims data for the Georgia Families program to determine if there have been changes in the adjudication of hospital 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.

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<sup>1</sup> The Georgia Families Program was implemented on June 1, 2006 for the Atlanta and Central Regions and September 1, 2006 for the remaining regions. Due to issues that could be expected with the implementation of the GF program, the Department indicated that we should only analyze the period from June 1, 2006 through November 30, 2006 for Children's Healthcare of Atlanta. For all other facilities, we would begin the analysis for on claims with dates of service on or after December 1, 2006.

# METHODOLOGY

The objective of this engagement is to apply agreed-upon procedures to test the accuracy of payments for a sample of inpatient hospital, outpatient hospital without emergency room, and outpatient hospital with emergency room 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 hospital 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 hospital provider.

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 for all hospitals other than CHOA. Therefore, for hospital claims paid or denied to Children’s Healthcare of Atlanta (CHOA), claims eligible for selection had dates of service between June 1, 2006 and August 31, 2007. For hospital claims paid or denied to any other hospital, claims had dates of service between December 1, 2006 and August 31, 2007.

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 hospitals, 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 by Dr. Robert Sandy and Dr. David Bivin, statistical consultants to Myers and Stauffer. Drs. Sandy and Bivin developed the methodology based on the results of a previous analysis of Georgia Medicaid and SCHIP fee-for-service claims data that covered State fiscal years 2004, 2005, and 2006.

Under the assumption that the mispayment generating process for hospital claims processed by the CMOs may have similar variability, it was estimated that the proposed sample sizes 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 limited data was 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 hospital 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 hospital claims.

Several sample size options were provided to the Department, ranging from 28,418 claims to 1,374 claims. The Department authorized a sample of 7,960 claims, including 3,615 CHOA claims and 4,345 claims from non CHOA facilities, distributed as follows:

**Table 2: Sample Sizes for CMO Hospital Claims**

Care Management Organization	Claims in Universe	Sample Size	Estimated Margin of Error on Total Mispayments
<b>AMERIGROUP</b>			
CHOA -Outpatient (non-ER)	4,113	368	\$41,130
CHOA -Outpatient (ER)	4,236	369	\$42,360
CHOA -Inpatient	270	192	\$2,700
Other -Outpatient (non-ER)	72,087	402	\$720,870
Other -Outpatient (ER)	72,925	402	\$729,250
Other -Inpatient	19,841	636	\$198,410
<b>AMGP Subtotal</b>	<b>173,472</b>	<b>2,369</b>	
<b>PEACH STATE HEALTH PLAN</b>			
CHOA -Outpatient (non-ER)	48,713	400	\$487,130
CHOA -Outpatient (ER)	21,073	396	\$210,730
CHOA -Inpatient	2,904	536	\$29,040
Other -Outpatient (non-ER)	130,364	403	\$1,303,640
Other -Outpatient (ER)	115,459	402	\$1,154,590
Other -Inpatient	34,504	645	\$345,040
<b>PSHP Subtotal</b>	<b>353,017</b>	<b>2,782</b>	
<b>WELLCARE</b>			
CHOA -Outpatient (non-ER)	34,170	399	\$341,700
CHOA -Outpatient (ER)	31,803	399	\$318,030
CHOA -Inpatient	3,607	556	\$36,070
Other -Outpatient (non-ER)	217,525	403	\$2,175,250
Other -Outpatient (ER)	213,906	403	\$2,139,060
Other -Inpatient	51,660	649	\$516,600
<b>WC Subtotal</b>	<b>552,671</b>	<b>2,809</b>	
<b>Total Sample Size</b>	<b>1,079,160</b>	<b>7,960</b>	

A data request was prepared for each CMO that included the entire universe of hospital 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 data submitted.

Once the claims universe was loaded and our questions addressed, 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 based on the service category and provider groups 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 provider category.

Each sampled claim was selected and tested at the “header” 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 the 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 hospital 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 whether the denial or suspension appeared to be appropriate.
- 3) If the claim payment status of “denied” or “suspended” appeared to not be appropriate, we computed the expected payment for the claim based on the contract between the hospital and the CMO.
- 4) If the claim payment status was “paid”, we computed the expected payment for the claim based on the contract between the hospital and the CMO.
- 5) We computed the dollar value of the mispayment, as applicable, for the claim.
- 6) The identified mispayments were sent to the CMO and/or hospital provider for comment and additional information. The CMOs were asked to provide their own calculation of the claim payment based on the contract with the provider. In the event of a dispute between Myers and Stauffer and the CMO, the Department’s decision regarding the mispayment constituted the final decision.

Upon completing the analysis for each sampled claim, the results were sent to Dr. Sandy and Dr. Bivin to complete the analyses of the mean per claim mispayment amounts, total mispayment amounts, and confidence intervals for each CMO. Dr. Sandy was not available to compute the estimates; therefore the estimates were computed by Dr. Bivin and Dr. Ye Zhang. 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 inpatient hospital claims, outpatient hospital claims without emergency room services, and outpatient hospital claims with emergency room services 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 hospital 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 hospital provider as necessary on the claims.

The claims universe included CMO paid and denied claims of both Medicaid and PeachCare members for the first several months of the Georgia Families program, but excluding the initial start-up period for all hospitals other than CHOA. For claims paid or denied to Children’s Healthcare of Atlanta (CHOA), claims have dates of service between June 1, 2006 and August 31, 2007. For all other claims (non-CHOA), paid or denied claims have dates of service between December 1, 2006 and August 31, 2007.

The following tables display the findings by CMO. For each CMO, separate tables are used to display the findings for Children’s Healthcare of Atlanta and all other hospitals.

**Table 3: Summary of Claims Payment Accuracy**

Table 3a: AMGP Claims Sample	Children’s Healthcare of Atlanta (CHOA) Dates of Service 6/1/06 through 8/31/07			All Other Hospitals – Dates of Service 12/1/06 through 8/31/07		
	Inpatient Claims	Outpatient Claims w/o Emergency Room	Outpatient Claims w/ Emergency Room	Inpatient Claims	Outpatient Claims w/o Emergency Room	Outpatient Claims w/ Emergency Room
Sample Size	192	368	369	636	402	402
Claims Paid/Denied Correctly	186	208	126	615	343	365
Percent of Claims Paid/Denied Correctly	96.87%	56.52%	34.15%	96.70%	85.32%	90.80%

<b>Table 3b: PSHP</b>	<b>Children's Healthcare of Atlanta (CHOA) Dates of Service 6/1/06 through 8/31/07</b>			<b>All Other Hospitals – Dates of Service 12/1/06 through 8/31/07</b>		
<b>Claims Sample</b>						
	Inpatient Claims	Outpatient Claims w/o Emergency Room	Outpatient Claims w/ Emergency Room	Inpatient Claims	Outpatient Claims w/o Emergency Room	Outpatient Claims w/ Emergency Room
Sample Size	536	400	396	645	403	402
Claims Paid/Denied Correctly	530	304	319	645	379	384
Percent of Claims Paid/Denied Correctly	98.88%	76.00%	80.56%	100.00%	94.04%	95.52%

<b>Table 3c: WellCare</b>	<b>Children's Healthcare of Atlanta (CHOA) Dates of Service 6/1/06 through 8/31/07</b>			<b>All Other Hospitals – Dates of Service 12/1/06 through 8/31/07</b>		
<b>Claims Sample</b>						
	Inpatient Claims	Outpatient Claims w/o Emergency Room	Outpatient Claims w/ Emergency Room	Inpatient Claims	Outpatient Claims w/o Emergency Room	Outpatient Claims w/ Emergency Room
Sample Size	556	399	399	649	403	403
Claims Paid/Denied Correctly	548	395	398	630	403	402
Percent of Claims Paid/Denied Correctly	98.56%	99.00%	99.75%	97.07%	100.00%	99.75%













## Table 5: Mispayment Statistics

The following is a summary of the number mispayments and percentage for the top 10 hospitals, by volume of mispayments, for each health plan.

Table 5a: AMGP (Sample Size = 2,369)		
Hospital Name	# of Mispayments	% of Sample
HUGHES SPALDING	398	16.80%
GRADY MEMORIAL HOSPITAL	23	0.97%
MEDICAL COLLEGE	21	0.89%
UNIVERSITY HOSPITAL	9	0.38%
NORTHEAST GEORGIA MEDICAL CENTER	8	0.34%
MEMORIAL HEALTH UNIVERSITY MEDICAL CENTER	8	0.34%
EMORY CRAWFORD LONG HOSPITAL	7	0.30%
ATHENS REGIONAL MEDICAL CENTER	6	0.25%
SCOTTISH RITE CHILDRENS MED CTR	6	0.25%
CHILDRENS HLTH CARE OF ATL EGLESTON	4	0.17%
All Other Hospitals (n=25)	36	1.52%
<b>Total</b>	<b>526</b>	<b>22.20%</b>

Table 5b: PSHP (Sample Size = 2,782)		
Hospital Name	# of Mispayments	% of Sample
SCOTTISH RITE CHILDRENS MED CTR	89	3.20%
CHILDRENS HLTH CARE OF ATL EGLESTON	70	2.52%
COFFEE REGIONAL MEDICAL CTR	7	0.25%
WEST GEORGIA MEDICAL CTR	5	0.18%
MEMORIAL HOSPITAL AND MANOR	5	0.18%
HENRY MEDICAL CENTER	4	0.14%
HOUSTON MEDICAL CENTER	3	0.11%
NORTHSIDE HOSPITAL – CHEROKEE	3	0.11%
PHOEBE PUTNEY MEMORIAL HOSPITAL	3	0.11%
SOUTH GEORGIA MEDICAL CENTER	3	0.11%
All Other Hospitals (n=23)	29	1.04%
<b>Total</b>	<b>221</b>	<b>7.94%</b>

Table 5c: WellCare (Sample Size = 2,809)		
Hospital Name	# of Mispayments	% of Sample
SCOTTISH RITE CHILDRENS MED CTR	7	0.25%
IRWIN COUNTY HOSPITAL	5	0.18%
CHILDRENS HLTH CARE OF ATL EGLESTON	4	0.14%
LIBERTY REGIONAL MEDICAL CENTER	4	0.14%
DOCTORS HOSPITAL	2	0.07%
SATILLA REGIONAL	1	0.04%
MEDICAL COLLEGE	1	0.04%
WAYNE MEMORIAL	1	0.04%
COLISEUM MEDICAL	1	0.04%
HAMILTON MEDICAL	1	0.04%
All Other Hospitals (n=6)	6	0.21%
<b>Total</b>	<b>33</b>	<b>1.17%</b>

# Recommendations

We make the following observations and recommendations regarding hospital 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, but excluding the initial start-up period for all hospitals other than CHOA. 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) There was limited information available regarding the CMOs' bundling, coding, and pricing policies. Detailed bundling policies and service limits should be identified within the contract or referenced when applicable. As included in a prior report, we noted that a high percentage of denied hospital claims was related to coding policies, coding inconsistencies, and benefit limits. Furthermore, we found that many of these policies and procedures do not appear to be clearly described or may not be available.
- 2) Contracts between CMOs and providers should clearly identify 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.
- 3) Contracts between the CMOs and providers should identify instances in which payments are limited to billed charges. One CMO indicated that, due to a contracting issue prior to the Georgia Families program implementation, many of their contracts did not correctly identify situations where claim payments were limited to billed charges. This CMO provided a list of providers that, according to the CMO's records, were limited to billed charges. In many cases, the information on this list contradicted the information in the hospital contract.
- 4) Contracts should identify situations in which the Medicaid fee-for-service fee schedules or payment policies are the default basis for payment.
- 5) Contracts we reviewed were not always clear with respect to payments for graduate medical education (GME). Many of the contracts suggested that GME payments would be made. Since GME payments are not made under the Georgia Families Program, references to GME, other than to

specify that payments will not be made, should be removed from provider contracts.

- 6) For the hospital providers noted in the tables above that constitute the greatest share of the mispayments within each CMO's claims sample, we recommend that each CMO carefully review the claims identified with mispayments for each hospital 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 offer additional educational opportunities to the provider.

### **Recommendation Applicable to DCH**

- 7) Responses from one CMO suggested that the CMO had loaded, perhaps incorrectly, a fee schedule at the implementation of the Georgia Families program. That particular fee schedule has payment amounts that were significantly different from the Medicaid fee schedule in effect. However, the contracts between the CMO and the provider permit the CMO to use their fee schedule in effect. Therefore, the CMO could use any version of a fee schedule and still technically be in compliance with that contract. The CMO could not provide documentation to support the use of this fee schedule. The CMO did provide the date that the fee schedule was changed and the fees included on the updated fee schedule more closely tie to the DCH fee schedule.

To address this issue, DCH may wish to require CMOs to publish fee schedules (i.e., not to include contracted payment rates) with clearly identifiable effective and end dates. If DCH chooses to implement this recommendation, updates to the fee schedule should only be made with public notice and consent from the Department. These fee schedules should be readily accessible.

### **Recommendation Applicable to Hospital Providers**

- 8) In some cases, the contracts between the CMOs and hospitals, as well as the provider manuals and written policies of the CMOs, include terms and information that might be subject to interpretation. Hospitals have ultimate responsibility for the contracts they execute and should exercise increased due diligence before signing contracts with the CMOs. Hospital 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.

- 9) Based on the findings above that indicate that a significant number of over and underpayments are occurring between providers and certain CMOs, we would encourage these providers and CMOs to continue to work together to resolve these payment issues.

### **Analytical Limitations**

- Certain hospital provider contracts for one CMO contain provisions for an annual increase in the rate paid for covered outpatient services. The calculation of this annual increase includes the hospital-reported aggregate percentage increase in charges effective each January 1<sup>st</sup>. In some cases, insufficient data was available to allow us to determine if the increase in the rates for these covered outpatient services occurred, or if claims processed using the increased rates were accurately adjudicated.
- In some cases, the CMOs appeared to adjust, reprocess, or correct 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 hospital providers by the CMO's or owed by hospital providers to CMOs.
- There were claims that we identified as potential mispayments that the CMOs did not agree were incorrect. We accepted the CMOs' responses as accurate, and did not test their responses for accuracy. Additional testing may be performed on these claims at the request of the Department.
- Due to limited information and documentation, we were not able to test the interest payment calculations from the CMOs.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the inpatient hospital and outpatient hospital 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  
October 16, 2008

# Exhibits

## EXHIBIT 1

**Department of Community Health  
State Fiscal Year (SFY) 2007  
Georgia Families Program  
Hospital Claims Testing  
February 19, 2008**

This document provides a summary of the study methodology and agreed-upon procedures used for Georgia Families Program hospital claims testing performed for 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.

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- **Adjudicate** – A determination of the outcome of a healthcare claim. 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 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.
- **Diagnosis Related Group (DRG)** – A group assigned to an inpatient hospital episode of care. Groups are based on similar resource requirements for the treatment of medical conditions. Claims are assigned a group using diagnosis and procedure codes, the age and sex of the patient, the patient status, and birth weight for neonates.
- **Georgia Families (GF)** – The risk-based managed care delivery program for Medicaid and PeachCare for where the Department contracts with Care Management Organizations to manage the care of eligible recipients.
- **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.

## **EXHIBIT 1**

- 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 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.
- 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

### **Objective**

The objective of this engagement is to apply agreed-upon procedures to test the accuracy of payments for a sample of inpatient, outpatient claims without emergency room, and outpatient claims with emergency room 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 hospital provider. If a claim is paid incorrectly, we will determine the amount of the underpayment (liability) or overpayment (receivable) for the claim in consultation with the CMO, the Department, and/or the hospital provider.

### **Claims Universe**

The claims universe will include CMO paid and denied claims of both Medicaid and PeachCare members for inpatient, outpatient claims without emergency room, and outpatient claims with emergency room. For claims paid or denied to Children’s Healthcare of Atlanta (CHOA), claims will have dates of service between June 1, 2006 and August 31,

## **EXHIBIT 1**

2007. For all other claims (non-CHOA), paid or denied claims will have dates of service between December 1, 2006 and August 31, 2007.

### **Deliverables**

Total liabilities, total receivables, and total net mispayments will be computed for the sample 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 service level and each CMO. This information will generally be presented as illustrated in the example tables below by CMO.

**EXHIBIT 1**

<b>CMO 1</b>	<b>Children's Healthcare of Atlanta (CHOA)</b>		
	<b>Claims Sample</b>		
	Inpatient Claims	Outpatient Claims w/o Emergency Room	Outpatient Claims w/ Emergency Room
Sample Liabilities			
Sample Receivables			
Sample Net Mispayments			
Claims in Sample			
Claims with Mispayments			
Percent Claims with Mispayments			

**EXHIBIT 1**

<b>CMO 1</b>	<b>Children's Healthcare of Atlanta (CHOA)</b>		
<b>Confidence Interval Total Population Mispayments</b>			
	Inpatient Claims	Outpatient Claims w/o Emergency Room	Outpatient Claims w/ Emergency Room
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			

**EXHIBIT 1**

<b>CMO 1</b>	<b>Other Hospitals</b>		
<b>Claims Sample</b>			
	Inpatient Claims	Outpatient Claims w/o Emergency Room	Outpatient Claims w/ Emergency Room
Sample Liabilities			
Sample Receivables			
Sample Net Mispayments			
Claims in Sample			
Claims with Mispayments			
Percent Claims with Mispayments			

**EXHIBIT 1**

<b>CMO 1</b>	<b>Other Hospitals</b>		
<b>Confidence Interval Total Population Mispayments</b>			
	Inpatient Claims	Outpatient Claims w/o Emergency Room	Outpatient Claims w/ Emergency Room
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			

## **EXHIBIT 1**

### **Sampling Methodology and Testing Procedures**

A random sample of paid and denied claims will be drawn from the universe of claims and the liability, receivable, and net mispayment for the sample will be computed for each CMO. The sample period for claims paid or denied to Children's Healthcare of Atlanta (CHOA) is claim dates of service between June 1, 2006 and August 31, 2007. For all other facilities (non-CHOA), paid or denied claims will have dates of service between December 1, 2006 and August 31, 2007. The Department requested that the sample of claims include the following characteristics:

- 10-15% of claims will be paper submissions.
- 10% of claims will be denials.
- At least 6 claims will be from a rural hospital.
- At least 6 claims will be from a large urban hospital.

All claims will be tested at the header level; all line level pricing for each sampled claim will be confirmed. We will test the final payment amount (i.e., net of all known adjustments as of date claims data was submitted to Myers and Stauffer) made to the provider by the CMO. We will independently re-price each claim in the sample based on the contract between the CMO and the hospital provider 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 determine whether the denial or suspension is appropriate.
- 3) If the claim payment status of 'denied' or 'suspended' is not appropriate, compute the expected payment for the claim based on the contract between the hospital and the CMO.
- 4) If claim payment status is 'paid', compute the expected payment for the claim based on the contract between the hospital and the CMO.
- 5) Compute the dollar value mispayment, as applicable, for the claim.
- 6) Identified mispayments may be sent to the CMO and/or hospital provider for comment. In the event of a dispute between Myers and Stauffer and the CMO, the Department's decision regarding the mispayment will constitute the final decision.

### **M&S Workpapers**

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

### **Data Sources**

Each CMO will supply us with 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, we will accept this information as accurate and reliable. The CMO may provide additional information on the selected claims as necessary.

### **Sample Size and Precision Requirements**

In a January 31, 2008 report entitled "Report on Sample Sizes for Georgia Care Management Organization (CMO) Claim Sampling", Drs. Sandy and Bivin presented several options for sample sizes and margin of error combinations. The Department instructed

## EXHIBIT 1

Myers and Stauffer to use the sample sizes associated with a  $\pm$  \$10 estimated margin of error. The total sample from all CMOs and hospital service categories is 7,960 claims, including 3,615 CHOA claims and 4,345 claims from other hospitals (i.e., non CHOA facilities). It should be noted that achieving the estimated margin of error within  $\pm$  \$10 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 hospital claims. Please refer to the aforementioned report for a description of the assumptions and methodology used by Drs. Sandy and Bivin.

<b>Sample Sizes for CMO Hospital Claims Based on the Per Claim Estimated Margin of Error</b>			
<b>Care Management Organizations</b>	<b>Universe</b>	<b><math>\pm</math> \$10 Margin of Error</b>	
	Claim Count	Sample Size	half width of total
<b>AMERIGROUP</b>			
CHOA -Outpatient (non-ER)	4,113	368	\$41,130
CHOA -Outpatient (ER)	4,236	369	\$42,360
CHOA -Inpatient	270	192	\$2,700
Other -Outpatient (non-ER)	72,087	402	\$720,870
Other -Outpatient (ER)	72,925	402	\$729,250
Other -Inpatient	19,841	636	\$198,410
<b>AG Subtotal</b>	<b>173,472</b>	<b>2,369</b>	
<b>PEACH STATE</b>			
CHOA -Outpatient (non-ER)	48,713	400	\$487,130
CHOA -Outpatient (ER)	21,073	396	\$210,730
CHOA -Inpatient	2,904	536	\$29,040
Other -Outpatient (non-ER)	130,364	403	\$1,303,640
Other -Outpatient (ER)	115,459	402	\$1,154,590
Other -Inpatient	34,504	645	\$345,040
<b>PSHP Subtotal</b>	<b>353,017</b>	<b>2,782</b>	
<b>WELLCARE</b>			
CHOA -Outpatient (non-ER)	34,170	399	\$341,700
CHOA -Outpatient (ER)	31,803	399	\$318,030
CHOA -Inpatient	3,607	556	\$36,070
Other -Outpatient (non-ER)	217,525	403	\$2,175,250
Other -Outpatient (ER)	213,906	403	\$2,139,060
Other -Inpatient	51,660	649	\$516,600
<b>WC Subtotal</b>	<b>552,671</b>	<b>2,809</b>	
<b>Total Sample Size</b>	<b>1079,160</b>	<b>7,960</b>	

### **Timeline**

Testing of claim payments will begin upon the Department's approval of these agreed upon procedures and continue through approximately April 2008. Approximately 6 weeks will be used to complete this analysis.

## EXHIBIT 2

### **Memorandum**

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**Date:** October 15, 2008

**From:** Ye Zhang

**RE:** Georgia Care Management Organization (CMO) Claim Confidence Interval and Margin of Error Check

The attached Excel workbook contains results produced by me from the three claims data file, namely, AmeriGroup, Peach State, and WellCare. Each spreadsheet in the workbook corresponds to one of the three CMOs.

The 95% confidence interval estimates for total liabilities, total receivables, and total mispayments are produced with statistical software, STATA. The red-highlighted cells are where my results differ from the original results, which were provided in the three original spreadsheets. The differences are due the more accurate approximation of the sampling distribution compared to the use of 1.96 in the original file, and I recommend adjusting the results according to my calculations. *[M&S Note: Results adjusted as recommended.]*

As a result of that, the margins of error, which are also highlighted in my file, need to be adjusted accordingly. *[See M&S Note above.]*

*[Regarding the]* Other part of the statistical analysis, my results are consistent with the original results, hence I confirm.